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Summary of Benefit Description

Trustees of the College of the Holy Cross

Medical Expense Reimbursement Plan

Effective as of January 1, 2015

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TRUSTEES OF THE COLLEGE OF THE HOLY CROSS
MEDICAL EXPENSE REIMBURSEMENT PLAN BENEFIT SUMMARY

The Trustees of the College of the Holy Cross Medical Expense Reimbursement Plan provides reimbursement for a portion of the inpatient hospital and outpatient hospital expenses as described below. Reimbursement through this plan is only for non-occupational injury and illness claims. In order to obtain reimbursement, employees must present a completed medical expense reimbursement claim form along with an invoice from an eligible provider and an explanation of benefits indicating that an inpatient and/or outpatient hospital copay, applicable under a College of the Holy Cross HMO or PPO medical plan(s) (non-High Deductible Health Plan), was incurred.

Eligibility:

- All Employees and Dependents insured under one of the College of the Holy Cross HMO or PPO group health plans. Employees and dependents enrolled in the College's high deductible health plan *are not eligible.*

Reimbursement Maximums:

The plan reimburses the maximum amount per service as noted in the following schedule:

Type of Service	*MERP Reimbursement Maximum*
Inpatient Hospital Copayment	$ 125.00
Outpatient Hospital Copayment	$ 50.00

INTRODUCTION

Plan Administrator

The Plan Administrator, **Trustees of the College of the Holy Cross,** is the Plan Sponsor and sole fiduciary of the Plan. The Plan Administrator exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The Plan Administrator shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The Plan Administrator has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The Plan Administrator may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the Plan Administrator, as described above.

Claims Administrator

Group Insurance Solutions, Inc. dba Sullivan Benefits
33 Boston Post Road W, Suite 120
Marlborough, MA 01752

Tax Identification Number
04-2103558

Plan Identification Number
506

Effective Date of the Plan
January 1, 2015

Plan Year
January 1- December 31

Method of Funding Benefits

The funding for the benefits is derived from the funds of the College. This Plan is not insured.

Name and Type of Plan

College of the Holy Cross Medical Expense Reimbursement Plan, to reimburse certain non-occupational injury and illness claims that are subject to the benefit description for inpatient and/or outpatient hospital copayments as described herein.

Name and Address of Plan Administrator

Trustees of the College of the Holy Cross
1 College Street
Worcester, MA 01610

College of the Holy Cross has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.**

Benefits described in this document are effective January 1, 2015. The terms and conditions of the Trustees of the College of the Holy Cross Medical Expense Reimbursement Plan are governed by the provisions in this document. Any and all other written communication regarding this Plan or the benefits provided under this Plan are superseded and are of no force or effect.

This Plan is in compliance with all applicable federal laws. In the event of a change in federal law, the Plan will be deemed to be in compliance and administered accordingly.

ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you and your eligible dependents are enrolled in one of the College of the Holy Cross HMO or PPO group medical plans (*those enrolled in the high deductible health plans are not eligible*).

B. Who Pays For Your Benefits

College of the Holy Cross funds the cost of providing the medical expense reimbursement plan benefits for you and your dependents.

C. Enrollment Requirements

If you desire Plan benefits, you must meet the eligibility requirements above and/or be enrolled in the College of the Holy Cross medical plans (except for the high deductible health plan) by completing and submitting the applicable enrollment forms to Human Resources within thirty-one (31) days of your eligibility date. Any dependents must also be enrolled in the medical plans to receive benefits under this plan. If you have eligible dependents at a later date, you must enroll dependents, including newborns, by completing and returning an enrollment form to Human Resources within thirty-one (31) days of the date they become your dependent(s). All employees and dependents that are enrolled in one of the College of the Holy Cross group medical plans (except for the high deductible health plan) are automatically enrolled in this plan.

D. Open Enrollment Period

The Open Enrollment Period begins at the end of October through November, effective January 1st.

E. When Coverage Begins

When the enrollment requirements are met, you are eligible for medical reimbursement on the first day that you and your eligible dependents are enrolled in the College of the Holy Cross applicable medical plans.

F. When Coverage Ends

Coverage for you and your eligible dependents ends the earliest of the date in which your employment terminates and/or the date you are no longer enrolled in the College of the Holy Cross applicable medical plans.

G. Continuation of Coverage (COBRA)

Refer to the College of the Holy Cross Trustees Health and Welfare Benefits Plan Consolidated Plan Document and Summary Plan Description, Section Four.

H. The Uniformed Services Employment And Re-employment Rights Act (USERRA)

This Plan will comply with the requirement of all the terms of the Uniformed Services Employment And Re-employment Rights Act of 1994 (USERRA). This is a federal law, which gives members and former members of the U.S. armed forces (active and reserves) the right to return to their civilian job they held before military service.

HIPAA/CREDITABLE COVERAGE

A. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the HIPAA law, individuals who lose group health coverage may obtain new coverage regardless of any pre-existing medical conditions. Effective with plan years beginning on or after July 1, 1997, group health plans and their insurers must reduce any pre-existing condition exclusion period by the individual's aggregate period of previous health insurance coverage.

SCHEDULE OF BENEFITS

Covered expenses are subject to the following limitations:

Eligibility:

- All Employees and Dependents insured under one of the College of the Holy Cross HMO or PPO group health plans. Employees and dependents enrolled in the high deductible health plan are not eligible.

Reimbursement Maximums

The plan reimburses the maximum amount per service as noted in the following schedule:

Type of Service	*MERP Reimbursement Maximum*
Inpatient Hospital Copayment	$ 125.00
Outpatient Hospital Copayment	$ 50.00

GENERAL PLAN EXCLUSIONS

This Plan will not provide benefits for any service or expense that is not described above. All other expenses are excluded.

PLAN ADMINISTRATION

Fiduciary Duties and Rights

The employer shall exercise all of the discretionary authority and control with respect to the management of this Plan.

The employer may delegate certain of its fiduciary responsibilities under this Plan to persons who are not named fiduciaries of this Plan. If the employer delegates its fiduciary responsibilities to another person, except as otherwise required by ERISA, the delegation shall be made in writing by the employer and a copy of the delegation will be kept with the records of this Plan.

Each fiduciary is solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibilities by another fiduciary with respect to this Plan unless (a) it participates knowingly in such breach, knowingly undertakes to conceal such breach or has actual knowledge of such breach and fails to take reasonable action to remedy such a breach or (b) through it's negligence in performing it's specific fiduciary responsibilities which gave rise to it's status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for breach of fiduciary duty before it became a fiduciary and nothing in this Plan shall relieve any person from liability for his or her own misconduct or fraud.

Plan Administrator and Plan Administration

As Plan Administrator, the employer will comply with all ERISA requirements. The Plan Administrator may also make rulings, interpret this Plan, describe procedures, gather needed information, receive and review financial information regarding this Plan, employ or appoint individuals to assist in any administrative function and generally do all things needed to administer this Plan.

The Plan Administrator has all powers and authority needed to enable it to carry out it's duties under this Plan, including by way of illustration and not limitation (a) the powers and authority contemplated by ERISA and (b) the powers and authority to make rules with respect to this Plan not inconsistent with the terms of this Plan or ERISA and to determine, consistent with those rules, all the status and rights of participants, beneficiaries and other persons.

Failure by this Plan or Plan Administrator to insist upon compliance with any provision of this Plan at any time or under any set of circumstances shall not operate to waive or modify any provision of this Plan or in any manner render it unenforceable as to any other situation or circumstance, whether the situation or circumstance is or is not the same. No waiver of any term

or condition of this Plan shall be valid or of any force or effect unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

This Plan shall be interpreted by the Plan Administrator under federal law, including ERISA.

GENERAL CLAIMS PROVISIONS

HOW TO FILE A CLAIM

Please follow the instructions below for applicable Inpatient and / or Outpatient Hospital copayments:

Employees must present and send a completed medical expense reimbursement claim form along with an invoice from an eligible provider and an explanation of benefits indicating that an Inpatient and/or Outpatient Hospital copay was incurred. If a claim form is needed, you can obtain one from your Human Resources Department or on the College's Benergy site.

Submit Claims to:

Sullivan Benefits
Attn: Leslie Schuster
33 Boston Post Road W, Suite 120
Marlborough, MA 01752
Fax: 508-439-4197

Information Necessary When Submitting a Claim

- A copy of the explanation of benefits indicating that Fallon Health or Harvard Pilgrim processed the claim and an Inpatient and/or Outpatient Hospital copayment was applied.
- Each bill or receipt must include the following information:
    - Name of patient;
    - Name, address of the provider of the services;
    - Date of Service
    - Amount of copayment paid.

Should you have any questions about claims payment, please contact Sullivan Benefits at 508-278-1734

Proof of Loss

Written proof of loss must be furnished to the Claims / Plan Administrator within one (1) year from the date of service. Claims submitted after one (1) year will be denied.

Notice given by or on behalf of the covered person to the Plan Administrator with particulars sufficient to identify the covered person shall be deemed to be notice to the Plan Administrator. The Plan Administrator, upon receipt of the notice required by this Plan, will furnish to the covered person such forms for filing proof of loss.

Proof of loss must be furnished to the Claims/Plan Administrator within one (1) year after the termination of the period for which claim is made or one (1) year after expenses are incurred, whichever comes first. Failure to furnish proof within the time provided in this Plan shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof. However, when a covered person's coverage terminates for any reason, written proof of loss must be given to the Plan Administrator within ninety (90) days of the date of termination of coverage, provided that this Plan remains in force. Upon termination of this Plan, final claims must be received within thirty (30) days of termination.

Each covered person shall file with the Plan Administrator such information as is necessary to determine eligibility or proof of dependency. It is the covered person's responsibility to provide this information or benefits under this Plan may be withheld until requested information is received.

CLAIMS PROCEDURES FOR FILING MEDICAL CLAIMS

Claims for Benefits

A claim for benefits is a request for a Plan benefit or benefits, made by a covered employee/dependent or their representative that complies with the Plan's reasonable procedure for making benefit claims.

Manner and Content of Notification of Claims Decision

The Plan Administrator will provide a claimant with written or electronic notification of the plan's claims decision. In the case of an adverse claims decision, the notification will include:

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the decision is based;
- A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why that material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action following an adverse claims decision on review;

Appeal of Adverse Claims Decisions

Upon receipt of an adverse claims decision, the claimant has up to 180 days to file an appeal with the Plan Administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

Notification of Claims Decision on Review

The Plan Administrator will notify the claimant of the plan's claims decision on review within a reasonable time period appropriate to the circumstances.

Manner of Content of Notification of Claims Decision on Review

The Plan Administrator will provide claimants with written or electronic notification of a plan's benefit determination on review. In the case of an adverse claims decision, the notification must set forth:

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the claims decision is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, without regard to whether those records were considered or relied upon in making the adverse claims decision on review, including any reports, and the identities of any experts whose advice was obtained;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about those procedures;

Time Limitation

If any time limitation of this Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted under the guidelines of ERISA and/or any federal law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Miscellaneous

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE

College of the Holy Cross Trustees (the "Plan Sponsor") sponsors the College of the Holy Cross self-funded Medical Expense Reimbursement Plan (the "Plan). Members of the College's workforce have access to the individually identifiable

health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

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.

OTHER IMPORTANT INFORMATION

ERISA Rights

As a participant in the College of the Holy Cross Medical Expense Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). All plan participant entitlements are outlined and disclosed in the College of the Holy Cross Trustees Health and Welfare Benefits Plan Consolidated Plan Document and Summary Plan Description, Section Seven.

No Rights of Employment

The Plan is not an employment contract. The Plan does not give you the right of employment with the College and does not in any way prevent the College from terminating your employment.

IN WITNESS WHEREOF, the College has caused this Plan to be executed in its name and on its behalf this ___ day of _____, 201_, by its duly authorized officer.

Trustees of the College of the Holy Cross

By _____

Name _____

Title _____