BOWDOIN COLLEGE
FLEXIBLE BENEFITS PLAN

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Bowdoin College (the "Employer") has established the Bowdoin College Flexible Benefits Plan (the "Plan") to provide its eligible employees with the choice of receiving non-taxable qualified employee benefits or cash compensation. The Plan is intended to qualify as a nondiscriminatory "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended. As amended and restated herein, the Plan is generally effective January 1, 2009, except as otherwise indicated, and provided that any provision affecting Unearned Compensation (as defined herein) shall not be effective before the adoption date written below.

ARTICLE I Definitions and Construction

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

to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

The Employee shall submit to the Plan Administrator written certification by a qualified physician with respect to the Child's incapacity initially within thirty-one (31) days of the date on which the Child attained age nineteen (19), and thereafter, at such reasonable intervals as may be requested by the Plan Administrator. In addition, the Plan Administrator may require that the Child be examined by a qualified physician selected by the Plan Administrator. A Child described in this subsection (c) shall cease to be treated as a Child as of (i) the date the individual ceases to be incapacitated, (ii) the date the Employee fails to submit proof of incapacity, or (iii) the date the Employee refuses to permit an examination of the Child by a qualified physician selected by the Plan Administrator.

1.4 "COBRA" means the health care continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 and Section 4980B of the Code, and the regulations and other official guidance issued thereunder, as amended from time to time.

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

1.6 "Contract Administrator" means the person or persons appointed by the Plan Administrator to perform any of the Plan Administrator's administrative functions, powers, and duties under the Plan. In the event that no Contract Administrator is appointed, the Plan Administrator shall be the Contract Administrator.

1.7 "Dependent" of a Parti

(f) the Employee and the Domestic Partner have filed a Certification of Domestic Partnership with the Employer; and

(g) the Domestic Partnership has been in existence for at least twelve (12) months prior to the effective date of the Certification submitted to the Employer.

1.9 "Eligibility Date" means the first day on which an Employee is eligible to participate in the Plan in accordance with Section 2.1.

1.10 "Eligible Employee" means an Employee who is regularly scheduled to work twenty (20) or more hours per week.

1.11 "Employee" means any individual who is employed by the Employer. The determination of an individual's employment status for all purposes under the Plan shall be made by the Employer in accordance with its standard classification and employment practices, which shall be nondiscriminatorily applied and communicated to its Employees, and without regard to the classification or reclassification of the individual by any other party.

1.12 "Employer" means Bowdoin College.

1.13 "ERISA" means the Employee Retirement Income Security Act of 1974, and any regulations and other official guidance issued thereunder, as amended from time to time, to the extent that ERISA affects this Plan.

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

1.15 "Group Health Plan" means a Benefit Plan that is a group health plan within the meaning of Code Section 5000(b)(1) and any regulations issued thereunder, as amended from time to time, that is made available under this Plan, and includes any coverage option (including any no-cluding time ERI r s a any 33 W: rde,

"Plan Administrator" means the person or persons appointed in accordance with Section 12.1.

Participation with respect to a Reimbursement Account shall cease on the last day of the Plan Year if the Participant fails to make a timely, proper Benefit Election with respect to the Reimbursement Account during the Open Enrollment Period for the next succeeding Plan Year.

In the event that a Participant's participation in the Plan ceases, the Participant may be eligible to elect continuation of coverage of certain Qualified Benefits in accordance with the provisions of Article VI or the terms of the Benefit Plans providing the Qualified Benefits.

ARTICLE III Coverage of Dependents and Domestic Partners

3.1 **Coverage under Certain Benefit Plans.**

4.2 **Initial Benefit Election.**

(a) An Eligible Employee's initial Benefit Election shall be effective as of his or her Eligibility Date provided the Benefit Election is filed with the Plan Administrator on or before the Eligibility Date.

(b) If an Eligible Employee's Benefit Election is not filed with the Plan Administrator on or before the Eligibility Date, then the Eligible Employee may file a Benefit Election within thirty (30) days of his or her Eligibility Date. If the Benefit Election is filed with the Plan Administrator on the first day of a month, then the Benefit Election shall become effective on the day filed. If the Benefit Election is filed with t

ARTICLE V Benefit Election Changes

A Participant may revoke a Benefit Election during a Plan Year and make a new election for the remaining portion of the year only in accordance with this Article.

5.1 **Special Enrollment** A Participant may change his or her Benefit Election to elect coverage under an Employer Group Health Plan during a Plan Year upon the occurrence of an event described in this Section 5.1 ("Special Enrollment event") if the Participant and/or his or her Spouse or Child, as the case may be, is otherwise eligible to enroll in the Group Health Plan.

(a) The Participant and/or his or her Spouse or Child lose coverage under another Group Health Plan during such year (the "Other Coverage") and -

(i) the Participant elected no coverage under the Employer Group Health Plan for himself or herself or for his or her Spouse or Child, in his or her most recent Benefit Election on account of the Other Coverage and, if required by the Plan Administrator at the time of the Benefit Election, stated in writing that the Other Coverage was the reason for the no-coverage election; and

(ii) the Other Coverage is lost for one the following reasons: (1) the Other Coverage is health care continuation coverage under COBRA, and the COBRA coverage has ceased for any reason other than the Participant's (or Spouse's or Child's) failure to pay premiums on a timely basis or termination of coverage for cause; or (2) the Other Coverage was not health care continuation coverage under COBRA and either the Participant or his or her Spouse or Child, as the case may be, has ceased to be eligible for the Other Coverage or contributions by any current or former employer toward the Other Coverage have terminated.

The Participant may elect coverage for himself or herself, if the Participant has lost Other Coverage, and may elect coverage for a Spouse or Child if such individual has lost Other Coverage. The Special Enrollment election shall be effective as of the first day of the calendar month coinciding with or next following the date that the completed election form is received by the Plan Administrator, provided the form is received within 31 days of the Special Enrollment event.

Notwithstanding the foregoing, if the Other Coverage is coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act ("Medicaid/CHIP Coverage"), then subsection (c) below shall apply in lieu of this subsection (a).

(b) An individual becomes the Spouse or Child of the Participant during such year. The Participant may elect coverage for (i) himself or herself; (ii) his or her Spouse, if either the Participant acquires the Spouse during the year or the Participant and his or her Spouse acquire a Child during the year; and/or (iii) his or her Child, if the Participant acquires the Child during the year. If the Special Enrollment event is the marriage of the Participant, then the Special Enrollment election to add the Spouse (and Participant if he or she so elects) shall be effective as the

first day of the month coinciding with or next following the date the completed election form is received by the Plan Administrator, provided the form is received within 31 days of the Special Enrollment event. If the Special Enrollment event is a birth, adoption, or placement for adoption, then the Special Enrollment election shall be effective as of the date of such birth, adoption, or placement for adoption, as the case may be, provided the Plan Administer receives the completed Special Enrollment election form within 31 days of the Special Enrollment event.

(c) The Participant and/or his or her Spouse or Child loses Medicaid/CHIP Coverage during such year, and the Medicaid/SCHIP coverage is terminated as a result of loss of eligibility for such coverage. The Participant may elect coverage for himself or herself, if the Participant has lost Medicaid/SCHIP Coverage, and may elect coverage for a Spouse or Child if such individual has lost Medicaid/SCHIP Coverage. The Special Enrollment election shall be effective as of the first day of the calendar month coinciding with or next following the date that the completed election form is received by the Plan Administrator, provided the form is received not later than 60 days after the Special Enrollment event.

(d) The Participant and/or his or her Spouse or Child becomes eligible for assistance, with respect to coverage under the Employer Group Health Plan, under a plan providing Medicaid/SCHIP Coverage (including under any waiver or demonstration project conducted under or

strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that results in the individual becoming or ceasing to be eligible for coverage under this Plan, a Benefit Plan, or a Family Member Plan due to eligibility requirements based on employment status;

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

(v) a change in the place of residence of the Participant or his or her Spouse or Child; and

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

(b) A Benefit Electio

5.4 **Entitlement to Medicare or Medicaid**. A Participant may make a prospective Benefit Election change during a Plan Year with respect to a Group Health Plan:

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

(b) if the Participant, Spouse or Child who has been enrolled for such coverage under Medicare or Medicaid loses eligibility for such coverage; provided the Benefit Election change shall be limited to commencing or increasing coverage for that individual under the applicable Group Health Plan.

5.5 **Significant Cost or Coverage Changes**. A Participant may make a Benefit Election change during a Plan Year (except with respect to a health care reimbursement plan) as a result of changes in cost or coverage as provided below:

(a) Cost Changes.

(i) If the cost of a Benefit Plan increases or decreases during a Plan Year and, under the terms of such plan, Participants are required to make a corresponding change in their contributions, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participants' contributions for such plan.

(ii) If the cost charged to a Participant for a Qualified Benefit or a coverage option under a Group Health Plan (collectively, "benefit package option") significantly increases or significantly decreases during a Plan Year, the Participant may make a corresponding Benefit Election change. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, making a Benefit Election change either to receive on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other option providing similar coverage is available.

For purposes of this paragraph (a), a cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether that increase or decrease results from an action taken by the Participant or by the Employer, or in the case a dependent care reimbursement plan, an action taken by the dependent care provider. This paragraph (a) applies in the case of a dependent care reimbursement plan only if the cost change is imposed by a dependent care provider who is not a relative of the Eligible Employee (as described in Code Section 152(a)(1) through (8), incorporating the rules of Code Section 152(b)(1) and (2).

(b) Coverage Changes

(i) If a Participant (or his or her Spouse or Child) has a significant curtailment of coverage under a plan during a Plan Year that is not a loss of coverage as described in subparagraph (ii) below, the Participant may make a Benefit Election change to revoke

his or her election for that coverage and, in lieu thereof, to receive on a prospective basis coverage under another benefit package option providing similar coverage. For this purpose, coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(ii) If a Participant (or his or her Spouse or Child) has a significant curtailment that is a loss of coverage, the Participant may make a Benefit Election change to revoke his or her election and, in lieu thereof, either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar option is available. For this purpose, a loss of coverage means a complete loss of coverage under the benefit package option or other coverage option, a substantial decrease in the medical care providers available under the option, a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Child is currently in a course of treatment, or any other similar fundamental loss of coverage.

(iii) If a Benefit Plan adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a Plan Year, an Eligible Employee (whether or not he or she has previously made a benefit election under the Plan or has previously elected the benefit package option) may make a Benefit Election change to revoke his or her Benefit Election under the Plan and, in lieu thereof, elect on a prospective basis coverage under the new or improved option.

(iv) A Participant may make a prospective Benefit Election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if (A) the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under Sections 5.1 through 5.6 of this Article V (disregarding this subsection 5.5(b)(iv)), or (B) the Plan Year under this Plan is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

(v) An Eligible Employee may make a Benefit Election change on a prospective basis to add coverage under the Plan for himself or herself, his or her Spouse or his or her Child, if the Employee, Spouse, or Child loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

(A) A State's children's health insurance program (CHIP) under Title XXI of the Social Security Act;

(B) A medical care program of an Indian Tribal government (as defined in Section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organizatio

5.6 **Family or Medical Leave**. A Participant taking a Family or Medical Leave may make a Benefit Election change during a Plan Year to revoke his or her existing election of a group health Qualified Benefit for the remaining period of coverage, and a Participant who returns to employment as an Eligible Employee following his or her Family or Medical Leave may make a Benefit Election change during a Plan Year to reinstate group health Qualified Benefits on the same terms as were in effect for the Participant immediately prior to the Family or Medical Leave, except where a further Benefit Election change is permitted under other provisions of this Article V.

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

(b) If a Participant elects to continue one or more group health Qualified Benefits during a Family or Medical Leave and the Family or Medical Leave is unpaid leave, the Participant may make a Benefit Election change -

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

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

Notwithstanding the foregoing to the contrary:

(iii) If a Participant f ny Familimta r ccoerRyqm Wth p3pyrm Wtnycou 3 W: ryb r Wk tpbc p

5.7 **Revocation and New Election**. A revocation of a Benefit Election (and a new Benefit Election) shall be made by such written, telephonic, or electronic means as shall be prescribed by the Plan Administrator and must be received by the Plan Administrator within thirty-one (31) days after the date of the event described in Sections 5.1 through 5.6 to which it relates (sixty (60) days for an event described in Section 5.1(c) and (d)), and if not so made and received shall be void. In such event, the revocation and new Benefit Election shall be effective as of the first day of the month coinciding with or next following the date that the Benefit Election is received by the Plan Administrator, except as provided in Section 5.1 and Code Section 9801(f)(2)(B).

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

ARTICLE VI Qualified Benefits

6.1 **Qualified Benefits.** The Qualified Benefits that Eligible Employees may elect under the Plan are listed in the Appendix to the Plan and described in the separate Benefit Plans, as amended from time to time. The Plan Administrator shall give written notice to each such Employee of the Qualified Benefits that he or she may elect and the amount of Employer contributions (withheld Unearned Compensation) required to purchase each such Qualified Benefit. The period during which all Qualified Benefits shall be available (period of coverage) is the Plan Year.

6.2 **Employer Contributions.** The maximum amount of Employer contributions on behalf of a Participant for any Plan Year shall not exceed Twenty Thousand Dollars ($20,000.00). Employer contributions shall mean Unearned Compensation withheld in accordance with Section 6.3 that has not been actually or constructively received by a Participant.

6.3 **Withholding Unearned Compensation.** By returning a Benefit Election form to the Plan Administrator, an Eligible Employee shall be deemed to have authorized the Employer to withhold each pay period from his or her Unearned Compensation the amounts necessary to provide the benefits or pay the insurance premiums which he or she has elected. The Employer shall promptly apply all amounts withheld to provide the Qualified Benefits.

6.4 **Unused Contributions or Benefits**. Except as otherwise provided herein, if at the end of any Plan Year it is determined that the amount of Employer contributions (withheld Unearned Compensation) on behalf of a Participant exceeds the amount of his or her approved benefit claims with respect to a Qualified Benefit elected by such Participant for such Plan Year, then the excess shall be forfeited by the Participant and applied by the Employer to defray administrative expenses. A Participant's unused Employer contributions or benefits may not be carried over to provide benefits to such Participant in a subsequent Plan Year.

6.5 **Receipt of Benefits.** All claims for benefits shall be subject to and governed by the terms and conditions of the particular Benefit Plan through which the benefit is provided. To the extent that a benefit is provided through the purchase of insurance, the Employer shall have no independent obligation to provide benefits in excess of those provided by the insurer.

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

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

In no event shall a Participant receive reimbursement for claims incurred under a Group Health Plan while he or she was not covered under such Group Health Plan.

7.3 **COBRA Continuation Coverage**

(a) Eligibility. A Participant and his or her Spouse or Child shall have the right to purchase COBRA Continuation Coverage provided such individual was a covered person under

no independent right to COBRA Continuation Coverage, except to the extent that such Child is a Qualified Beneficiary.

(d) Duration of COBRA Continuation Coverage. COBRA Continuation Coverage shall continue for the periods described below.

(i) If Continuation Coverage is due to termination of employment or a reduction in hours, then the maximum Continuation Coverage period is 18 months.

(ii) If Continuation of Coverage is due to the Participant's termination of employment or a reduction in hours, and a second Qualifying Event occurs during the 18-month period, then the Spouse and Child(ren) may be entitled to elect up to 18 months of additional coverage for a maximum Continuation Coverage period of 36 months. This extended coverage for a second Qualifying Event is available only if the Plan Administrator is notified of the second event in accordance with Section 7.3(g)(i).

(iii) If Continuation Coverage is due to death, divorce, legal separation, Medicare enrollment, or ceasing to be a Dependent Child, then the maximum Continuation Coverage period is 36 months.

(iv) If a Participant becomes enrolled in Medicare Part A or B and then experiences a termination of employment or reduction in hours, then the maximum Continuation Coverage period is the later of 36 months from the date of Medicare enrollment or 18 months (29 months if there is a disability extension) after the Covered Employee's termination of employment or reduction in hours.

(e) Special Provisions for Disability. If a Participant loses coverage as a result of his or her termination of employment or reduction in hours, and the Participant or another Qualified Beneficiary is determined to be disabled in accordance with Title II or Title VI of the Social Security Act at any time during the first 60 days of Continuation Coverage, then the 18-month coverage period may be extended by an additional 11 months for all Qualified Beneficiaries up to 29 months. The first 60 days of Continuation Coverage are measured from the Participant's date of termination of employment or reduction in hours or, if later, the date on which the Participant would lose regular coverage as a result of his or her termination of employment or reduction in hours. This extended coverage for disability is available only if the Plan Administrator is notified of the disability determination in accordance with paragraph (g) below.

(f) Special Provisions for Region-Specific Plans. Qualified Beneficiaries who lose coverage on account of moving outside of the service area of a region-specific plan (, an HMO plan), will be offered alternative coverage (if such alternative coverage is available to active Employees). Such alternative coverage, if any, must be offered by the date the Qualified Beneficiary relocates, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage. However, the Company need only provide benefit

(g) Notice Requirements.

(i) The Participant or covered Spouse or Child must notify the Employer of a divorce, legal separation, or a Child's loss of dependent status under a Plan within 60 days of the later of (A) the date of the event or (B) the date on which coverage would be lost because of the event. In addition, if the Participant or another Qualified Beneficiary is determined by the Social Security Administration to be disabled, then the disabled person must notify the Plan Administrator in writing within 60 days of the date that is the later of (i) the date he or she is determined to be disabled, and (ii) the date on which the Qualified Beneficiary is informed of both the responsibility to provide the notice to the Plan Administrator and the procedures for providing the notice. Notwithstanding the foregoing, the notice must be provided before the end of the initial 18-month Continuation Coverage Period. A Qualified Beneficiary also must notify the Plan Administrator of the occurrence of a second Qualifying Event after he or she has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

(ii) The Employer shall notify the Plan Administrator of the Qualifying Event within 30 days of the Employee's or Dependent's death, termination of employment, or reduction in hours, Medicare entitlement, or if the Employer commences a bankruptcy proceeding.

(iii) A Qualified Beneficiary who is determined by the Social Security Administration to no longer be disabled is responsible for notifying the Plan Administrator of such determination within 30 days of the determination. A Qualified Beneficiary also is responsible for notifying the Plan Administrator if he or she becomes covered under another Group Health Plan.

When the Plan Administrator is notified that one of the events described in (i) or (ii) has occurred, the Plan Administrator shall in turn notify the Qualified Beneficiaries of their right to elect Continuation Coverage within 14 days of the date on which the Plan Administrator is notified of a Qualifying Event. Notice to Participant's Spouse shall be treated as notice to any Children who reside with the Spouse.

Effective for Plan Years beginning on or after January 1, 2004, or such later date as is permitted by law, when the Plan Administrator is notified of one of the events described in paragraphs (i) or (iii) and determines that an individual is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide such individual with an explanation as to why the individual is not entitled to elect COBRA Continuation Coverage. The notice shall be provided within 14 days of the date on which the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary shall be responsible for notifying the Employer in the event of the birth or adoption of a child during the Continuation Coverage period, within 30 days of the birth or adoption. An election for Continuation Coverage of a newborn child or newly adopted child may result in an increase in COBRA premium payments.

(h) Group Health Plans. Any continuation of coverage shall be provided for under this Plan where required by applicable law, or where not so required, under the separate Benefit

Plan constituting the applicable Group Health Plan. Where continuation of coverage is required to be provided under this Plan, and an individual elects such coverage in accordance with paragraph (g) of this Section, the individual shall be a Participant under the Plan and his or her applicable Benefit Election for the Plan Year in which the Qualifying Event occurs shall continue in effect, with respect to the applicable Group Health Plan(s) only, until the earlier to occur of (1) the date determined under paragraph (d) of this Section, or (2) the date on which he or she makes a permitted election to discontinue his or her coverage under the applicable Group Health Plan(s) pursuant to his or her Benefit Election (whether at the time he or she files or fails to file a new Benefit Election with respect to a subsequent Plan Year or at such other time as may be permitted under the Plan). Notwithstanding the foregoing to the contrary, if coverage provided under any Group Health Plan to similarly situated Participants is changed or eliminated, COBRA Continuation Coverage also shall be changed or eliminated.

(i) Benefit Costs; After-Tax Contributions. In any case where an individual elects continuation of coverage with respect to a Group Health Plan, such Participant shall be required, in accordance with procedures prescribed by the Plan Administrator, to make contributions in the same amounts as are necessary to pay: (i) 100% of the costs for the coverage he or she has in effect under such continued Group Health Plan or as may be provided for under any subsequent Benefit Election or a permitted change in an existing Benefit Election, and (ii) any additional amounts that may be charged to an individual electing health care Continuation Coverage under COBRA, up to 2% of the cost (up to 50% of the cost if coverage is continued due to disability). The contributions by a Participant under this Section shall be made on an after-tax basis.

(j) Continuation Elections in General. A Qualified Beneficiary's continuation of coverage under this Section, and his or her continuation of his or her Benefit Election in accordance with the provisions of this Section (including any subsequent Benefit Election he or she files while he or she is eligible for such continuation), shall be subject to all relevant provisions of the Plan, including, without limitation, those provisions relating to the filing of a Benefit Election and making permitted changes with respect to a Benefit Election. If the Qualified Beneficiary returns to employment status as an Eligible Employee, he or she shall be eligible to resume regular participation in the same manner as described for a former Participant in Section 2.4.

(k) Coordination with Family or Medical or Leave. Notwithstanding anything in this Article to the contrary, in the event a Participant terminates his or her employment during or upon the conclusion of an unpaid Family or Medical Leave, the eighteen (18) month period described in Section 7.3(d)(i) shall commence as of the later of: (i) the last day of FMLA Leave and (ii) the date that coverage is lost.

(l) Domestic Partner Continuation Coverage. The Domestic Partner of a Participant shall not be entitled to COBRA Continuation Coverage under this Plan unless he or she is the Participant's Spouse. Similarly, the child of a Domestic Partner shall not be entitled to COBRA Continuation Coverage under this Plan unless he or she constitutes the Participant's Child and Dependent. The Domestic Partner and/or child of a Domestic Partner may be entitled, however, to COBRA or similar Continuation Coverage under the terms of the applicable Benefit Plan(s).

(m) Termination of COBRA Continuation Coverage. COBRA Continuation Coverage shall terminate on the earliest of:

(i) eighteen (18) months from the date on which a Qualifying Event that is the Participant's termination of employment or reduction in hours occurs;

(ii) thirty-six (36) months from the date on which any Qualifying Event other than the Participant's termination of employment or reduction in hours occurs;

(iii) the first day of the month that is more than 30 days after the date of a final determination that a Participant or Qualified Beneficiary is no longer disabled (where coverage has been extended for 29 months due to disability);

(iv) the last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required contribution within thirty-one (31) days of the date it is due;

(v) except in the case of certain retirees and their Spouses and Children pursuant to Code Section 4980B(g)(1)(D), the date (after the date on which COBRA Continuation Coverage was elected) that the Qualified Beneficiary becomes enrolled in Medicare Part A or B;

(vi) the date (after the date on which COBRA Continuation Coverage was elected) on which the Qualified Beneficiary becomes covered under another Group Health Plan not containing a limitation or exclusion as to any preexisting condition of such individual (other than a limitation or exclusion that does not apply to (or is satisfied by) such individual by reason of chapter 100 of the Internal Revenue Code of 1986, Sections 701 through 707 of ERISA, or title XVII of the Public Health Service Act);

(vii) the date on which the Continuation Coverage is terminated for cause (, submission of fraudulent claim), provided that regular coverage would be terminated for a similarly situated non-COBRA beneficiary; or

(viii) the date the Company (and all Affiliates or other affiliated employers) terminates all Group Health Plans.

(n) Notice of Termination. Effective January 1, 2004, or such later date as may be permitted by law, the Plan Administrator shall provide notice to each Qualified Beneficiary to whom COBRA Continuation Coverage is being provided of any termination of COBRA Continuation Coverage that takes effect earlier than the end of the maximum period of Continuation Coverage applicable to the Qualifying Event.

The notice required by this paragraph shall be furnished by the Plan Administrator as soon as practicable following the Administrator's determination that Continuation Coverage shall terminate and shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) the reason that Continuation Coverage has terminated earlier than the end of the maximum period of Continuation Coverage applicable to the Qualifying Event;

(ii) the date of termination of Continuation Coverage; and

(iii) any rights the Qualified Beneficiary may have to elect an alternative group or individual coverage.

(o) Temporary COBRA Premium Assistance. Anything in this Plan or a Group Health Plan to the contrary notwithstanding, effective February 17, 2009, COBRA continuation coverage shall be offered and administered in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009.

7.4 **Other Continuation Coverage**. Except as specifically provided in this Plan, Coverage under a Group Health Plan shall be continued only as required by law, or in accordance with the Employer's personnel policies and guidelines.

ARTICLE VIII Preexisting Condition Limitations and Certificates of Creditable Coverage Under Group Health Plans

8.1 **Preexisting Condition Limitations.** The maximum preexisting condition limitation or exclusion that may be imposed by a Group Health Plan shall be twelve (12) months (eighteen (18) months in the case of a late enrollee). For this purpose, a "preexisting condition" is one for which medical advice, diagnosis, care, or treatment was recommended for or received by a Participant or covered Dependent within the six (6)-month period ending on the Participant's or Dependent's enrollment date. The "enrollment date" shall be the earlier of: (a) the Participant's or Dependent's enrollment date in the Plan, or (b) the first day of any waiting period

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8.4 **Certificate of Coverage.**

(a) The Employer shall provide each Participant or Dependent who experiences a loss of coverage under a Group Health Plan with a certificate of creditable coverage. For this purpose, a "loss of coverage" shall occur when: (I) the Participant of Dependent ceases to be covered under the Group Health Plan or becomes covered under COBRA or another similar continuation requirement; or (II) the Participant or Dependent ceases to be covered under COBRA or another continuation requirement. Such certificate of creditable coverage shall contain the information set forth in Code Section 9801(e) and the regulations.

If a loss of coverage is a COBRA event, then the certificate shall be provided to the Participant or Dependent within fourteen (14) days, or, if not, then such certificate shall be provided within a reasonable period of time following the loss of coverage. The certificate of coverage shall be mailed first class to the Participant's or Dependent's last known address.

8.5 **Definition of Group Health Plan.** For purposes of this Article VIII, the term "Group Health Plan" shall not include the Bowdoin College Health Care Reimbursement Plan or any other plan providing excepted benefits under Code Sections 9831 and 9832(c).

8.6 **Assistance Eligible Individuals.** Anything in this Plan or a Group Health Plan to the contrary notwithstanding, effective February 17, 2009, the requirements of this Article and Code Section 9801 shall be administered in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009.

ARTICLE IX Nonalienation

9.1 **General Prohibition.** Except as may be required by applicable law or as may be permitted under the terms of any separate Benefit Plan included as a Qualified Benefit under the Plan with respect to the benefits provided under such Qualified Benefit, and subject to the further provisions of this Plan, no benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, assignment, transfer, pledge or encumbrance, and any attempt to anticipate, alienate, sell, assign, transfer, pledge or encumber shall be void; nor shall such benefits be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Participant, Dependent or beneficiary.

9.2 **Exception.** Notwithstanding the foregoing to the contrary, and effective for judgments, orders, and decrees issued, and settlement agreements entered into on or after August 5, 1997, this Article shall not apply to any offset of a Participant's benefit payments against an amount that the Participant is ordered or required to pay to the Plan and the Plan shall not be treated as failing to meet the requirements of Sections 401(a)(13) of the Code solely by reason of such an offset, provided the order or requirement to pay arises:

(a) under a judgment of conviction for a crime involving the Plan;

(b) under a civil judgment (including a consent order or decree) entered by a court in an action brought in connection with a violation (or alleged violation) of Part 4 of subtitle B of Title I of ERISA; or

(c) pursuant to a settlement agreement between the Secretary of Labor and the Participant, or a settlement agreement between the Pension Benefit Guaranty Corporation and the Participant, in connection with a violation (or alleged violation) of Part 4 of subtitle B of Title I of ERISA by a fiduciary or any other person.

ARTICLE X Qualified Medical Child Support Orders

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

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

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

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

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

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

(iii) does not require the Plan to provide any type or form of be

10.3 **Representative.** Any alternate recipient named in a medical child support order received by the Plan shall have the right to designate, by notice in writing to the Plan Administrator, a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to such medical child support order.

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

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

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

ARTICLE XI Compliance With Privacy Rules

The Employer and the Plan Administrator shall at all times, to the extent applicable and required by law, operate, administer, and interpret the Group Health Plans offered under this Plan in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations issued thereunder, including, but not limited to the Privacy Rules issued in 45 C.F.R. Parts 160 and 164.

ARTICLE XII Administration

12.1 **Appointment.** The Employer may appoint a person or persons to administer the Plan. If more than one (1) person is appointed, they shall be known as the Administrative Committee. Any Administrative Committee shall act by a majority of its members either at a meeting or in writing without a meeting. Any member may participate in a meeting by means of a conference telephone or similar communications equipment, provided that all persons participating in the meeting can hear each other. If an Administrative Commit

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

12.3 **Powers and Duties.** The Plan Administrator shall be a named fiduciary for purposes of Section 402(a)(1) of ERISA to the extent applicable, shall administer the Plan in accordance with its terms, and shall have complete discretionary authority and all powers necessary to carry out its term

(k) to amend the Plan, as necessary, to ensure that the appendices accurately describe the Qualified Benefits that Eligible Employees may elect.

12.4 **Restrictions.** Except as provided in Section 12.3, the Plan Administrator shall have no power to amend or terminate the Plan. In addition, the Plan Administrator shall not be responsible for the failure to provide benefits under any Benefit Plan, unless caused by the Plan Administrator's act or omission.

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

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

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

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

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

12.10 **Reliance on Reports.** The Plan Administrator shall be entitled to rely upon all certificates, memoranda and reports made by any counsel, accountant, actuary or other person employed or retained to assist in administering the Plan, and upon all such documents properly executed by the plan administrators of the Benefit Plans or by Employees.

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

12.12 **Compensation and Expenses.** The Employer shall pay all reasonable expenses properly and actually incurred by the Plan Administrator in administering the Plan, and such rea-

case of an Urgent Care Claim, a Health Care Professional with knowledge of a claimant's medical condition shall be permitted to act as such claimant's Authorized Representative.

(c) "Concurrent Care Decision" means any decision to continue or discontinue previously granted benefits or treatments being provided to a claimant over a period of time.

(d) "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(e) "Plan Rule" means an internal rule, guideline, protocol, or other similar instrument under which the Plan is established or operated.

(f) "Post-Service Claim" means any claim for a benefit under the Plan that is not a Pre-Service Claim or an Urgent Care Claim.

(g) "Pre-Service Claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(h) "Relevant" means, with respect to a claim for benefits, that a document, record or other information –

(i) was relied upon in making the benefit determination;

(ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

(iii) demonstrates compliance with the administrative processes and safeguards required under ERISA and the applicable regulations in making the benefit determination; or

(iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(i) "Urgent Care Claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The decision as to whether a claim is an Urgent Care Claim shall be determined by the Contract Administrator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Furthermore, any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim will be treated as such for purposes of this Section.

13.3 **Timing of Initial Benefit Determination.**

(a) Group Health Plans.

(i) **Urgent care claims.** In the case of an Urgent Care Claim, the Contract Administrator shall notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. Notwithstanding the foregoing, in the event that the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Contract Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan of the specific information necessary to complete the claim. The claimant shall be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Contract Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

(A) the Plan's receipt of the specified information; or

(B) the end of the period afforded the claimant to provide the specified additional information.

(ii) **Concurrent Care Decisions** If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments–

(A) reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Contract Administrator shall notify the claimant, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of such Adverse Benefit Determination before the benefit is reduced or terminated.

(B) any request by a claimant or his or her Authorized Representative to extend the course of treatment beyond the period of time or number of treat-

(iii) **Pre-Service Claims.** In the case of a Pre-Service Claim, the Contract Administrator will notify the claimant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. However, if a claimant or his or her Authorized Representative fails to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. Such notification must be made only if the failure –

(A) is a communication by a claimant or his or her Authorized Representative that is received by the individual or organizational unit customarily responsible for handling the Plan's benefit matters; and

(B) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

The notification will be provided to the claimant or Authorized Representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of an Urgent Care Claim) following the failure. Such notification may be oral, unless written notification is requested by the claimant or Authorized Representative.

(iv) **Post-Service Claims.** In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant of an Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan.

(b) Disability Plans.

if an extension of the initial benefit determination period is necessary due to a failure of the claimant to submit the information necessary to decide the claim, (i) the notice of extension will specifically describe the required information and will afford the claimant not less than 45 days from receipt of the notice to provide the specified informatio

13.5 **Manner and Content of Notification of Initial Benefit Determination.** The Contract Administrator shall provide a claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by ERISA Reg. §§2520.104b-1(c)(1)(i), (iii), and (iv). The notification will set forth the following, in a manner calculated to be understood by the claimant:

(a) the specific reason or reasons for such Adverse Benefit Determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) if a Plan Rule was relied upon in making the Adverse Benefit Determination, either the specific Plan Rule or a statement that such a Plan Rule was relied upon in making the Adverse Benefit Determination and that a copy of such Plan Rule will be provided free to the claimant upon request;

(d)

(a) may submit to the Contract Administrator written comments, documents, records, and other information relating to the claim for benefits;

(b) shall be provided, upon request and free of charge, reasonable access to and cop-

(e) 60 days after receipt of the claimant's request for review of an Adverse Benefit Determination from a claim under a Benefit Plan other than a Group Health Plan or Benefit Plan providing disability benefits.

13.8 **Manner and Content of Notification of Benefit Determination on Appeal.** The written or electronic notification of any Adverse Benefit Determination on appeal shall set forth, in a manner calculated to be understood by the claimant –

(a) the specific reason or reasons for such adverse determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) if a Plan Rule was relied upon in making the Adverse Benefit Determination, either the specific Plan Rule or a statement that such a Plan Rule was relied upon in making the Adverse Benefit Determination and that a copy of such Plan Rule will be provided free to the claimant upon request;

(d) 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;

(e) if the Adverse Benefit Determination was based on a medical necessity or experimental treatment or some other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free to the claimant upon request;

(f) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and

(g) a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

All decisions relating to the merits of any claim on appeal, including all decisions as to the amount, manner and time of payment of any benefit under the Plan, shall be made solely by the Contract Administrator, and the interpretation and construction by the Contract Administrator of any provisions of the Plan and the Contract Administrator's exercise of any discretion granted under the Plan shall be final and binding, provided, however, that if the Contract Administrator is either the individual who made an Adverse Benefit Determination that is the subject of an appeal, or is the subordinate of such individual, then, for purposes of such appeal, the Employer shall appoint an appropriate person or entity to decide the appeal in lieu of the Contract Administrator, and all references to the Contract Administrator in connection with the appeal procedures set forth in this Article II, shall be deemed references to the person or entity so appointed.

13.9 **Calculating Time Periods.** For purposes of Section 13.3, the period of time within which a benefit determination must be made shall begin at the time a claim is filed in ac-

cordance with Section 13.1, without regard to whether all of the information necessary to make a

APPENDIX Qualified Benefits

The Qualified Benefits under the Plan are made available through the following Bowdoin College Benefit Plans:

Health Plan
Dental Plan
Short-Term Disability Plan
Health Care Reimbursement Plan
Dependent Care Reimbursement Plan
Supplemental Group-Term Life Insurance Plan