TRUSTEES OF THE COLLEGE OF THE HOLY CROSS

HEALTH AND WELFARE BENEFITS PLAN

CONSOLIDATED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Restated January 1, 2018

The College reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the College expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

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INTRODUCTION

This document sets forth and describes the ***Trustees of the College of the Holy Cross*** Health and Welfare Benefits Plan (the "Plan") ***originally effective January 1, 2013 and restated effective January 1, 2018.*** Some of the terms in the Plan are capitalized. These terms are defined in the Glossary. The purpose of this Plan is to provide certain health and welfare benefits to you and your eligible dependents under one or more Welfare Benefit Contracts, as more fully described herein. Each health and welfare benefit offered under the Plan is referred to as a "Coverage Feature" of the Plan. The Coverage Features offered under the Plan are either "Non-Contributory Coverage Features," which are provided to you at the College's expense, or "Contributory Coverage Features," which require you to pay all or part of the costs of the Coverage Feature.

The Non-Contributory Coverage Features are:

- Basic Life and Accidental Death and Dismemberment Insurance
- Long Term Disability Coverage
- Medical Expense Reimbursement Plan (MERP)

The Contributory Coverage Features are:

- Group Medical
- Group Dental
- Voluntary Vision Care Benefits
- Employee Voluntary and Dependent Voluntary Life Insurance
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

Each Coverage Feature has its own requirements for eligibility and enrollment. These requirements are set forth more fully in this Plan and in the Welfare Benefit Contracts, which are incorporated by reference into the Plan.

This document, together with the Welfare Benefit Contracts identified in Schedule A, constitute both the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan. The provisions of the Welfare Benefit Contracts are incorporated by reference into this Plan document. If there is any conflict between this document and the Welfare Benefit Contracts, the Welfare Benefit Contracts will control.

PART ONE: ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible to participate under the Plan if you are an Eligible Employee.

Eligible Dependents and Beneficiaries

The Welfare Benefit Contracts identify which Coverage Features may cover your Eligible Dependents or beneficiaries, as well as any requirements for their coverage. Upon request, you must provide proof of your dependents' eligibility for coverage.

Enrollment

If you are an Eligible Employee, you and your Eligible Dependents may enroll in a Coverage Feature once you meet the requirements for enrollment set forth on Schedule A. The Plan Administrator may establish enrollment procedures for each Coverage Feature in accordance with the Welfare Benefit Contracts for you and your Eligible Dependents under the Plan. The Plan Administrator may prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan. As a requirement of enrollment in one or more of the Coverage Features, the Plan Administrator may require that you and your Eligible Dependents provide certain personal information, including without limitation addresses and social security numbers.

Timing of Enrollment and Enrollment Changes

With respect to the following Coverage Features, once you have met the requirements for enrollment set forth on Schedule A, you will be automatically enrolled and will remain enrolled so long as you are an Eligible Employee:

- Basic Life and Accidental Death and Dismemberment Insurance
- Long Term Disability Coverage
- Medical Expense Reimbursement Plan (MERP)

With respect to the following Coverage Features, once you have met the requirements for enrollment set forth on Schedule A, you may enroll, cancel your enrollment or change your election at any time (subject to evidence of insurability):

- Employee Voluntary and Dependent Voluntary Life Insurance

With respect to all other Coverage Features, your opportunities to enroll, as well as to change or cancel your enrollment, are limited to the following:

- You (and your Eligible Dependents) may enroll at the time you first meet the requirements for enrollment set forth on Schedule A;
- You (and your Eligible Dependents) may enroll, or change or cancel your enrollment, during an Annual Enrollment Period; or

- You (and your Eligible Dependents) may enroll, or change your enrollment, if you become eligible for a "special enrollment right" as described below.

Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in any Coverage Feature that is a "group health plan" under Section 701 of ERISA after you first become eligible or during the Annual Enrollment Period, you may be able to enroll under the special enrollment rules under HIPAA that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you or your Eligible Dependent initially declined coverage because you had other health care coverage and you (or your Eligible Dependent) have lost eligibility for that other health care coverage through no fault of your (or his or her) own; or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption or placement for adoption of a child) and wish to cover that person. In the former case, you must have given (in writing if a written statement was required at the time by the Plan Administrator and you were provided with a notice of that requirement and its consequences at that time) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you (and/or your Eligible Dependents) meet the necessary requirements under the group health plan (including eligibility requirements), you can enroll both yourself and all Eligible Dependents in the group health plan within ***30 days*** after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child. Enrollment of your Eligible Dependents is generally conditioned upon your enrollment.

You may also be able to enroll yourself and your dependent in a group health plan pursuant to a special enrollment right created by the Children's Health Insurance Program Reauthorization Act of 2009. If you or your dependent is eligible for, but not enrolled, for coverage under the terms of a group health plan, you (and/or your dependent) may enroll for coverage under the terms of the group health plan if either of the following conditions is met:

- You or your dependent is covered 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 and your (or your dependent's) coverage under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the group health plan not later than 60 days after the termination of such coverage; or

- You or your dependent become eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the group health plan not later than 60 days after the date you or your dependent is determined to be eligible for such assistance.

Unless otherwise provided in the applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits. Please contact the Plan Administrator for details about special enrollment.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for one parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any qualified medical child support order it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under Section 609 of ERISA;

- Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of any medical child support order, and the group health plan's procedures for determining whether medical child support orders are qualified medical child support orders; and

- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

A copy of the Plan's QMCSO procedures is available, without charge, upon request from the Plan Administrator.

Tax Implications

Medical, dental and vision care are generally treated as non-taxable under federal tax law if they are provided to you, your spouse, your dependents, or your children who have not attained the age of 27 as of the end of a taxable year. Your "spouse" for this purpose includes any individual married to you in a state whose laws authorize your marriage (generally referred to as the "state of celebration"), in accordance with such state's laws, whether the spouse is of the opposite or the same sex as you. Your "children" and "dependents" are as defined under Section 105(b) of the Code. In addition, if the College has established a "Cafeteria Plan" under Section 125 of the Code, you may have the ability to pay any employee portions of premiums for yourself and such individuals on a pre-tax basis.

If, however, a Coverage Feature makes medical, dental or vision care available for any individual who is not your spouse, child under age 27, or dependent (each as defined above), the value of the coverage provided to such individual is taxable to you for federal law purposes. Situations where these taxes may arise include civil unions (where the civil union partner is not your tax dependent), coverage of non-dependent grandchildren and ex-spouses, and coverage of a child beyond the end of the taxable year in which the child reaches age 26. This additional income, known as "imputed income," will be reported on your pay statement and Form W-2 Wage and Tax Statement for the year in which the coverage was provided. You will be required to pay taxes on this additional income, as required by the IRS and, if applicable, state tax authorities.

This document does not address every tax situation that may apply to every Plan Participant. For example, benefits provided under the Plan to certain individuals who are not common law employees of the College (such as partners in a partnership) may be subject to unique and complicated federal tax laws rules. In addition, this document does not address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, please consult your tax adviser.

When Coverage Ends

Except in the case of COBRA rights described below, benefits for you and your Eligible Dependents under the Plan will terminate upon the earliest of:

- Except as required by applicable state law, the end of the month after the date you cease to be an Eligible Employee, provided that termination is not for gross misconduct.

- The date when you or your Eligible Dependent(s) no longer meet the eligibility requirements set forth on Schedule A or in an applicable Welfare Benefit Contract, provided that, effective for Plan Years beginning on or after October 9, 2009, if an Eligible Dependent is a Dependent Child on a Medically Necessary Leave of Absence, the coverage under a Group Medical Coverage

Feature (other than an Excepted Benefit) shall not end until the earlier of (1) the date that is one year following the first day of the Medically Necessary Leave of Absence or (2) the date on which coverage under the Group Medical Coverage Feature would otherwise terminate under the terms of the Group Medical Coverage Feature.

- The time when you or your Eligible Dependent(s) have exhausted the benefits available under a Coverage Feature, as set forth in the applicable Welfare Benefit Contract,

- With respect to any Contributory Coverage Features, the last day for which necessary contributions are made,

- With respect to any insured Coverage Feature, the date when the group insurance policy applicable to the Coverage Feature terminates,

- With respect to any Coverage Feature, the date when the College amends the Plan to eliminate such Coverage Feature, or changes such Coverage Feature to eliminate eligibility for you and/or your Eligible Dependents, or

- The date the College terminates the Plan.

As noted below, the College reserves the right to change or eliminate benefits under the Plan and may amend or terminate the Plan at any time.

Certain Coverage Features may provide conversion rights. That is, when you cease to participate in the Coverage Feature, you have the right to convert your group coverage under the Coverage Feature into an individual policy. You will be responsible for all costs associated with such individual policy. See the Welfare Benefit Contracts for more details.

Retiree Coverage

If you are a tenured faculty member, you could be eligible for retiree health coverage if, at retirement, you are at least 62 years of age and have accrued at least 15 years of service with the College. If you think you might be entitled to this coverage, please contact the Plan Administrator.

Michelle's Law

Michelle's law provides, in general, that a dependent child who takes a medically necessary leave of absence from full time studies must remain covered under a parent's plan until the earlier of (1) one year from the first day of the medically necessary leave of absence or (2) the date such coverage would otherwise terminate under the terms of the plan. The law is effective for Plan years beginning on or after October 9, 2009.

PART TWO: BENEFITS AND CONTRIBUTIONS

General

Each Coverage Feature, including any amounts you must contribute towards a Contributory Coverage Feature, is more fully described (and subject to the limitations contained) in the Welfare Benefit Contracts and on Schedule A.

Benefit and Coverage Options

Each Contributory Coverage Feature may offer a selection of benefits from which you may choose. In addition, the Coverage Features may contain one or more coverage levels including, without limitation:

- Eligible Employee only
- Eligible Employee plus spouse
- Eligible Employee plus child(ren)
- Eligible Employee plus family
- Certain Coverage Features may also offer coverage of grandchildren, former spouses, or other individuals, either pursuant to state law or per the Plan's design

The cost of your coverage may vary depending on which coverage or benefit option you select. Your options are more fully described (and subject to the limitations contained) in the Welfare Benefit Contracts and on Schedule A.

How Do I Pay for Contributory Coverage Features?

Your contributions for each Contributory Coverage Feature are set forth on Schedule A. The applicable Participating Employer will pay the remaining costs, if any, for each Contributory Coverage Feature.

The Plan Administrator may require that your contributions be made by payroll deduction. Your contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from you or withheld from your pay through payroll deduction.

Claims and Appeal Procedure.

Any claim for benefits under the Plan and any subsequent appeal shall be filed in accordance with the provisions of the applicable Welfare Benefit Contract. Notice of the decision on such claim and any right to appeal such decision shall be provided by the Plan Administrator or, if delegated, by the insurance College or third-party administrator issuing the applicable Welfare Benefit Contract in accordance with the provisions of such contract, Section 503 of ERISA and PPACA and any regulations thereunder in effect at the time the claim for benefits is made under the Plan. Despite anything to the contrary in this Plan, the claims procedure to be used by the Plan Administrator with respect to benefits provided under a Non-Grandfathered group health plan subject to PPACA shall comply with the rules relating to internal claims and appeals and external review processes established under PPACA.

Unless otherwise expressly stated in the applicable Welfare Benefit Contract, you may not bring a lawsuit on a claim for benefits unless you have exhausted the claim and appeal procedures described in the Welfare Benefit Contract. Any suit for benefits must be brought within twelve (12) months after the date of the final disposition of the claim under the applicable claim and appeal procedures.

Special Benefit for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from a plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be. Unless otherwise provided in an applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Special Benefit for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage will be provided in a manner determined in consultation with the attending physician and the patient, and includes coverage for: (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; (iii) prostheses; and (iv) physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Coverage Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits. Unless otherwise provided in an applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Mental Health and Substance Use Disorder Parity

If any Group Medical Coverage Feature (1) provides both medical and surgical and mental health or substance use disorder benefits and (2) is not subject to an Increased Cost Exemption:

- The Group Medical Coverage Feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Group Medical Coverage Feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any Group Medical Coverage Feature with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the Wellstone Act) to any current or potential Participant upon request.
- The reason for any denial under the Plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the Wellstone Act, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the Group Medical Coverage Feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPA and the Wellstone Act.

"Mental health benefits" and "substance use disorder benefits" mean benefits with respect to items or services for mental health conditions and substance use disorders, respectively, and shall be as defined in the Welfare Benefit Contract applicable to the Group Medical Coverage Feature, pursuant to applicable state and Federal law, and consistent with generally recognized independent standards of current medical practice.

Unless otherwise provided in an applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Patient Protections

The Group Medical Coverage Feature generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Group Medical Coverage Feature network and who is available to accept you or your family members. Until you make this designation, the Group Medical Coverage Feature designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services through the phone number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Group Medical Coverage Feature or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services through the phone number on your ID card.

Unless otherwise provided in an applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

PART THREE: PLAN ADMINISTRATION

The Plan Administrator

The Plan Administrator has sole and absolute discretion and authority to (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, including enrollment procedures, (iv) to determine the conditions under which benefits become payable under the Plan, (v) to make determinations of eligibility under the Plan, (vi) to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, or dependent of an employee, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, or other documentation deemed appropriate by the Plan Administrator, and (vii) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Any interpretation or determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity. However, under no circumstances can the Plan be modified by oral statements of the Plan Administrator.

Duties of the Plan Administrator

The Plan Administrator (i) administers the Plan in accordance with its terms, (ii) decides disputes which may arise relative to a Plan Participant's rights, (iii) keeps and maintains the Plan documents and all other records pertaining to the Plan, (iv) pays or arranges for the payment of claims, (v) establishes, communicates and implements procedures to determine whether a medical child support order is qualified under section 609 of ERISA, and (vi) performs all necessary reporting and disclosure as required by ERISA.

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan unless paid by the College.

The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary has breached its fiduciary responsibility under section 405(a) of ERISA.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Eligible Employees and their Eligible Dependents and beneficiaries, and defraying reasonable expenses of Plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation, and in accordance with Plan documents to the extent that they are consistent with ERISA.

Examination of Records

The Plan Administrator will generally make available to each Eligible Employee such of his or her records under the Plan as pertain to him or her for examination at reasonable times during normal business hours, but the Plan Administrator shall have no obligation to disclose any records or information which the Plan Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

Reliance on Tables

In administering the Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by or in accordance with the instructions or recommendations of accountants, counsel, actuaries, consultants or other experts employed or engaged by the Plan Administrator.

Indemnification of Administrator

The College agrees to indemnify and to defend to the fullest extent permitted by law any employee or Participating Employer serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the College) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

HIPAA Privacy Provisions

HIPAA requires group health plans to protect the confidentiality of your private health information. The Plan and the College will not use or further disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health plan operations and Plan administration, or as otherwise permitted or required by applicable law. In particular, the Plan will not, without authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the College. In addition, the Plan requires all of its business associates (that is, service providers who help us administer the Plan) to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the College's privacy officer.

Medical Loss Ratio Rebates

To the extent a rebate is paid to the College under the rules governing medical loss ratio with respect to the Group Medical Coverage Feature, the rebate will be apportioned between the College and Plan Participants in the discretion of the Plan Administrator in accordance with the principles set out in Department of Labor Technical Release 2011-04 (published December 2, 2011).

PART FOUR: COBRA CONTINUATION COVERAGE

Introduction

If you are participating in any group health plan subject to COBRA, you may be entitled to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, upon your termination of employment with a Participating Employer. Your spouse and other qualified beneficiaries may also be entitled to COBRA continuation coverage in specified circumstances. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only an overview of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under federal law, you should ask the Plan Administrator.

COBRA continuation coverage for the group health plan is administered by:

Sullivan Benefits
33 Boston Post Road, W
Suite 120
Marlborough, MA 01752

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

In addition to COBRA, there may be other coverage options available to you and your family. For example, you may be eligible to buy medical insurance coverage through the Marketplace. In the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage under any group health plan subject to COBRA 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, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct;

If you are the spouse of an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator of the birth or adoption.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Eligible Employee, or the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the College must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You should send this notice, in writing, describing the qualifying event, to the ***COBRA Administrator.*** If you do not provide timely notice, you may not be eligible for COBRA coverage.

COBRA Coverage and FMLA Leave. The taking of leave under FMLA does not constitute a qualifying event under COBRA. However, a qualifying event will generally occur if your FMLA leave ends and you do not return to work. Please contact the Plan Administrator for more information on your (and your spouse's or dependent children's) COBRA eligibility during and following your FMLA leave.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an

independent right to elect COBRA continuation coverage. Covered Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Employee, the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To obtain the 11-month extension, notice must be sent to the ***COBRA Administrator*** before the end of the first 18-month period of COBRA continuation coverage. Further, you (or a covered family member) must make sure that the Plan Administrator is notified of the SSA's determination within 60 days of the later of: (a) the date of the SSA determination; (b) the date of the qualifying event; (c) the date you would otherwise lose coverage under the Plan; or (d) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. Notice should be sent in writing, postmarked within the above timeframes, to the ***COBRA Administrator***; however, the ***COBRA Administrator*** may, in its discretion, accept oral notice if such oral notice is received within the above timeframes and complete written notice follows within one week of such oral notice.

If the SSA determines that you (or a covered family member) are no longer qualified for Social Security disability benefits, notice must be sent to the ***COBRA Administrator*** within 30 days of the later of: (a) the date of the SSA's determination or (b) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. The disability extension coverage will terminate upon such determination. Notice should be sent in writing, postmarked within the above timeframes, to the ***COBRA Administrator***; however, the ***COBRA Administrator*** may, in its discretion, accept oral notice if such oral notice is received within the above timeframes and complete written notice follows within one week of such oral notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children

receiving continuation coverage if the Eligible Employee or former Eligible Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must notify the ***COBRA Administrator*** of the second qualifying event within 60 days of the second qualifying event. You should give this notice prior to the qualifying event, or as soon as possible thereafter (but not more than 60 days after the qualifying event). Once the ***COBRA Administrator*** receives your notice, it must in turn notify you, your spouse, and children (individually or jointly) of their right to elect COBRA coverage. This notice must be sent to the ***COBRA Administrator.***

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate early if:

- The required premium payment is not paid when due;
- You and your spouse or dependent child(ren), if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any of your preexisting conditions (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under PPACA);
- You, your spouse or dependent child(ren), if any, become entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA coverage is elected;
- All of the College's group health plans are terminated; or
- If coverage is extended to 29 months due to disability, a determination that the individual is no longer disabled. NOTE: Federal law requires that the individual inform the ***COBRA Administrator*** of any final determination that he or she is no longer disabled within 30 days of such a determination.

Continuation coverage under COBRA is provided subject to your eligibility. The ***COBRA Administrator*** reserves the right to terminate your COBRA coverage retroactively, subject to PPACA, if you are determined to be ineligible for coverage.

How Can You Elect Continuation Coverage?

Each qualified beneficiary has 60 days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to inform the ***COBRA Administrator*** that he or she wants to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the Eligible Employee and the Eligible Employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. **There is no extension of the election period**.

If you, your spouse or dependent chooses continuation coverage and pays the applicable premium within the time period specified in the qualifying event notice, the College is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to

similarly situated active employees or family members. If the College changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

In considering whether to elect continuation coverage you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

When And How Must Payment For Continuation Coverage Be Made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage at the time of your election. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date your election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the ***COBRA Administrator*** to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:
Sullivan Benefits
33 Boston Post Road, W
Suite 120
Marlborough, MA 01752

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the ***1st of every month.*** If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Periodic payments for continuation coverage should be sent to:
Sullivan Benefits
33 Boston Post Road, W
Suite 120

Marlborough, MA 01752

Grace periods for periodic payments

Although periodic payments are due on the ***1st of each month***, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the ***COBRA Administrator***. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the ***COBRA Administrator*** informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the ***COBRA Administrator***.

PART FIVE: RECOVERY PROVISIONS

Refund of Overpayments

Whenever a payment has been made under any Coverage Feature in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), you or any other Covered Person must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In case of a recovery from a source other than the Plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan that should have been made under another group plan. In that case, the Plan may recover the payment from one or more of the following: any other insurance College, any other organization, or any person to or for whom payment was made.

The Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to the Covered Person or his/her survivors; stopping future benefit payments that would otherwise be due under the Plans (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the Covered Person.

With respect to the ***Long Term Disability Coverage Feature*** the Plan Administrator reserves the right to recover funds related to disability benefits for any Overpayment when a Covered Person receives state benefits, including Workers' Compensation and Social Security benefits.

Reimbursement

This section applies when you or any other Covered Person recovers damages - by settlement, verdict, or otherwise - for an injury, sickness, or other condition. If the Covered Person has made - or in the future may make - such a recovery, including a recovery from an insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the Plan does pay for or provide benefits for such an injury, sickness, or other condition, the Covered Person or the legal representatives, estate, or heirs of the Covered Person will promptly reimburse the Plan for all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdict, or insurance proceeds received by the Covered Person (or by the legal representatives, estate, or heirs of the Covered Person) to the extent that medical benefits have been paid for or provided by the Plan to the Covered Person.

If the Covered Person receives payment from a third party or his or her insurance College as a result of an injury or harm due to the conduct of another party and the Covered Person has received benefits from the Plan, the Plan must be reimbursed first. In other words, the Covered Person's recovery from a third party may not compensate the Covered Person fully for all the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the Covered Person receives.

The Covered Person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement rights. That means that by accepting benefits from the Plan, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance College) in connection with or related to the conduct of another party.

The Covered Person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The Covered Person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health plan maintained by the Participating Employer to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, each Covered Person hereby:

- Agrees that, with respect to any amounts paid by the Plan for the Covered Person's injury, sickness, or other condition, the Plan will be reimbursed in full from any policy proceeds, judgment, or settlement before any amounts from such policy proceeds, judgment, or settlement (including attorney's fees incurred by the Covered Person) are paid to any other person, regardless of the manner in which the recovery is structured or worded;

- Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the Covered Person to the extent of all benefits provided in an effort to make the Plan whole;

- Assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage; the Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits;

- Agrees that the costs of legal representation retained by the Covered Person shall be borne solely by the Covered Person; and

- Will cooperate with the Plan and its agents and will:

  -- Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;

  -- Provide any relevant information; and

  -- Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the Covered Person does not sign and deliver any such documents for any reason (including, but not limited to, the fact that the Covered Person was not given an agreement to sign or is unable or refuses to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the Covered Person under the Plan.

If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the Covered Person has signed the agreement. The Covered Person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness, or other condition (including insurance carriers that are so liable) and the Plan has provided or paid for benefits.

The Plan is subrogated to all the rights of the Covered Person against any party, including any insurance carrier, liable for the Covered Person's injury or illness or for the payment for the medical treatment of

such injury or occupational illness to the extent of the value of the medical benefits provided to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person.

The Covered Person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with relevant information requested by them; signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. Further, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance College) in connection with or related to the conduct of another party.

The Covered Person hereby agrees that, with respect to any amounts paid by the Plan for a Covered Person's injury, sickness, or other condition, the Plan will be reimbursed in full from any policy proceeds, judgment, or settlement before any amounts from such policy proceeds, judgment, or settlement (including attorney's fees incurred by the Covered Person) are paid to any other person, regardless of the manner in which the recovery is structured or worded.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation retained by the Covered Person shall be borne solely by the Covered Person.

Misrepresentation

If a Participant or any other person makes any intentional misrepresentation or uses fraudulent means in applying for coverage under the Plan, making a change in his or her existing coverage election under the Plan, or filing a claim for benefits under the Plan, his or her coverage under the Plan will be subject to immediate termination, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity subject to and in accordance with applicable law.

The Plan Administrator has the sole and absolute discretion and authority to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, domestic partner or dependent of an employee, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, proof of domestic partnership, or other documentation deemed appropriate by the Plan Administrator. The Plan Administrator has the sole and absolute discretion to refuse enrollment or continuing participation in the Plan to any individual who refuses or otherwise fails to provide such proof of eligibility.

PART SIX: GENERAL INFORMATION ABOUT THE PLAN

This section contains general information which you may need to know about the Plan.

General Plan Information
Trustees of the College of the Holy Cross Health and Welfare Benefit Plan is the name of the Plan.
The College has assigned Plan Number ***506*** to your Plan.
The provisions of the Plan become effective ***on January 1, 2018.***
The Plan Year begins on ***January 1 and ends on December 31.***
See also Schedule A and the Welfare Benefit Contracts for more information on each Coverage Feature.

College Information

The College's name, address, and identification number are:

Trustees of the College of the Holy Cross
1 College Street
Worcester, MA 01610
E.I.N.: 04-2103558

Plan Administrator Information

The Plan Administrator is:

Trustees of the College of the Holy Cross
1 College Street
Worcester, MA 01610
508-793-2514

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

Service of Legal Process

The name and address of the Plan's agent for service of legal process is:
Trustees of the College of the Holy Cross
1 College Street
Worcester, MA 01610

Service of legal process may also be made upon the Plan Administrator.

Type of Welfare Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

Type of Administration

While the Plan Administrator administers the Plan generally, Plan administration varies for each Coverage Feature. Some Coverage Features furnished under the Plan are administered by the providers/insurers of the applicable Welfare Benefit Contract. Other Coverage Features are administered by the College. If you have questions about the Plan or any Coverage Feature, you may contact the Plan Administrator or the contact listed for a particular Coverage Feature on Schedule A.

The College reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the College expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

Amendment of the Plan

The College reserves the power to amend the provisions of the Plan at any time and to any extent that it may deem advisable. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by the College or any other Participating Employer.

Termination of the Plan

Although the College has established the Plan with the intention and expectation that it will be continued indefinitely, neither the College nor any other Participating Employer has any obligation whatsoever to maintain the Plan for any given length of time. The College may discontinue or terminate the Plan at any time without liability.

PART SEVEN: YOUR ADDITIONAL RIGHTS

Your Rights Under ERISA

General Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

- 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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) available at the Public Disclosure Room of the Employee Benefits Security Administration;

- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make 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;

- Continue coverage under any group health plan subject to COBRA for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. See Part Four of the Plan;

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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Participants. No one, including the College, a Participating Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in

Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration: (866) 444-EBSA. You may also visit their website at www.dol.gov/ebsa.

Rights for Participants who are Absent on Military Leave: USERRA

If you take a military leave of absence - whether for active duty or for training - you are entitled to continue your coverage under certain Coverage Features pursuant to the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

Leave less than 31 days. If you are absent from work due to a period of active duty in the military for less than 31 days, your participation in any applicable Coverage Feature will not be interrupted, subject to your payment during such period of your regular Employee contribution for such coverage.

Leave 31 days or greater. If your absence extends for 31 days or greater, you may continue to maintain your coverage under an applicable Coverage Feature for up to 24 months from the date your absence for purpose of performing military service began. The College may require you to pay up to 102% of the full premium under each selected Coverage Features, which represents the College's share, your share, plus 2% for administrative costs.

Notice of election. The Plan Administrator may develop reasonable procedures addressing how continuing coverage may be elected, consistent with the terms of the Plan and USERRA. If you think you may be affected by USERRA, contact the Plan Administrator.

Coordination with COBRA. USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available. However, you should contact your Plan Administrator for more information, since a continuation of coverage under COBRA may be available to your spouse or dependent children in certain circumstances.

Rights For Participants on Family Leave under the FMLA

FMLA may entitle you, subject to certain eligibility requirements, to take a job-protected leave for your own serious illness, for the birth or adoption of a child, or to care for a spouse, child or parent who has a serious health condition. If you are the spouse, son, daughter, parent or next of kin for a covered servicemember, extended FMLA leave may be available to care for that servicemember. If you take a leave of absence that qualifies under the FMLA, you may continue your participation in any Coverage Feature subject to continued coverage under FMLA so long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during FMLA leave will be made pursuant to procedures established by the Plan Administrator. If you lose any coverage during any FMLA leave because you did not make the required contributions, you may re-enroll when you return

from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

Genetic Nondiscrimination

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of individuals or their family members. To comply with this law, the Plan Sponsor is asking you not to provide any genetic information when responding to any request for medical information under the Plan. "Genetic information" that should not be disclosed pursuant to GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, genetic information of a fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART EIGHT - MISCELLANEOUS PROVISIONS

- Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Eligible Employee any right to be retained in the employ of the College or any Participating Employer.

- A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

- Headings and numbers in this Plan are included for convenience of reference only, and if there shall be any conflict between any of the numbers and headings and the text of the Plan, the text shall control.

- Participants shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

- Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, the College or any of the Participating Employers, and in no event will the terms of employment or service of any Eligible Employee be modified or in any way affected hereby.

- All benefits and rights under this Plan (including the right to bring a lawsuit) are personal to the Plan participants or their properly designated beneficiaries and cannot be sold, assigned, or transferred to any other person or entity.

- The Plan is maintained for the exclusive benefit of the Participants.

- No employee of the College or any other Participating Employer, whether or not a Participant in, or eligible to participate in, the Plan, nor any Eligible Dependent, shall at any time have any vested rights to benefits provided under the Plan or under any Welfare Benefit Contract.

- To the extent any Coverage Feature under the Plan is self-insured by any Participating Employer, the benefits provided hereunder will be paid solely from the general assets of the Participating Employer. Nothing herein will be construed to require the Participating Employers or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in this Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Participating Employers from which any self-insured benefit payment under the Plan may be made.

- The College shall act for and on behalf of any and all Participating Employers in all matters pertaining to the Plan, and every act done by, agreement made with, or notice given to the College shall be binding on all such Participating Employers.

- To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan shall be governed by, and construed in accordance with, the laws of ***Massachusetts.***

- The College does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program.

- To verify whether a particular service is covered under a Coverage Feature, please contact the applicable provider or administrator set forth on Schedule A and seek written verification of the coverage determination.

PART NINE - GLOSSARY OF TERMS

"Annual Enrollment Period" means ***Annual Enrollment Period that begins every October 1st through November 30th.***

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as described in Part Four.

"COBRA Administrator" means the party who administers COBRA continuation coverage, as identified in Part Four.

"Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

The "College" means ***Trustees of the College of the Holy Cross*** and any successor to all or a major portion of its assets or business that assumes the obligations of ***Trustees of the College of the Holy Cross*** under the Plan.

"Coverage Feature" means a health and welfare benefit offered under the Plan, and may include "Non-Contributory Coverage Features," which are paid for by the College, and "Contributory Coverage Features," which require you to contribute towards the cost.

"Covered Person" means a Participant as well as any Eligible Dependent or beneficiary who is or becomes covered under one or more Coverage Features.

"Dependent Child" means the child of a Participant who

- Is an Eligible Dependent; and
- Was enrolled in the Group Medical Coverage Feature, on the basis of being a student at a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), immediately before the first day of a Medically Necessary Leave of Absence.

Your "Eligible Dependents" must be U.S. Citizens or legal residents and, must meet all eligibility requirements under an applicable Welfare Benefit Contract, and generally are:

- Your spouse (defined as an individual married to you in a state whose laws authorize your marriage, (generally referred to as the "state of celebration"), in accordance with such state's laws, whether the spouse is of the opposite or the same sex as you); if you are legally separated or divorced, your spouse or former spouse is not an eligible dependent unless either mandated by state law or, with respect to a Coverage Feature, expressly deemed to be an Eligible Dependent under the Welfare Benefit Contract of such Coverage Feature;
- With respect to the Group Medical and Dental Coverage Features, any child of a covered Eligible Employee who has not attained age 26;
- With respect to any Coverage Feature, any individual expressly deemed to be an Eligible Dependent under the Welfare Benefit Contract of such Coverage Feature.

You are an "Eligible Employee" if you meet all eligibility requirements under an applicable Welfare Benefit Contract, and

- You work in the United States for a Participating Employer, and
- You are an active full-time employee regularly scheduled to work 27.5 hours or more a week and at least 40 weeks per year, and
- You meet any other eligibility requirements, as set forth on Schedule A, and
- You are legally authorized to work in the United States for a Participating Employer, and
- You are not:
    - Engaged under an agreement that states you are not eligible to participate in the Plan or a Coverage Feature;
    - A non-resident alien performing services outside the United States;
    - Classified by the College as an independent contractor or consultant; or
    - Employed by a staffing firm.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"Excepted Benefit" means a benefit described in Section 732(c) of ERISA and the regulations promulgated thereunder.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Grandfathered" means the Plan is "grandfathered" within the meaning of § 1251 of PPACA.

"Group Dental Coverage Feature" is as designated on Schedule A.

"Group Medical Coverage Feature" is as designated on Schedule A.

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

"HMO" means a Health Maintenance Organization.

"Human Resources Department" means ***College of the Holy Cross, Human Resources Department, One College Street, P.O. Box HR, Worcester, MA 01610-2395, (508) 793-2426.***

"Increased Cost Exemption" means an exemption from the mental health and substance abuse parity rules set forth in Part 2 due to increased costs of providing such coverage, as determined in accordance with Section 712(c)(2) of ERISA.

"Marketplace" is as defined in Part 7.

"Medically Necessary Leave of Absence" means a leave of absence of a Dependent Child from a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

- Commences while such Dependent Child is suffering from a serious illness or injury;
- Is medically necessary; and
- Causes such Dependent Child to lose student status for purposes of coverage under the Group Medical Coverage Feature.

No leave of absence (or other change of enrollment) shall be considered a Medically Necessary Leave of Absence unless the Plan receives written certification by a treating physician of the Dependent Child that the Dependent Child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

"MHPA" means the Mental Health Parity Act of 1996, as amended from time to time and as described in Part Two.

"Non-Grandfathered" means, with respect to a Group Medical Coverage Feature, that such Coverage Feature is not "grandfathered" within the meaning of §1251 of PPACA.

"Overpayment" is defined in Part Five.

"Participant" means an Eligible Employee or Eligible Dependent who is eligible under a Welfare Benefit Contract to participate in a Coverage Feature and becomes covered under such Coverage Feature either automatically or through his or her enrollment, as applicable.

"Plan" means the ***Trustees of the College of the Holy Cross Health and Welfare Benefits Plan (Plan Number 506)*** as set forth in this plan document and summary plan description (including any and all amendments and supplements hereto) and the Welfare Benefit Contracts, which are incorporated by reference into the Plan.

"Plan Administrator" means the College or such other person or committee as may be appointed from time to time by the College to supervise the administration of the Plan.

"PPACA" means, collectively, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

"QMCSO" means a Qualified Medical Child Support Order, as described in Part One.

"SSA" means the United States Social Security Administration.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

"Welfare Benefit Contract" means any contractual arrangement maintained by the College, and described on Schedule A, under which group health or other welfare benefits are available to Employees and their eligible dependents, including any description of benefits, certificate of coverage, summary plan description, subscriber agreement, evidence of coverage, or other related materials relating to such benefits.

The "Wellstone Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time, and any regulations and guidance issued thereunder including, without limitation, 29 CFR §2590.712.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as described in Part Two.

IN WITNESS WHEREOF, the College has caused this Plan to be executed in its name and on its behalf this ___ day of _____, 2018, by its duly authorized officer.

Trustees of the College of the Holy Cross

By _____

Name _____

Title _____

Trustees of the College of the Holy Cross Health and Welfare Benefits Plan

Schedule A

Summary of Welfare Benefits as of January 1, 2018

Coverage Options	*Welfare Benefit Contract Information*	*Eligibility requirements*	*Employee/ Employer Premium Cost Per Month*	*For More Information*
Group Medical Coverage Feature				
Fallon Health HMO Direct Care	Contract: C002230026C01 Group#:4449680	First day of the month following date of employment	Employee per Month: Single: $92.56 EE+Sp: $194.38 EE+Ch(ren): $166.61 Family: $280.46 Employer per Month: Single: $568.59 EE+Sp: $1,194.03 EE+Ch(ren): $1,023.46 Family: $1,722.82	Fallon Health Plan 10 Chestnut Street Worcester, MA 01608 800-868-5200 www.fchp.org
Fallon Health Plan HMO Select Care	Contract: C002230026C01 Group#: 2230026	First day of the month following date of employment	Employee per Month: Single: $193.74 EE+Sp: $406.88 EE+Ch(ren): $348.73 Family: $587.04 Employer per Month: Single: $568.59 EE+Sp: $1,194.03 EE+Ch(ren): $1,023.46 Family: $1,722.82	
Fallon Health Plan HMO HDHP Direct Care	Contract: C002230026C01 Group#: 4510961	First day of the month following date of employment	Employee per Month: Single: $20.75 EE+Sp: $43.58 EE+Ch(ren): $37.35 Family: $62.88 Employer per Month: Single: $498.06 EE+Sp: $1,045.91 EE+Ch(ren): $896.50 Family: $1,509.10	
Fallon Health Plan HMO HDHP Select Care	Contract: C002230026C01 Group#: 4510962	First day of the month following date of employment	Employee per Month: Single: $108.16 EE+Sp: $227.14 EE+Ch(ren): $194.69 Family: $327.72 Employer per Month: Single: $498.06 EE+Sp: $1,045.91 EE+Ch(ren): $896.50 Family: $1,509.10	
Fallon Health Plan PPO Preferred Care	Contract: C002230026C01 Group#: 9990381	First day of the month following date of employment	Employee per Month: Single: $369.10 EE+Sp: $775.10 EE+Ch(ren): $664.36 Family: $1,118.37 Employer per Month: Single: $568.59 EE+Sp: $1,194.03 EE+Ch(ren): $1,023.46 Family: $1,722.82	
Fallon Health Plan PPO Preferred Care	Contract: C002230026C01 Group#: 9983137	First day of the month following date of employment Tenured faculty members on sabbatical.	Employee per Month: Single: $193.74 EE+Sp: $406.88 EE+Ch(ren): $348.73 Family: $587.04 Employer per Month: Single: $568.59 EE+Sp: $1,194.03 EE+Ch(ren): $1,023.46 Family: $1,722.82	

Coverage Options	*Welfare Benefit Contract Information*	*Eligibility requirements*	*Employee/ Employer Premium Cost Per Month*	*For More Information*
Harvard Pilgrim Health Plan HMO	Group #: 060215	First day of the month following date of employment	Employee per Month: Single: $725.60 EE+Sp: $1,394.36 EE+Ch(ren): $1,435.52 Family: $1,844.78 Employer per Month: Single: $568.59 EE+Sp: $1,194.03 EE+Ch(ren): $1,023.46 Family: $1,722.82	Harvard Pilgrim HealthCare 93 Worcester Street Wellesley, MA 02481 888-888-4742 www.hphc.org
Tufts Health Plan Medicare Preferred HMO Rx plan	Group #: 01899000	Retirees of College of the Holy Cross who are Medicare Part B eligible	Employee per Month: Single: $310.00	Tufts Health Plan 705 Mt. Auburn Street Watertown, MA 02472 617-972-9400 www.tuftshealthplan.com
Tufts Health Plan Medicare Preferred Prime Medicare Supplement with PDP Plus	Group #: 01899000	Retirees of College of the Holy Cross who are Medicare Part B eligible	Employee per Month: Single: $413.00	Tufts Health Plan 705 Mt. Auburn Street Watertown, MA 02472 617-972-9400 www.tuftshealthplan.com
Medical Expense Reimbursement Plan (MERP)				
Trustees of the College of the Holy Cross MERP	Self-Insured	First day of the month following date of employment and enrollment in the HMO or PPO group health plans. (High deductible health plans and Retiree plans are not eligible).	100% Employer Paid	College of the Holy Cross Human Resources Department 1 College Street Worcester, MA 01610
Group Dental Coverage Feature				
Delta Dental of Massachusetts PPO Plus Premier	Group#: 006049 Self-Insured	First day of the month following date of employment	Employee per Month: Single: $16.00 EE+Sp: $45.00 EE+Ch(ren): $41.00 Family: $53.00 Employer per Month: Single: $26.00 EE+Sp: $82.00 EE+Ch(ren): $82.00 Family: $82.00	Delta Dental of MA 465 Medford Street Boston, MA 02129 800-451-1249 www.deltadentalma.com
Voluntary Vision Coverage Feature				
EyeMed Insight Network	1014882 / 1001 – Materials Only 1014882 / 1002 – Exam & Materials	First day of the month following date of employment	100% Employee Paid	EyeMed Vision Care 400 Luxottica Place Mason, Ohio 45040 866-939-3633 www.eyemed.com
Group Life/ AD&D Coverage				
Sun Life Group Life & Accidental Death & Dismemberment	#900760	First day of the month following date of employment	100% Employer Paid	Sun Life Financial 96 Worcester Street Wellesley Hills, MA 02481 781-237-6030 www.sunlife.com
Employee Voluntary and Dependent Voluntary Life Insurance			100% Employee Paid Age Banded Rates	

Coverage Options	*Welfare Benefit Contract Information*	*Eligibility requirements*	*Employee/ Employer Premium Cost Per Month*	*For More Information*
Group Long Term Disability				
Group Long Term Disability Plan	#900760	First day of the month following 1 year of service.	100% Employer Paid, Gross-Up	Sun Life Financial 96 Worcester Street Wellesley Hills, MA 02481 781-237-6030 www.sunlife.com
Flexible Spending Account				
Health Care Spending Account	Administered by Benefit Strategies, LLC.	Active Employees: On January 1st of each year. New Hires: First day of the month following date of employment	Employee pays 100%	Benefit Strategies, LLC. 967 Elm Street Manchester, NH 03101 603-647-4666 www.benstrat.com
Dependent Care Spending Account			Employee pays 100%	
Employee Assistance Program				
KGA, Inc. Employee Assistance Program	Administered by KGA, Inc.	All Employee's from Date of Hire	Employer Paid	KGA, Inc. 161 Worcester Road Suite 409 Framingham, MA 01701 Phone: 800-648-9557 www.kgreer.com

TRUSTEES OF THE COLLEGE OF THE HOLY CROSS HEALTH AND WELFARE BENEFITS PLAN

Schedule B

Group Medical Coverage Feature: Full Time Employee Policy

Effective January 1, 2015

Introduction

The Affordable Care Act imposes new rules governing offers of group health plan coverage by employers to their full-time employees. The purpose of this schedule is to describe how we determine whether newly hired and other (ongoing) employees are considered to be full-time for purposes of our Group Medical Coverage Feature. These rules are important, since they determine the circumstances under which our employees qualify for coverage under our Group Medical Coverage Feature.

New Hires

Upon hire, each of our employees is classified as full-time, part-time, variable hour, or seasonal.

- A "full-time employee" is an employee who is expected to work on average 27.5 or more hours per week during each calendar month.
- A "part-time employee" is an employee who is not expected to work on average 27.5 or more hours per week during each calendar month.
- A "seasonal employee" is an employee who is hired into a position for which the customary annual employment is six months or less.
- A "variable hour employee" is an employee who we cannot determine is reasonably expected to be employed on average at least 30 hours of service per week during his or her "initial measurement period" (described below) because the employee's hours are variable or otherwise uncertain.

New hires classified as full-time will be eligible to participate in our Group Medical Coverage Feature on the first day of the calendar month immediately following date of hire.

Employees classified as part-time, seasonal and variable hour employees are not eligible to participate in our Group Medical Coverage Feature upon hire, but may become eligible under the look-back measurement method for new hires. Under the look-back measurement method for new hires, part-time, seasonal and variable hour employees must first complete a **12-month** initial measurement period (that starts on the first day of the month following date of hire) during which they are not eligible to participate in the Group Medical Coverage Feature. At the completion of the **12-month** initial measurement period, a part-time, seasonal or variable hour employee who has worked on average at least 27.5 hours of service per week during that period will be eligible to participate in our Group Medical Coverage Feature **on the first day of the next month** and will remain eligible for a **12-month** period (called the "stability period") irrespective of their hours during the stability period, provided they remain employed with the College. An employee who fails to work on average at least 27.5 hours per week during his or her initial measurement period is not eligible for coverage during the corresponding **12-month** stability period (subject to the transition rules described below).

Ongoing Employees

Once an employee has been employed with the College continuously for one **12-month** "standard measurement period," he or she is no longer classified as full-time, part-time, seasonal, or variable hour employee; rather, he or she is considered to be an "ongoing employee" and tested for full-time status using the look-back measurement method for ongoing employees. Under the look-back measurement method for ongoing employees, the standard measurement period is a fixed, **12-month** period that runs from **December 1 to the following November 30.** An ongoing employee who works on average at least

30 hours of service per week during a standard measurement period will be eligible to participate in the Group Medical Coverage Feature during a corresponding stability period, which is **January 1 to December 31**. An ongoing employee who fails to work on average at least 27.5 hours per week during a standard measurement period is not eligible for coverage during the corresponding stability period.

Transition from New to Ongoing Employee Status

The following rules govern the transition from a new hire to an ongoing employee:

- If an employee is determined to be "full time" during the initial measurement period, he/she remains eligible to participate in the Group Medical Coverage Feature for the entire stability period associated with the initial measurement period.

- If, however, an employee is determined to be not "full time" during the initial measurement period, but is considered "full time" during the overlapping standard measurement period, the "not full time" stability period is cut short and the employee is eligible to participate in the Group Medical Coverage Feature for the entire stability period associated with the overlapping standard measurement period.

Employees Terminated and Rehired

If an employee terminates employment with the College and is rehired by the College, he or she will be treated as a new hire for purposes of this policy only if the period between the termination and rehire exceeds the lesser of:

- ***26 weeks for educational organizations***, or

- A period of no less than four weeks and at least as long as the employee's period of employment with the College prior to termination.

How We Count Hours of Service

Hours of service include each hour for which an employee is paid, or entitled to payment, by the College for the performance of duties for the College, as well as each hour for which an employee is paid, or entitled to payment, by the College on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of service performed for certain affiliates of the College may be considered to be hours of service for the College in some cases. The College counts hours of service from records of hours worked and hours for which payment is made or due.

For purposes of the look-back measurement method, unpaid FMLA, jury duty and USERRA leave are excluded from both the numerator and the denominator in determining an employee's average hours during a measurement period.