BOWDOIN COLLEGE

RETIREE HEALTH REIMBURSEMENT ACCOUNTS PLAN

(effective July 1, 2019)

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BOWDOIN COLLEGE
RETIREE HEALTH REIMBURSEMENT ACCOUNTS PLAN

INTRODUCTION

The Plan Sponsor hereby adopts this Bowdoin College Retiree Health Reimbursement Accounts Plan (the "Plan") for the purpose of allowing certain retired employees of the Plan Sponsor to obtain reimbursement of eligible medical expenses incurred by such eligible retired employees. The Plan Sponsor intends the Plan to qualify as a "health reimbursement arrangement" as that

1.5 Effective Date:

(a) ☐ New Plan Effective Date:________________

(2) ☐ (Specify):________________________________

(3) ☐ Not Applicable – No Exclusions.

1.7 Dependent:

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

the child's ________th birthday.

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

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

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

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

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

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

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

(a) ☑ (Specify): Prescription drug expenses

(b) ☐ (Specify):________________________________

(c) ☐ Not Applicable – No Exclusions.

1.10 Benefit Credit:

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

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

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

(3) ☐ (Specify formula):____________________

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

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

(2) ☐ Fixed Dollar Amount of $__________ per Plan Year,

(3) ☐ (Specify formula): __________, or

(4) ☑ Not Applicable – No Benefit Credits on behalf of Eligible Dependent Spouses.

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

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

(b) ☐ Has health coverage under a policy or plan provided by his or her Spouse's employer

(c) ☐ Resides outside the United States

(d) ☑ Not Applicable – Eligible Retirees must obtain an individual insurance policy through Via Benefits in order to receive Benefit Credits under the Plan.

1.12 Account Structure:

(a) ☐ *Combined Account*. Only one HRA Account will be established for all Participants in a single family and all Benefit Credits for all such

ARTICLE II
DEFINITION OF TERMS

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

(a) "HRA Account" means the notional account established for a Participant to

(l) "Health Care Expense" means an expense incurred by a Participant for medical care as defined in Code Section 213(d) and the rules, regulations, and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance

ARTICLE III
PARTICIPATION

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

(a) [illegible] an Eligible Retiree;

(b) obtained an individual health insurance policy through Via Benefits or any affiliate or, if elected by the Plan Sponsor under Section 1.11, provided satisfactory evidence to the Plan Administrator or Claims Administrator that he or she satisfies an exception to this requirement; and

(c) completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

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

(a) the date he or she ceases to be an Eligible Retiree for any reason, including death;

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

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

(1) the amount of the Health Care Expense for which reimbursement is requested;

(2) the date the Health Care Expense was incurred;

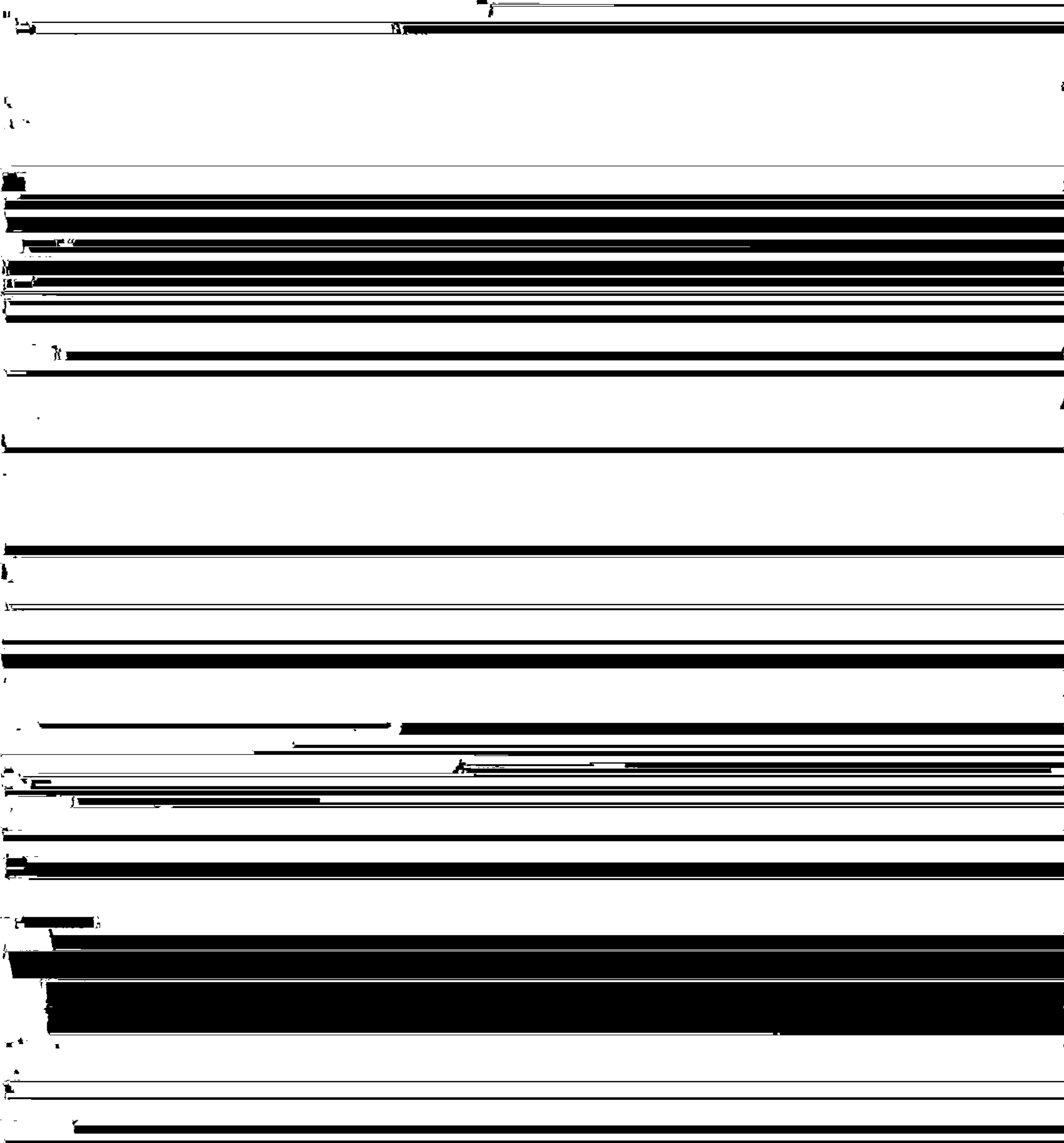
(3) a brief description and the purpose of the Health Care Expense;

(4) the name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;

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

(c) *Timing*: The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial thirty (30)-day period that the Claims Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the

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



[illegible] Administrator in [illegible]

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

ARTICLE VI
CONTINUATION COVERAGE

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

(a) "COBRA Continuation Coverage" means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.

(b) "Election Period" means a period of at least sixty (60) days' duration that begins

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

(a) The date the Qualified Beneficiary's HRA Account is exhausted;

(b) The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;

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

[illegible] by the Plan Administrator a Qualified

(5) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;

(6) To accept, modify, or reject Participant elections under the Plan;

(7) To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;

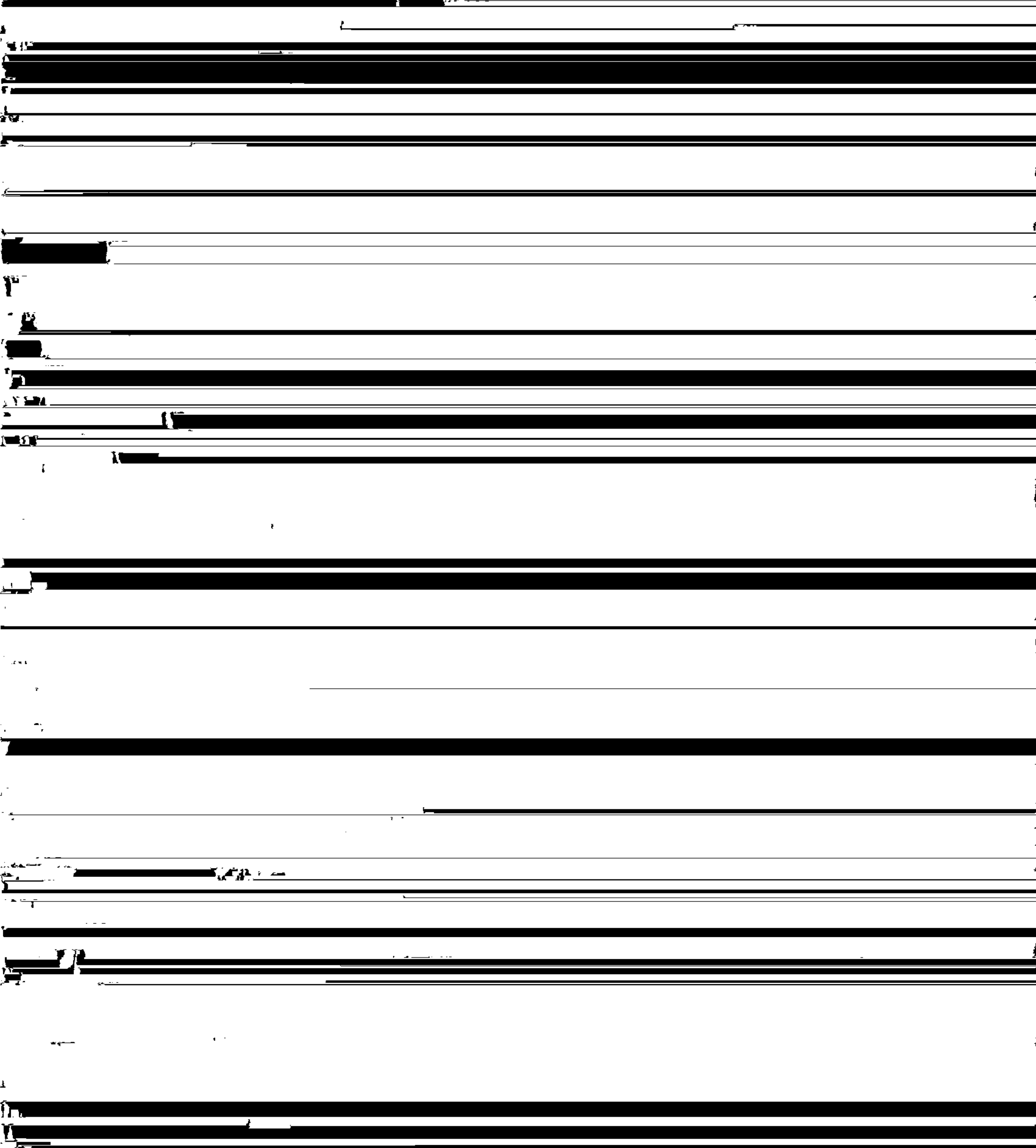
(8) To determine and enforce any limits on benefit elections hereunder; and

(9) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

7.3 Allocation and Delegation of Duties.

(a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers, or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or member to whom responsibilities have been allocated shall periodically

7.4 Indemnification. The Employer shall indemnify and save the Plan Administrator, and any employees to whom the Plan Administrator has allocated or delegated its responsibilities



(b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant

(1) Collection of individual premiums or contributions;

(2) Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, and related functions;

(4) Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;

(5) Conducting or arranging for medical review, legal services, and auditing [illegible] fraud and abuse detection and compliance programs;

(1) *Access to Medical Information.* The following employees or individuals under

by those employees

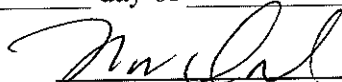
8.4 Other HIPAA Rules.

(a) *Exempt Enrollment Information.* The Plan may disclose to the Plan [illegible] enrollment information regarding the Plan with respect to any

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

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

Executed this 4 day of JUNE, 2019.

Plan Sponsor: 
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