CHAPMAN UNIVERSITY

Chapman University Health Welfare Plan

Health and Welfare Plan Document and Summary Plan Description

Amended: January 1, 2012

This document, together with the applicable certificates of insurance and/or policy booklets issued by the Employer constitutes the written Plan document as required under ERISA §402 and Summary Plan Description required by ERISA §102.

Employer is Chapman University, and also includes the Eligible Employees of Brandman University.

TABLE OF CONTENTS

1. Introduction

Chapman University ("Employer") maintains the **Chapman University Health Welfare Plan** ("Plan") for the exclusive benefit of Eligible Employees and their eligible Dependents. **Employer is Chapman University, and also includes the Eligible Employees of Brandman University.** Currently, these benefits are provided under various insurance contracts entered into by the Employer for the Plan. The Plan benefits are summarized in the certificates of insurance and/or policy booklets issued by the applicable insurance companies. **This document, together with the certificates of insurance and/or policy booklets constitutes the Summary Plan Description required by ERISA §102. Participants should read this entire Plan document, including all exhibits and/or attachments to ensure that all requirements and conditions of the Plan are fully understood.**

2. General Information About the Plan

Plan Name:	**Chapman University Health Welfare Plan**
Type of Plan:	Welfare Benefits Plan, including medical, dental, vision, flexible spending accounts (FSA), basic life/AD&D, long term disability, short term disability (non-faculty employees only), supplemental life/AD&D, employee assistance program (EAP), prepaid legal, and transit/commuter coverages.
Plan Year:	January 1 – December 31
Fiscal Year:	June 1 – May 31
Plan Number:	**501**
Grandfathered Status:	The medical coverages within this ERISA plan are ***non-grandfathered*** under health care reform legislation "Patient Protection and Affordable Care Act" (PPACA) as of January 1, 2011.
Funding Medium and Type of Administration:	This Plan provides fully insured benefits provided under group insurance contracts, as well as self funded benefits under an administrative services only contract, to Eligible Employees and their Dependents. Contracts are entered into between the Employer and the insurance companies identified in this document. Claims for benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims, not the Employer. Note that the insurance companies and the Employer share responsibility for administering the plan.

Plan Sponsor and Plan Administrator:	**Chapman University** One University Drive Orange, California 92866 714.628.2734
Plan Sponsor's EIN:	**95-1643992**
Medical Insurance Company:	Kaiser Permanente 393 East Walnut Street Pasadena, CA 91101 800.464.4000
Policy Number:	Southern CA – 102313 Northern CA – 603127
Medical Insurance Company:	Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367 800.888.8288
Policy Number:	175211
Basic Life/AD&D, **Supplemental Life** Insurance Company:	Standard Insurance Company P.O. Box 2800 Portland, OR 97208-1203 800.628.8600
Policy Number:	(Basic) 132072-C (Supp.) 132072-D
Short Term Disability, **Long Term Disability** Insurance Company:	Standard Insurance Company P.O. Box 2800 Portland, OR 97208-1203 (STD) 800.368.2859 (LTD) 800.368.1135
Policy Number:	(STD) 132072-B (LTD) 138116-A
Dental Insurance Company:	Delta Dental P.O. Box 997330 Sacramento, CA 95899-7330 800.765.6003
Policy Number: (a self funded benefit)	7583

Dental Insurance Company:	Delta Care USA P.O. Box 1810 Alpharetta, GA 30023 800.422.4234
Policy Number:	1795
Vision Insurance Company:	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195
Policy Number:	1130783
Employee Assistance Program Company:	Horizon Health horizoncarelink.com 888.293.6948
Policy Number:	138116-A
Prepaid Legal Services Insurance Company:	Hyatt Legal Plans 1111 Superior Avenue Cleveland, OH 44114 800.821.6400
Policy Number:	7090001
Flexible Spending Accounts; Transportation Benefit Company:	Flex-Plan Services P.O. Box 53250 Bellevue, WA 98015-3250 800. 669.3539
Policy Number:	CHU
Named Fiduciary and Agent for Service of Legal Process:	**Chapman University** One University Drive Orange, California 92866 714.628.2734

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

The written plan document required by ERISA §402 consists of this document, together with group insurance contract(s) entered into between the Employer and the insurance companies.

Important Disclaimer: The benefits hereunder are provided pursuant to insurance contracts between the Plan Sponsor and the applicable insurance companies. If the terms of this document conflict with terms of the applicable insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.

3. Eligibility and Participation Requirements

To determine whether you and your Dependents are eligible to participate in the various benefit options offered by the Plan, please read the eligibility information contained in the certificates of insurance and/or policy booklets. Eligible Employees must complete an application for coverage to enroll and must pay the required premium, if applicable.

Eligibility Waiting Period:
Coverage begins on the first of the month following your **date of hire.**

Eligibility Definition:
Eligible Employees are Faculty and regular status Employees, working a minimum of **20 hours** per week, who may only participate in:

- Short term disability (non-faculty employees only)
- Supplemental life/AD&D
- Employee assistance program (EAP)
- Prepaid legal

Faculty and regular status Employees working a minimum of **30 hours** per week, may participate in the above benefits, plus:

- Medical
- Dental
- Vision
- Flexible spending accounts (FSA)
- Basic life/AD&D
- Long term disability
- Transit/commuter

4. Summary of Plan Benefits

The Plan provides Eligible Employees and their Dependents, if applicable, with **medical, dental, vision, flexible spending accounts (FSA), basic life/AD&D, long term disability, short term disability (non-faculty employees only), supplemental life/AD&D, employee assistance program (EAP), prepaid legal, and transit/commuter** coverages. The insured benefits are provided under group insurance contracts entered into between the Employer and the insurance companies. A summary of the benefits provided under the Plan is set forth in the certificates of insurance and/or policy booklets.

This Plan shall provide benefits in accordance with the applicable requirements of federal laws, such as COBRA (see section 9), the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act, and other legislation as it becomes enacted.

Under the federal law entitled **Newborns' and Mothers' Health Protection Act** of 1996, group health plans and health insurance issuers offering group insurance coverage generally may not 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 normal vaginal delivery, or less than 96 hours following a cesarean

section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours) or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

The federal law entitled the **Women's Health and Cancer Rights Act** requires group health plans providing coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

(a) reconstruction of the breast on which the mastectomy has been performed;
(b) surgery and reconstruction of the other breast to produce a symmetrical appearance prostheses;
(c) treatment of physical complications of all stages of mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions applicable to the mastectomy.

This Plan will also provide benefits as required by any **Qualified Medical Child Support Order** (QMCSOs), as defined in ERISA § 609(a). A copy of the procedures governing QMSCOs may be obtained without charge from the Plan Administrator. This Plan will also provide benefits to Dependent children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants or beneficiaries, in accordance with ERISA § 609(c).

5. How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, the Employer and the duly authorized person(s) who acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan. The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a claim fiduciary to receive, review, and process claims for benefits. The Employer bears the incidental costs of administering the Plan.

This Plan provides fully insured benefits provided under group insurance contracts, as well as self funded benefits under an administrative services only contract, entered into between the Employer and the applicable insurance companies. Claims for the insured benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims, not the Employer.

The applicable insurance company or claims administration firm is responsible for:

(a) Determining eligibility for and the amount of any benefits payable under the Plan.
(b) Prescribing claims procedures to be followed and the claims forms to be used by Employees pursuant to the Plan.

Those entities also have the authority to require Employees to furnish them with such information deemed necessary for the proper administration of the Plan. If you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the applicable insurance company or claims administration firm.

6. Funding Policy and Contributions

Funding Policy:
Chapman University has established the **Chapman University Health Welfare Plan** to provide employee benefits to certain of its Employees. In order to carry out the purposes of the Plan the Employer has determined that the Plan shall be funded with both Employer and Employee contributions. Employee contributions for certain qualifying coverages will be paid on a pre-tax basis through the Employer's **Cafeteria Plan.** From time to time this determination shall be reviewed by the Employer who may decide to change this funding policy.

Contributions:
The Employer and Participants may share in the cost of the Plan. The amount of Participant contributions is announced each year at open enrollment.

7. HIPAA Rights for Health Care Benefits

Under HIPAA (the Health Insurance Portability and Accountability Act of 1996), if you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

A Certificate of Creditable Coverage will provide information to this health plan about your prior coverage. Prior creditable coverage is used to reduce the pre-existing condition limitation, if applicable, to this plan.

When coverage ends under this health plan, A Certificate of Creditable Coverage will be issued, automatically and without charge, under the following circumstances:

(a) For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.

(b) For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.

(c) For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant (or by another person authorized by the former Plan Participant).

The Certificate of Creditable Coverage shall be in the form required by HIPAA. Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information.

8. Medicaid and Children's Health Insurance Program (CHIP)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), additional enrollment opportunities include:

Termination of Medicaid or CHIP Coverage: If you and/or your Dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated as a result of loss of eligibility, you may be able to enroll yourself and/or your Dependents in this Plan, as it may trigger a special enrollment right. To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date Medicaid or state-sponsored CHIP coverage ends.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children And Families

If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an Employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your Employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your Dependents are eligible, but not already enrolled in the Employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your Employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/ Pages/ default.aspx Phone: 1-800-635-2570
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	

ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 1-800-635-2570	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP

Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-0555	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	Website: http://www.nyhealth.gov/health_care/ medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://ihrsa/sites/DCS/COB/default.aspx Phone: 1-800-562-6136
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

9. COBRA Continuation of Coverage

Under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA), an Employee and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan. However, you must pay the full cost of Plan coverage, not to exceed 102% of your employer's cost.

An Employee or any Dependent covered under the regular Plan may make his or her own election for COBRA continuation coverage whether you elect it or not.

Coverage may be continued up to 18 months for an Employee and/or Dependent in the event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of an Employee.

Continuation coverage may be extended from 18 months to 36 months for Dependent(s) who are qualified beneficiaries, if during the 18-month period a second qualifying event occurs, such as the Employee dies, enrolls in Medicare, or divorces or legally separates from his spouse. This extension may also apply upon the loss of Dependent status by 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.

Continuation coverage may extend from 18 months to 29 months for an Employee and/or Dependent if one of you becomes totally disabled (as determined by the Social Security Administration under Title 2 or Title 16) at any time during the first 60 days of COBRA continuation coverage. However, you and/or your Dependent must give notice of the disability within 60 days of the Social Security determination and must request to extend the continuation period before the end of the first 18 months. If during the continuation coverage the Social Security Administration determines that the individual is no longer disabled, the individual must inform the Plan of this re-determination within 30 days of the date it is made. Your cost will be 150% of your employer's cost during the 11 month extension for disability.

Coverage may be continued for up to 36 months for a Dependent in the event of:

(a) Your death;
(b) Your divorce or legal separation from your spouse;
(c) Your becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the Plan by yourself and your Dependents;
(d) The loss of Dependent status by a Dependent child under the terms of this Plan.

Coverage will be continued only for an Employee and/or Dependent who were covered under the Plan on the day immediately preceding termination. However, if a child is born to you or placed for adoption with you during the period of COBRA continuation coverage, your child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

(a) The date ending the period for which any required contribution has been paid;
(b) The date you and/or your Dependent first become entitled to Medicare, or first become covered under another group health plan without being subject to that plan's pre-existing limitations;
(c) The date your employer ceases to provide any group health plan.

If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act or 1985 (as amended), the provision is changed to comply with the law.

Note: All Plan Participants must notify the Plan within sixty (60) days of:

(a) Divorce or legal separation;
(b) Covered Dependent child ceasing to qualify as a Dependent;
(c) Acceptance of coverage under another employer's group health plan (whether or not as an Employee), if that plan does not limit coverage for pre-existing conditions;
(d) Second qualifying event;
(e) Qualified beneficiary's disability or cessation of disability;
(f) Death of the Employee.

Written notice must be provided to the Claims Administrator or the designated COBRA Claims Administrator, if applicable. The notice must include the name of the Employee with identification number, Plan name and number, date and type of the qualifying event and name(s) of the applicable Dependent(s).

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

10. Cal-COBRA Continuation of Coverage

You have the option to further continue coverage under Cal-COBRA for medical benefits only if your federal COBRA ended following:

(a) 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
(b) 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under Cal-COBRA. You are not eligible to further continue coverage under Cal-COBRA if you:

(a) Are entitled to Medicare;
(b) Have other coverage or become covered under another group plan, as long as you are not subject to a pre-existing condition limitation under that coverage; or

(c) Are eligible for or covered under federal COBRA. Coverage under Cal-COBRA is available for medical benefits only.

Within 180 days prior to the date federal COBRA ends, the medical insurance company will notify you of your right to further elect coverage under Cal-COBRA. If you choose to elect Cal-COBRA coverage, you must notify them in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under Cal-COBRA, whichever is later. If you don't give them written notification within this time period, you will not be able to continue your coverage.

You will be required to pay the entire cost of your Cal-COBRA continuation coverage. This cost will be:

(a) 110% of the applicable *group* rate if your coverage under federal COBRA ended after 18 months; or
(b) 150% of the applicable *group* rate if your coverage under federal COBRA ended after 29 months.

11. Circumstances Which May Affect Benefits

Your eligibility for Plan benefits terminates on the day that you terminate from employment with the Employer. Certain benefits may extend to the last day of the coverage month. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims. (See the certificates of insurance and/or policy booklets for more information.) Coverage for your Dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the certificates of insurance and/or policy booklets, such as divorce or child attains the limiting age. Benefits will also cease for Employees and Dependents upon termination of the Plan.

Depending on the reason why coverage was terminated, you and your covered Dependents might have the right to continue coverage temporarily under COBRA. See Section 9 for information about COBRA rights.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to pre-existing conditions, and exclusions for certain medical procedures) are described in the certificates of insurance and/or policy booklets. Please read the booklets carefully. See also any Plan notices and other important information about the exclusions due to pre-existing conditions and special enrollment rights you may have, copies of which may have been previously furnished to you. Please contact the Plan Administrator if you need another copy.

12. Leave of Absence

If an Employee takes a leave of absence, paid or unpaid, you may still participate in the Plan. Options for continuing, suspending, or revoking participation in the Plan may vary according to the leave status as defined by Family Medical Leave Act (FMLA) or non-FMLA.

The Participant should contact Human Resources in advance of the leave for more information.

13. Right to Receive Medical Information Necessary to Determine Benefits

By accepting coverage under this Plan, Eligible Employees and their Dependents agree to supply information about medical conditions and records or other coverage when requested by the Plan. All private health information will be kept confidential and will be used on a need only basis for purposes of administering Plan benefits.

14. Amendment or Termination of the Plan

The Plan Administrator shall have the unlimited right to amend, terminate, or merge, the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be binding upon all Employees and Dependents (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. Any such change must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document. An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

15. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

16. Claim Procedures

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the Plan Sponsor is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer’s form.

In that case, the form is available from the Plan Administrator.

The insurance company, as the claim fiduciary, will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence, as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

S**ee the certificates of insurance and/or policy booklets for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.**

17. Statement of ERISA Rights

As a Participant in the **Chapman University Health Welfare Plan** you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all Plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, a copy of the latest annual report (Form 5500) and updated Summary Plan Description. 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 (SAR).

Continue Group Health Plan Coverage

Continue health care coverage for yourself or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

If you have creditable coverage from another plan, you may be able to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your health plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, 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 time 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 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 suite in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.

18. Summary and Protected Health Information

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations, issued under the Privacy Regulations at 45 C.F.R. Parts 160 and 164.

Disclosure of Summary Health Information

This Plan shall disclose to the Plan Sponsor summary health information (information that does not and could not be used to identify an individual) if the Plan Sponsor requests such information for the purpose of:

(a) obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
(b) modifying, amending, or terminating this Plan.

Disclosure of Protected Health Information (PHI)

The Plan will disclose PHI (information that identifies or could identify an individual) to the Plan Sponsor only in accordance with HIPAA Privacy laws. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan Sponsor hereby acknowledges and agrees to the following provisions in this document:

(a) Not to use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
(b) To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
(c) Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
(d) To report to the Plan any PHI use or disclosure that it becomes aware is inconsistent with the uses or disclosures for which provision is made;
(e) To make available protected health information in accordance with 45 CFR §164.524;
(f) To make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526;
(g) To make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
(h) To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;

(i) If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and

(j) To ensure that adequate separation between the Plan and the Employer, as required by 45 CFR §164.504(f), is established and maintained.

Limitations of PHI Access and Compliance

Access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out plan administration functions that the Plan Sponsor performs for the Plan. The access and use of PHI by the Plan Sponsor and staff described above is limited to purposes of the administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

19. Legal Compliance/Conformity

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Employer's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

No clerical errors made by the Employer, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

20. Definitions

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Domestic Partner consists of the following:

- A domestic partner is of same-sex gender, or opposite sex if over age 62.
- A domestic partner is a legal relationship between individuals who live together and share a common domestic life but are not joined in a traditional marriage or a civil union.
- Neither person is related by blood closer than permitted by state law for marriage.
- The partners must be financially interdependent.

Eligible Dependent means an individual who meets the requirements for such status as defined by the applicable certificates of insurance.

Eligible Employee means a person who is an Employee of the Employer, regularly scheduled to work sufficient hours for the Employer in an Employer/Employee relationship and who meets the requirements for such status as defined by the applicable certificates of insurance.

Employer is Chapman University, and also includes the Eligible Employees of Brandman University.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Medicare is the Health Insurance for the Aged and Disabled program under Title XL of the Social Security Act, as amended.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Plan means **Chapman University Health Welfare Plan,** which is a benefit plan for certain Employees of Employer.

Plan Administrator is **Chapman University**.

Plan Year is the twelve-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year that is a short Plan Year, as noted in Section 2.

NOTE: This document, together with the applicable certificates of insurance and/or policy booklets issued for each coverage constitutes the Summary Plan Description required by ERISA §102.