SANTA CLARA UNIVERSITY
GROUP BENEFIT PLAN

Originally Effective November 1, 1988
Amended and Restated as of July 1, 2015

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SECTION 1 – ESTABLISHMENT AND PURPOSE

1.1 Establishment and Purpose

Santa Clara University (SCU) has established the Santa Clara University Group Benefit Plan (Plan) for the purpose of providing welfare benefits to its eligible employees and their eligible dependents. This Plan is established in conformance with and is to be construed as an employer provided welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), with the documentation requirements of the Health Insurance Portability and Accountability Act of 1996 and its regulations (HIPAA) for purposes of the health plan components contained herein, and with the requirements imposed on health plans under the Patient Protection and Affordable Care Act (ACA).

1.2 Original Effective Date

This Plan originally took effect on November 1, 1988.

1.3 Amendment and Restatement

This Restatement reflects all changes made to the Plan, including all changes required to achieve compliance with applicable federal regulations as of July 1, 2015.

1.4 The Plan

The complete terms and conditions of the Plan are contained in the insurance policies purchased by SCU on behalf of its employees and the self-insured plan documents (Component Plans). These policies and self-insured plan documents when taken with this Plan document constitute the entire Plan which is intended to conform to the written plan requirements under Section 402 of ERISA.

1.5 Health Insurance Portability and Accountability Act

This Plan document contains a complete description of the Health Plan Component's use and disclosure of Protected Health Information (PHI) as permitted by HIPAA with regard to health care treatment, payment for health care and health care operations. It also sets forth the agreement by SCU to use and disclose PHI only as permitted by HIPAA. The HIPAA provisions described herein apply to the health plan components described in this Plan. They do not apply to non-health component coverage contained in this Plan.

1.6 Patient Protection and Affordable Care Act

Component Health Plans also have become subject to certain provisions of the ACA. This Plan has been written to comply with the relevant provisions of ACA currently in effect.

SECTION 2 – PLAN SPONSOR AND PLAN ADMINISTRATOR

2.1 Plan Sponsor and Plan Administrator

SCU is the Plan Sponsor and Plan Administrator as defined by ERISA.

SCU shall have the duty and authority to interpret and construe the Plan with regard to all questions of eligibility, the status and rights of any person under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each Employee shall, from time to time, upon request of SCU, furnish to SCU such data and information as SCU shall require in the performance of its duties under the Plan.

SCU may adopt such rules and procedures, as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

SCU shall discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

SCU may employ such counsel and agents and may arrange for such clerical and other services as it may require in carrying out the provisions of the Plan.

SCU, as Plan Administrator, shall retain the authority to delegate to officers and employees of SCU such responsibilities as are imposed on SCU by ERISA and by the terms of this instrument, together with the authority to control and manage the operation and administration of the Plan.

2.2 Named Fiduciary

Pursuant to ERISA Section 402(a)(1), SCU is a Named Fiduciary of the Santa Clara University Group Benefit Plan.

SCU also hereby appoints each group insurance policy issuer (issuer) listed in Appendix A as a Named Fiduciary with such powers as may be necessary to determine the benefits payable under the insurance policies and resolve all questions pertaining to the applicability of the benefit provisions of the insurance policies.

SCU hereby intends that each issuer shall be deemed to have complied with the requirements of ERISA Section 503 (claims procedure) in its exercise of its authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

SCU also hereby appoints the Contract Administrator as a Named Fiduciary of the self-insured (Component Health Plans) with such powers as may be necessary to determine the benefits payable with respect to said plans and to resolve all questions pertaining to the applicability of the benefit provisions of those plans.

SCU hereby intends that the Contract Administrator shall be deemed to have complied with the requirements of ERISA Section 503 (claims procedure) in its exercise of its authority, unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

2.3 Amendment and Termination

SCU intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can terminate the Plan by providing written notice to the Plan participants. In amending or terminating the Plan,

SCU cannot retroactively reduce the benefits to which a participant is entitled prior to the termination or amendment.

SECTION 3 – ELIGIBILITY AND BENEFITS

3.1 General Eligibility for Benefits

Each person who is an Employee will become a participant in the Plan on the first day after he or she has satisfied the applicable eligibility requirements of the applicable Component Plan, provided that such person makes a timely coverage election and makes all contributions required under the Plan, at the time and in the manner specified by SCU. The eligibility requirements with respect to Employees covered under each of the Component Plans are set forth in Appendix C of this Plan document.

Each Spouse, domestic partner (if eligible), child or other dependent of a Covered Employee will become a dependent and a participant on the first day after he or she has satisfied the applicable eligibility requirements for dependent coverage under the applicable Component Plan that provides such dependent coverage, provided that the dependent or the Covered Employee makes a timely coverage election and makes all contributions required under the Plan at the time and in the manner specified by SCU. The eligibility requirements for dependent coverage under those Component Plans that provide dependent coverage are set forth in the official documents for each plan.

3.2 Enrollment Procedures

SCU may from time to time prescribe enrollment procedures that are consistent with the terms of the Plan. Such enrollment procedures may require an Employee's authorization of payroll deductions for all applicable contributions required under the Plan with respect to the Employee and any covered dependents.

3.3 Change in Coverage

SCU may from time to time prescribe the terms, conditions and procedures under which a Plan participant may modify or terminate coverage under the Plan or under one or more Component Plans.

3.4 Termination of Coverage

The coverage of a Plan participant will terminate in accordance with the terms and conditions set forth in the Summary Plan Description and Evidence of Coverage for the applicable Component Plan.

3.5 Benefits

The applicable benefits and coverage options provided under the Component Plans are set forth in the Certificate Booklets or Evidence of Coverage for each such plan. The availability of coverage options will be determined by SCU from time to time and may differ among groups of participants on the basis of any factors determined by SCU in its discretion.

3.6 Source of Benefits

Benefits under any Component Plan will be provided and paid solely by the Plan pursuant to the terms of the applicable insurance policy or service agreement or applicable self-insured plan document. SCU neither guarantees nor has any responsibility for the quality of the health care or services provided or the level of benefits paid under any insurance policy or Service Agreement.

3.7 Deductibles, Co-payments and Out-of-Pocket Limits

SCU may establish from time to time (i) any amount that must be paid by a participant as a deductible before a Component Plan will reimburse the participant for expenses that otherwise would be eligible for benefits, (ii) any co-payment which must be paid by a participant to a provider at the time services are received under a coverage option, and (iii) any maximum out-of-pocket amount that a participant must pay during any one Plan Year. Deductibles, co-payments and out-of-pocket limits may vary among the coverage options available under the Component Plans, among the different features of a single coverage option,

among groups of participants, or in any other manner determined in the discretion of SCU. SCU will have the full power to determine the applicable deductibles, co-payments and out-of-pocket maximums under each coverage option, and to adjust such annual limits from time to time. In establishing the amount of any such annual limit or condition, SCU may rely on tables, appraisals, valuations, projections, opinions or reports furnished by agents employed or engaged by SCU, and may take into account the projected or anticipated costs and expenses relating to the Plan or any Component Plan, including administrative costs. Notwithstanding the foregoing, in no event shall the out-of-pocket limit for non-grandfathered plans exceed amounts permissible under PHS Act Section 2707(b), as applicable.

3.8 Coordination of Benefits

The applicable coordination of benefits provisions for the Component Plans are set forth in the Certificate Booklet and Evidence of Coverage for each such plan.

3.9 Recovery of Overpayment

Any amount paid to any person in excess of the amount to which he is entitled under the Plan will be repaid to the Plan or, if applicable, the Insurer, promptly following receipt by the person of a notice of such excess payments. In the event such repayment is not made, such repayment may be made, at the discretion of SCU or, if applicable, the Insurer, by reducing or suspending any further payments due under the Plan to the person and by taking such other or additional action as may be permitted by applicable law.

3.10 Special Open Enrollment Rights

If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30 days after the other coverage ends (or 30 days after the employer ceases contributions for the coverage). If the other coverage is COBRA coverage, the entire COBRA continuation coverage period must be exhausted before the employee can be enrolled in this Plan.

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so. The eligible employee also may be subject to additional limitations on the coverage available at that time.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the Plan.

3.11 Consolidated Omnibus Budget Reconciliation Act of 1985

Notwithstanding anything in the Plan to the contrary, to the extent required by Code Section 4980B and IRS Regulations thereunder (COBRA), a qualified beneficiary who would lose coverage under a health care plan upon the occurrence of a qualifying event (as defined in Code Section 4980B(f)(3)) shall be permitted to continue coverage under the Plan by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with COBRA. SCU shall provide notice to each covered Employee and his Spouse of their rights under COBRA in accordance with applicable law.

3.12 Continuation of Coverage under California Group Health Policies

COBRA Qualified Beneficiaries under federal law who are covered under a group health policy issued in California are eligible to receive up to 18 months of additional COBRA coverage for medical care upon completion of the 18 months received under federal COBRA. This provision does not apply to self-funded medical plans. *The combination of federal and state COBRA coverage may not exceed 36 months in any event.* The 36 month period dates back to the original qualifying event. The additional COBRA period of coverage terminates the earliest of:

- The date the maximum period of coverage expires;
- The date coverage ceases because a premium payment is not made on time;
- The date the employer no longer provides any group health plan; or,
- The date the employee or qualified beneficiary moves out of insurer's services area.

3.13 Shorter Maximum for Health FSAs

The maximum federal COBRA period for a health flexible spending arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event) ends on the last day of the plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

3.14 USERRA: Employees on Military Leave

Employees going into or returning from military service will have rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 with regard to their benefit plans. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their dependents covered under the Plan before leaving for military service.

3.15 FMLA: Family and Medical Leave Act of 1993 (FMLA)

Notwithstanding the above rule regarding termination of participation or any other provision to the contrary in this Plan, when a Plan Participant commences a qualifying leave under FMLA, the following rules will apply. To the extent required by FMLA, health benefits shall be continued on the same terms and conditions as though the Plan participant were still an active employee. Except as otherwise provided by FMLA, Plan participation will cease prior to the expiration of FMLA leave, when the Plan Administrator learns that the employee does not intend to return to work following FMLA leave. Otherwise, Plan participation will cease upon expiration of FMLA leave, if the employee fails to return to work at that time. If the employee fails to return to work after the FMLA leave, the employee will be required to reimburse the Plan for the cost of the coverage provided to the employee while on FMLA leave.

3.16 FMLA: Military Family Leave

FMLA includes the following additional leave rights:

- Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active military duty or a reservist being called to active military duty in the Armed Forces and is deployed to a foreign country (servicemember).
- Eligible employees may take "qualifying exigency" leave to care for the parent of a servicemember when the parent is incapable of self-care and the need for leave arises out of the servicemember's covered active duty or call to active duty.

- An eligible employee who is the spouse, son, daughter, parent, or next of kin of an eligible covered servicemember as defined below is entitled to up to 26 work weeks of leave in a single 12-month period to care for the servicemember. For purposes of this subparagraph, "eligible covered servicemember" shall mean a veteran who was a member of the Armed Forces (including a member of the National Guard or a military reservist) who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury. A "serious illness or injury" includes illnesses or injuries that either (i) occurred during the servicemember's active duty, or (ii) existed prior to the servicemember's active duty and which were aggravated by service in the line of duty. The military service of the eligible covered servicemember must have ended within 5 years of the first date the eligible employee takes leave.
- An eligible employee who is the spouse, son, daughter, or parent of a servicemember may take "rest and recuperation" leave of up to 15 days to spend time with the servicemember who is on a short-term, temporary, rest and recuperation leave during the period of the servicemember's deployment. SCU may require the eligible employee to provide a copy of the servicemember's orders that indicate the dates of the servicemember's rest and recuperation leave.

3.17 Michelle's Law

All group health care coverage maintained under this Plan that requires a certification of student status for any period of dependent coverage shall comply with Michelle's Law. Eligibility for such coverage for a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the dependent child to lose eligibility for coverage under the group health care coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

3.18 Mental Health and Addiction Equity

All group health care coverage maintained under this Plan, which provide both medical and surgical benefits and offer mental health or substance use disorder benefits thereunder shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

3.19 Genetic Information Nondiscrimination Act of 2008

GINA prohibits this Plan from discriminating against individuals on the basis of genetic information. In general, GINA:

- Prohibits this Plan from adjusting premiums or contribution amounts for a group on the basis of genetic information;
- Prohibits this Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, providing that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a a genetic test in making a determination regarding payment;

- Allows this Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and,
- Prohibits this Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

To comply with this law, the Plan asks that Plan Participants not provide any genetic information when responding to any request for medical information. 'Genetic information' as defined by 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, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 4 – PATIENT PROTECTION AND AFFORDABLE CARE ACT

4.1 Effective Date

The following provisions in this Section are effective as of January 1, 2011 unless otherwise stated.

4.2 Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children available until they turn age 26. The mandate applies to any adult child whether or not he or she is eligible to enroll in some other employer-sponsored group health plan. Adult children shall include those who are a child of the Plan participant, whether or not they are:

- Married or not married;
- Live at home;
- A dependent on the employee's tax return; or,
- A student.

4.3 Essential Health Benefits

ACA generally defines Essential Health Benefits to include the following coverages. Essential Health Benefits covered under this Plan are subject to certain additional requirements under ACA.

- Ambulatory patient services (i.e. outpatient care received without being admitted to the hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

4.4 Lifetime and Annual Dollar Limits on Essential Health Benefits

Prohibition on Lifetime Dollar Limits. Group health plans are prohibited from imposing a lifetime limit on the dollar value of Essential Health Benefits. This Plan is required to notify all individuals whose coverage under the Plan was terminated due to exhaustion of a lifetime dollar limit prior to the effective date of ACA that there is an opportunity to re-enroll in the Plan during a special enrollment period.

Prohibition on Annual Dollar Limits. Effective as of January 1, 2014, this Plan may not establish annual limits on the dollar amount of Essential Health Benefits. This Plan is not prohibited, however, from placing annual dollar limits on specific covered benefits that are *not* Essential Health Benefits to the extent such limits are otherwise permitted under applicable federal or state law.

4.5 Preexisting Condition Exclusions (PCEs)

Effective as of January 1, 2014, this Plan is prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

4.6 Rescissions

The Component Health Plans in this Plan are generally prohibited from rescinding the coverage of a participant. Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is *not* a prohibited rescission if it:

- Only has a prospective effect; or,
- Is effective retroactively due to a failure to timely pay required premiums or contributions toward the cost of coverage.

Rescissions are permitted for fraud or the intentional misrepresentation of fact by the participant as prohibited by the terms of the plan. The plan must provide at least 30 days' advance notice to the affected participant before coverage may be rescinded, and only as permitted under Section 2702(c) or Section 2742(b) of ACA.

4.7 90-Day Waiting Period Limit

Effective as of January 1, 2014, this Plan may not apply a waiting period for coverage that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. ACA regulations permit plans to condition health coverage eligibility on an employee's completion of an employment-based orientation period of up to one month before application of the 90-day waiting period limits. A reasonable and bona fide employment based orientation period is permissible if it is not designed to avoid compliance with the 90-day waiting period limitation.

4.8 Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are made after December 31, 2010.

4.9 Insurance Issuer Rebates

In the event that SCU qualifies and receives a return of premium (Rebate) as a result of the issuer's failure to meet the Medical Loss Ratio (MLR) requirements under ACA, the Plan Sponsor, at its option shall either:

- Reimburse Plan participants through a payroll adjustment in the amount determined under the ACA regulations; or,
- Reduce employee contributions (current or future) by an amount determined under ACA regulations to reflect the employee's share of the Rebate; or,
- Use the Rebate to enhance benefits under the Plan by an amount determined under ACA regulations.

4.10 Patient Protections

Emergency Services. If a non-grandfathered Component Health Plan provides benefits for emergency services, the plan:

- May not require preauthorization, including for emergency services provided out-of-network;
- Must provide coverage regardless of whether the provider is in- or out-of-network;
- May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed for in-network emergency services; and
- Cannot impose a co-payment amount or co-insurance rate that is higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency services must be provided in an amount equal to the greatest of the following three amounts:

- the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
- the amount the Plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the Plan's usual cost-sharing generally applicable to out-of-network services, or
- the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.

Primary Care Provider Designation. If this Plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members. For children, the participant may designate a pediatrician as the primary care provider.

Access to Obstetrical or Gynecological Care. A participant shall not need prior authorization from the Plan 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 the Plan's network who specializes in obstetrics or gynecology.

Access to Pediatric Care. If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

4.11 Preventive Care

Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual as recorded by the plan:

- Evidence-based items or services with an A or B rating currently recommended by the United States Preventive Services Task Force (USPSTF) with respect to the individual seeking care;
- Immunizations for routine use in children, adolescents, or adults currently recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
- For infants, children and adolescents: Evidence-informed preventive care and screenings supported by the Health Resources and Services Administration (HRSA), including well-woman preventive services and preconception/ prenatal care that are age- and developmentally-appropriate; and,
- For women: Evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.
    - HRSA guideline recommendation includes all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. Effective for plan years beginning on or after July 10, 2015, Plans must cover at least one form of contraception in each of the currently 18 distinct methods the FSA has identified in its Birth Control Guide.

      Eligible organizations with religious objections to covering some or all required contraceptive services have the option to elect an exemption from the contraceptive mandate through a self-

certification process. The issuer of the Component Health Plan then must provide the contraceptive services to covered women without imposing any cost-sharing requirements.

- USPSTF recommended genetic counseling and BRCA testing to determine a family history potentially associated with an increased risk for mutations in breast cancer susceptibility genes must be provided to women with positive screen results as well as women who previously have had breast cancer, ovarian cancer or other non-BRCA-related cancer who are currently asymptomatic and cancer-free.

4.12 Cost-Sharing Limitations on Essential Health Benefits (Out-of-Pocket Maximums)

ACA requires group health plans to apply a uniform maximum limit for out-of-pocket expenses (deductibles, co-insurance, co-pays, or similar charges) on all Essential Health Benefits of no greater than the maximum amounts set annually by the Internal Revenue Service (IRS) for HSA-eligible high-deductible health plans as adjusted for inflation using the "premiums adjustment percentage."

- The overall cost-sharing limit only applies to benefits provided in-network. A plan may include out-of-network expenses at its discretion.
- Out-of-pocket expenditures on all Essential Health Benefits must accrue to one out-of-pocket maximum, without consideration for whether a plan uses more than one service provider to administer benefits.
- Plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not Essential Health Benefits.
- Embedded Rule: For plan years beginning in 2016, the self-only cost-sharing limit must apply to each covered individual, whether the individual has self-only, family, or other coverage.

4.13 Coverage for Clinical Trials

Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. The coverage does not apply for the actual device, equipment, or drug that is typically given to participating patients free of charge by the company sponsoring the trial.

4.14 Claims Appeal Process

In addition to the claims appeals procedures described in this Plan and the Summary Plan Description, a non-grandfathered group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.
- A group health plan shall also:
- Comply with the applicable state External Review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,

- Implement an effective External Review process that meets minimum standards established by the Secretary through guidance and that is similar to the process applicable to the internal claims process:
  - if the applicable state has not established an External Review process that meets the requirements applicable to the internal claims process; or
  - if the plan is a self-insured plan that is not subject to state insurance regulation (including a state law that establishes an External Review process whose terms are similar to the process applicable to the internal claims process.)

4.15 Continuing Effect of This Section 4

The provisions of ACA described in this Section 4 shall continue in effect, for the Component Health Plans contained herein, as modified by further legislation and regulatory guidance.

SECTION 5 – CLAIMS AND APPEAL PROCEDURES

Insofar as these procedures are consistent with the provisions of ACA, the procedures outlined below must be followed by Plan participants ("claimants") to obtain payment of benefits under this Plan.

5.1 Non Health Claims

For purposes of all non-health insured welfare plan coverage (disability, Life, AD&D, etc.) the certificate booklet provided by the issuers contains a detailed description of the issuer's claims submission rules and claims appeal procedures.

5.2 Health Claims

The procedures outlined below must be followed by claimants to obtain payment of benefits under this Plan.

For purposes of the Health Claims and Claims Appeal Procedure contained in this Plan, the term "Administrator" will mean either the issuer or the Plan Administrator depending upon the policy or plan under which the claim has been filed.

All claims and questions regarding health claims should be directed to the Administrator. The Administrator shall have final authority for adjudicating all claims and a full review of the decision on such claims in accordance with the following provisions and with ERISA.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant has failed to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Urgent Pre-Service, Non-urgent Pre-Service, Concurrent and Post-Service.

- **Pre-Service Claims**. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

  Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-Service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

- **Concurrent Claims.** A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan

determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

- **Post-Service Claims**. A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

5.3 When Health Claims Must Be Filed

Health claims must be filed with the Administrator within one year of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within this time frame.

The Plan, upon receipt of a written notice of a claim, will furnish to the participant a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, the participant will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrator in accordance with the Plan's procedures. However, a Post-Service claim is considered to be filed when the following information is received by the Administrator:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the participant; and,
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim. If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days (48 hours in the case of Pre-Service Urgent Care Claims) from receipt by the claimant of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

5.4 Timing of Claim Decisions

The Administrator shall notify the claimant, in accordance with the provisions set forth below, of a denial (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following time frames:

- **Pre-Service Urgent Care Claims.** If the claimant has provided all of the necessary information, the Administrator will notify the claimant of its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the Administrator will notify the claimant as to what specific information is needed as soon as possible, but

not later than 24 hours after receipt of the claim. The Administrator will notify the claimant of its determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the information.

- **Pre-Service Non-urgent Care Claims.** If the claimant has provided all of the information needed to process the claim, the Administrator will notify the claimant of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. If an extension has been requested, the Administrator will notify the claimant of its decision prior to the end of the 15-day extension period.

  If the claimant has not provided all of the information needed to process the claim, the Administrator will notify the claimant as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be given at least 45 days from receipt of the notice within which to provide the specified information.

- **Concurrent Claims:**
  - **Plan Notice of Reduction or Termination.** If the Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the Administrator will notify the claimant of its decision sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
  - **Request by Claimant Involving Urgent Care.** If the Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the Administrator will notify the claimant of its decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care time frame.
  - **Request by Claimant Involving Non-urgent Care**. If the Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments and the claim does not involve Urgent Care, the request will be treated as a new benefit claim and will be decided within the time frame appropriate to the type of claim (either as a Pre-Service Non-urgent Claim or a Post-Service Claim).
- **Post-Service Claims.** If the claimant has provided all of the information needed to process the claim, the Administrator will notify the claimant of its decision within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  If the extension described above is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. The claimant shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

- **Extensions – Pre-Service Urgent Care Claims**. No extensions are available in connection with Pre-Service Urgent Care Claims.
- **Extensions – Pre-Service Non-urgent Care Claims.** This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-

day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Extensions – Post-Service Claims**. This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

5.5 Claims Appeal Procedure

Nature of Denial. The notice of a denial of a claim shall be written or in electronic form (in compliance with ERISA regulations), or oral in the case of a Pre-Service Urgent Care claim, as long as a written or electronic notice is furnished to the claimant within 3 days of the oral notice, and shall set forth:

- The specific reason for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based including a copy of any internal guideline used in the benefit determination or notice of where and how to obtain a copy free of charge;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary;
- An explanation of the Plan's claims appeals procedures;
- Claimant's right to bring a civil action under ERISA Section 502(a);
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how to obtain a copy free of charge; and,
- For purposes of Pre-Service Urgent Care Claims, a description of the expedited review process.

5.6 Timing of an Appeal

- **Pre-Service** Claims For Pre-Service Urgent Care Claims, Appendix B contains the names of all appeals contacts, addresses and phone numbers.
- **All Other Claims**. Within 180 days after the receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:
  - Request a review by providing written notice to the Administrator;
  - Submit written comments, documents, records and other information relating to the claim; and,
  - Upon request, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

5.7 Timing of Notification of Benefit Determination on Review

The Administrator shall notify the claimant of the Plan's benefit determination on review within the following time frames:

- **Pre-Service Urgent Care Claims.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- **Pre-Service Non-urgent Care Claims.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- **Concurrent Claims.** The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.
- **Post-Service Claims.** Within a reasonable period of time, but not later than 60 days after receipt of the appeal**.**
- **Calculating Time Periods.** The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

5.8 Internal Review and Decision

Full and Fair Review. The Plan Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by the claimant without regard to whether the information was submitted with the original claim and without deference to the original determination. The decision shall be based in whole or in part on a medical judgment, with consultation with the appropriate independent health care professionals, if the claim involves investigational or experimental treatment, or issues of medical necessity, and shall identify such professionals.

Decision. The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. The claimant shall also have a right to bring a civil action under ERISA Section 502(a) following the denial of the appeal. If the appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, the claimant will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how to obtain a copy. If the health plan is subject to California law, the claimant shall have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services through the Department of Managed Care and/or the Department of Insurance.

5.9 External Review

Non-grandfathered group health plans subject to ACA must also offer claimants the opportunity to pursue External Review following exhaustion of the Internal Appeals procedures set forth in this section.

- **Requesting an External Review.** In the event that an Internal Appeal results in a denial based upon medical judgment or a rescission (in whole or in part), the claimant may request an External Review by giving written notice of the appeal to the Plan Administrator within 120 days after the claimant receives the notice of decision on the Internal Appeal.
- **Eligibility for External Review.** Within 5 business days following the date of receipt of the External Review request, the Plan Administrator will complete a preliminary review of the request to determine whether the matter is eligible for External Review. A matter is eligible for External Review only if it meets all of the following requirements:
  - The claimant is or was covered under the Plan at the time the health care item or service was requested;
  - The denial does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan (in other words, the External Review process does not apply to eligibility determinations);
  - The claimant has exhausted the Plan's Internal Appeal process; and
  - The claimant has provided all the information required to process an External Review.

- **Notice of External Review Eligibility.** Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. The notification will advise claimant that:
  - The claim is not eligible for External Review;
  - The claim is eligible and ready for External Review; or
  - It is unclear whether the claim is eligible for External Review because claimant has not provided all the information required.
- **External Review Process.** If the claim is eligible and ready for External Review, the Plan Administrator will assign an Independent Review Organization (IRO) that is accredited by URAC (a nonprofit organization promoting healthcare quality by accrediting healthcare organizations) or by a similar nationally recognized accrediting organization to conduct the External Review.
  - The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for External Review, including a statement that the claimant may submit in writing, within 10 business days, additional information which the IRO must then consider when conducting the External Review; and
  - Within 5 business days after the date of assignment to the IRO, the Plan Administrator will provide the IRO the documents and any information considered in deciding the Initial Claim and the Internal Appeal.
  - Within 45 days after it receives the request for External Review, the IRO will deliver a notice of decision to claimant.
  - The IRO's decision shall be binding on all parties unless and until there is a judicial decision otherwise.
- **Eligibility for Expedited External Review.** Claimant may request an "expedited" External Review in the following circumstances:
  - Claimant (a) has received a decision on an initial claim involving either urgent care or concurrent care, (b) has filed a request for an appeal, and (c) has a medical condition for which the timeframe for completion of an appeal would seriously jeopardize claimant's life or health or would jeopardize claimant's ability to regain maximum function.
  - Claimant (a) has completed an Internal Appeal, and (b) has a medical condition for which the timeframe a standard External Review would seriously jeopardize claimant's life or health, would jeopardize claimant's ability to regain maximum function.
  - Claimant (a) has completed an Internal Appeal, (b) the Appeal concerns an admission, availability of care, continued stay, or health care item or service for which claimant received emergency services, and (c) Claimant has not been discharged from the facility.
- **Expedited External Review Process:**
  - A request for an expedited External Review must be accompanied by a written statement from claimant's physician that claimant's medical condition meets the criteria above.
  - The IRO will provide notice of its decision on an expedited External Review as expeditiously as claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO's receipt of claimant's request. If the notice is not in writing, the IRO will provide written notice to claimant within 48 hours after its decision.

SECTION 6 – THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

6.1 Health Plans

The Group Health Plans contained in this Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

6.2 Health Plan Payments

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of benefit, plan maximums and co-payments as determined for an individual's claim);
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of changes;
- utilization review, including precertification, preauthorization, concurrent review and retrospect live review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health plan); and,
- reimbursement to the Plan.

6.3 Health Care Operations

Health Care Operations include, but are not limited to, the following activities:

- quality assessment
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing and credentialing activities;
- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for

reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment method or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
  - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers.
- resolution of internal grievances; and,
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

6.4 Business Associates

The Plan may disclose PHI to its Business Associates (as such term is defined under HIPAA) who have agreed in writing to comply with all applicable HIPAA regulations for purposes related to the administration of the Plan.

6.5 Third Parties with Authorization

With the exception of uses and disclosures of PHI for health care treatment, payment for health care and health care operations, the Plan will disclose PHI to third parties only upon authorization by the participant. The Plan will not require any participant to complete an authorization as a condition of payment, enrollment or eligibility for benefits.

6.6 Plan Sponsor

The Plan will disclose PHI to Santa Clara University only upon receipt of a certification from the Plan Sponsor that this Plan document contains the limitations and conditions required by HIPAA and contained in this Section.

6.7 Conditions and Limitations on Use and Disclosure by Plan Sponsor

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- not use or disclose PHI that is genetic information for underwriting purposes;

- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosures of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- report breaches of unsecured PHI as described in Section 7.13;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- ensure adequate separation between the Plan and SCU as required by 45 C.F.R. Section 164.504(f)(2)(iii) and described in this Plan.

6.8 Organized Health Care Arrangement

The Plan Administrator may intend the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 C.F.R. Section 160.103) provided by SCU.

6.9 Access to PHI

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the Privacy Officer; and,
- staff designated by the Privacy Officer.

6.10 Limitations of PHI Access and Disclosure

The persons described in Section 6.9 may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

6.11 Noncompliance Issues

If the persons described in Section 6.9 do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

6.12 Security Rules

SCU further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information, de-identified information or summary health information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and it will ensure that any agent (including subcontractors) to whom it provides such electronic PHI shall agree in writing to implement reasonable and appropriate security measures to protect the information. SCU will report to the Plan any security incident of which it becomes aware.

SCU will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

6.13 Breach Notification Rules

In the event of a breach of unsecured PHI, the Plan will notify affected individuals, the Department of Health and Human Services, and/or the media in the form and method described under HIPAA. A breach is presumed to occur unless a risk analysis is performed by the Plan and the risk analysis shows a "low probability" that the PHI has been compromised.

6.14 HITECH Rules

To the extent that SCU transmits health information electronically in connection with a Covered Transaction as defined by the HIPAA Privacy Rules, it shall do so in a manner which meets the criteria established by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and its regulations.

SECTION 7 – GENERAL PROVISIONS

7.1 Expenses

All costs and expenses incurred in administering the Plan and other administrative expenses shall be paid by SCU.

7.2 Nonassignability

It is a condition of the Plan, and all rights of each person eligible to receive benefits under the Plan shall be subject thereto, that no right or interest of any such person in the Plan shall be assignable or transferable in whole or in part, either directly or by operation of law or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, or bankruptcy, but excluding devolution by death or mental incompetence, and no right or interest of any such person in the Plan shall be liable from, or subject to, any obligation or liability of such person, including claims for alimony or the support of any spouse.

7.3 Employment Noncontractual

The Plan confers no right upon any Employee to continue in employment.

7.4 Premiums and Certain Benefits Solely from General Assets

The premiums required hereunder and certain self-funded benefits will be paid solely from the general assets of SCU. Nothing herein will be construed to require SCU or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any participant, and no participant or any other person shall have any claims against, right to, or security or other interest in, any fund, account or asset of SCU from which any payment under the Plan may be made.

7.5 Limitation of Benefits

Notwithstanding the above, no benefits under the Plan shall be provided for any Plan Year to a participant where such benefit violates the applicable IRS rules by discriminating in favor of highly compensated individuals and/or key employees.

7.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor SCU makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal or state tax nor that any other favorable tax treatment will apply to or be available to any participant with respect to such amounts. It shall be the obligation of each participant to determine whether each payment under this Plan is excludable from the participant's gross income for federal and state tax purposes, and to notify the Plan Administrator if the participant has reason to believe that any such payment is not so excludable.

7.7 Indemnification of SCU by Participants

If any participant receives one or more payments or reimbursements under the Plan that are not for an allowable expense, such participant shall indemnify and reimburse SCU for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursement. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the participant would have owed if the payments or reimbursements that had been made to the participant as regular cash compensation, including the participant's share of any Social Security tax that would have been paid on such compensation, less any additional income and Social Security tax actually paid by the participant.

7.8 Notices

Notices, accountings and reports required to be given by the Plan Administrator to third parties other than Plan participants may be given by personal delivery or by mail addressed to the party involved at the last address of such party recorded on the general address files of the Plan Administrator. If given by mail, the date of mailing shall be deemed to be the date of which the same was given or furnished to the addressee. The Plan Administrator shall provide all notices to Plan participants in the manner and form required by federal or state law, including the use of electronic means in conformance with the federal rules governing this method, if permitted.

7.9 Governing Law

The Plan is intended to constitute a welfare benefit plan within the meaning of Section 3(1) of ERISA or any other federal law. To the extent not preempted by ERISA, this Plan shall be interpreted and construed in accordance with the laws of the State of California.

7.10 Gender and Number

Whenever used in the Plan, words in the masculine gender shall include masculine or feminine gender, and unless the context otherwise requires, words in the singular shall include the plural, and words in the plural shall include the singular.

IN WITNESS WHEREOF, the undersigned authorized representative has executed this amended and restated Plan document this _____day of _____, 20____, on behalf of Santa Clara University to evidence the adoption of the Plan as set forth herein.

For Santa Clara University

By: _____

Title: _____

Date: _____

APPENDIX A
SANTA CLARA UNIVERSITY GROUP BENEFIT PLAN

Insurance Policy Issuers and Contract Administrators

Issuer Name and Address	Policy No.	Type of Benefit
Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367	175028	Life/AD&D Voluntary Life Medical – HMO, PPO, High Deductible PPO (HSA compatible) Vision – PPO
Cigna Life Insurance Company of North America 1601 Chestnut Street Philadelphia. PA 19192	ABL 657881	Business Travel Accident (BTA)
The Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	GLT402673	Long Term Disability Short Term Disability
Kaiser Foundation Health Plans, Inc. Ordway Building 1 Kaiser Plaza Oakland, CA 94612	979	Medical – HMO
Managed Health Network (MHN) 2370 Kerner Boulevard San Rafael, CA 94901	2261	Employee Assistance Program (EAP)

Contract Administrators	Contract No.	Type of Benefit
CBIZ 6050 Oak Tree Blvd., Suite 500 Cleveland, OH 44131	—	Section 125 Plan (FSA)
Delta Dental of California 100 First Street, Suite 400 San Francisco, CA 94105	4224	Dental – PPO

APPENDIX B
SANTA CLARA UNIVERSITY GROUP BENEFIT PLAN

Component Health Plans Claims Appeals Contact Information

Name	Phone/FAX/Address *(Use Address and Phone Number on ID Card if different)*	
Anthem Blue Cross	*For Medical Claims:* Attn: Claims Unit Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060 PPO/High Deductible Phone: (800) 888-8288 HMO Phone: (800) 227-3771	*For Vision Claims:* Attn: Claims Department Blue View Vision P.O. Box 8504 Mason, OH 45040-7111 Phone: (866) 723-0515 *Grievances and Appeals:* Attn: Appeals or Grievance Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91367
Kaiser Foundation Health Plans, Inc.	Attn: Claims Department Kaiser Permanente P.O. Box 12923 Oakland, CA 94604-2923 Phone: (800) 464-4000	*Claims Appeals:* Attn: Special Services Unit Kaiser Permanente P.O. Box 23280 Oakland, CA 94623 Phone: (800) 464-4000
Managed Health Network (MHN)	Attn: Claims/Appeals MHN P.O. Box 10697 San Rafael, CA 94912 Phone: (800) 535-4985	

Contract Administrators	Phone/FAX/Address
CBIZ	Attn: Flex Claims CBIZ 2797 Frontage Road, Suite 2000 Roanoke, VA 24017 Phone: (800) 815-3023 Fax: (800) 584-4185
Delta Dental of California	Attn: Customer Service Delta Dental P.O. Box 997330 Sacramento, CA95899-7330 Phone: (888) 335-8227

APPENDIX C
SANTA CLARA UNIVERSITY GROUP BENEFIT PLAN

Eligibility and Participation Requirements

Employee Class	Line(s) of Coverage	Effective Date of Eligibility	Definition of Full-time
All	All	First day of the month following date of hire	20 hours per week

Dependent Eligibility

- Coverage for dependents, if elected, begins on the date employee coverage begins, unless specified otherwise under the applicable Component Plan document.
- Coverage also may be available to eligible domestic partners and their eligible dependents as determined by the applicable Component Plan.
- The terms, "spouse" and "dependent" shall have the same meaning as used by the applicable Component Plan document.

Waiting Periods

An employee who is reasonably expected to be a full-time employee as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified above. An employee who is not reasonably expected to be a full-time employee as of his or her start date, or an employee who is seasonal (in a position for which the customary annual employment is six months or less), will be determined to be a full-time employee based on whether such employee satisfies the full-time employee hourly requirement specified above under either the Monthly Measurement Method or the Look-Back Measurement Method, in accordance with the policies adopted by the employer.