

Misstatements and Misrepresentations

In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existent coverage, or benefits under the plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

HIPAA Notice of Privacy Practice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the Consolidated Welfare Plan of California Institute of Technology and the Caltech Retiree Health and Life Benefits Program for Campus and JPL retirees. The plan covered by this notice may share health information to carry out treatment, payment, or health care operations.

The plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not the Institute as an employer – that's the way the HIPAA rules work. Different policies may apply to other Institute programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance.
- **Health care operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development.

The amount of health information used, disclosed or requested will be limited and, when needed restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH THE INSTITUTE

The Plan may disclose your health information without your written authorization to the Institute for plan administration purposes. The Institute may need your health information to administer benefits under the Plan. The Institute agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. HR Campus and JPL Benefits Office employees are the only Institute employees who will have access to your health information for plan administration functions.

The Plan may disclose “summary health information” to the Institute if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying,

amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

In addition, you should know that the Institute cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Institute from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made – for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	8]gVc g fYg]b fYgdcbg' hc U'Vti fh'cf UXA]b]gfUhj Y'cfXYfz g VdcYbUzX]gWj YfmfYei YgZ cf'chYf'Uk Z 'dfcWgg flAY'DUb'a UmVY'fYei]fYX'hc'bc hZmnci 'cZ hAY'fYei Ygh'cf'fYW]j Y' gUhgZUWc'fmUgg fUbw'Zfca 'hAY'dUfmgY]b['mci f'YU'h]bZ'fa Uh]cb' hUhYZc'fng k YfY' a UXY'hc'bc hZmnci 'cf'hc'cVh]b'U'ei U]ZYX' dfchVWj Y'cfXYf'W'bwfb]b['hAY']bZ'fa Uh]cbE
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and

the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid for the item or service, in full out of pocket.

Right to receive communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals.

However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Effective February 17, 2010, you may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;

- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement

that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2010. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice under the Institute's normal distribution process.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint contact the Campus or JPL Benefits Office

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Campus or JPL Benefits Office.

Non-Assignment of Benefits

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, a plan participant may request, in writing, that all or a portion of benefits provided by the plan may be paid directly to the institution in which he or she was hospitalized, or to a provider who has provided the services. In such instances, the Plan Administrator or Claims Administrator may, at its discretion, make payment directly to a doctor, hospital, or other provider of care. This is solely for the convenience of the plan participant, and does not create any enforceable assignment of benefits or the right to bring a cause of action against the plan by any doctor, hospital, or other provider of care. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan and the Institute to the extent of such payment. The plan reserves the right to make payment directly to the plan participant.

Non-Discrimination Clause

This plan shall be maintained so as to not discriminate in favor of "highly compensated employees," as that term is defined in various sections of the Internal Revenue Code, with respect to benefits or Institute contributions. Furthermore, if the operation of this plan violates any non-discrimination rule under the Internal Revenue Code, the Plan Administrator or Plan Sponsor shall have the right to unilaterally and/or retroactively modify elections, place limitations on an employee's pre-tax salary reduction contributions, and modify benefit selection, availability, and/or the method of allocating the employee's pre-tax salary reduction contributions with respect to any prohibited group member, in order for the plan to meet such non-discrimination requirements. Any changes in the rate of employees' pre-tax salary reduction contributions of prohibited group members shall be applied in a fair and consistent manner.

Coordination of Benefits Rules

Unless otherwise specified in the applicable Benefit Booklet, the plan will coordinate benefits with any other health plan that covers you or your eligible dependents under the rules below.

Other health plans with which the plan will coordinate include:

- Group or nongroup coverage, whether insured or uninsured, including HMOs;
- The medical care component of long-term care contracts, such as skilled nursing care;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under federal government programs, except that coverage under a federal government program may be limited to hospital, medical and surgical benefits of the government program, and coverage does not include Medicare supplemental policies or Medicaid policies; and
- The medical benefits coverage in group or individual automobile "fault" or "no-fault" coverage.

Order of Benefit Determination

The rules below determine whether this plan or another plan will pay primary (first) or secondary. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this plan.

- COB/Non-COB Provision: The benefits of a plan which does not contain a coordination of benefits (COB) provision always shall be determined before the benefits of a plan which does contain a COB provision.
- No Fault Auto Insurance: The benefits of a plan which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this plan, regardless of whether the no-fault policy has been selected as secondary.
- Non-Dependent/Dependent: The benefits of a plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be

determined before those of the plan which covers the person as a dependent (unless "Medicare Coordination" below applies).

- Dependent Child/Parents not Separated or Divorced: When this plan and another plan cover the same child as a dependent of different persons, called "parents":
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - If the parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits. For a dependent who has coverage under either or both parents and also has coverage as a dependent under a spouse's plan, see "Longer-Shorter Length of Coverage" below.

- Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child;
 - Then, the plan of the spouse of the parent with custody of the child;
 - Then, the plan of the parent not having custody of the child; and
 - Finally, the plan of the spouse of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year starting after the plan is given notice of the court decree.

This plan will not cover the expenses of any child who does not meet the definition of dependent as defined in this plan except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

- Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- Continuation Coverage: If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:
 - First, the benefits of a plan covering the person as an employee or retiree (or as the dependent of an employee or retiree);
 - Second, the benefits of coverage under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer-Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which has covered the person longer are determined before those of the plan which has covered that person for the shorter time.
- Medicare Coordination:
 - Employees and/or Spouses Entitled to Medicare Due to Age: Unless an active employee entitled to Medicare due to age gives the plan notice (in the form and manner requested by the Plan Administrator) waiving his or her right to plan benefits, the plan is primary. With respect to the spouse of an active Employee who is entitled to Medicare due to age, unless the employee gives the plan notice (in the form and manner requested by the Plan Administrator) waiving plan benefits, the plan is primary.

- Medicare Disabled Covered Persons: If required by law, the plan is primary with respect to a covered person who is also entitled to Medicare because of disability. Otherwise, the plan is secondary.
- Covered Persons with End-Stage Renal Disease: For the period required by law, if any, the plan is primary with respect to a covered person entitled to Medicare because of end-stage renal disease. Otherwise, the plan is secondary.

Disagreement on Order of Benefits

If the plan and the other health plan cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plan shall immediately pay half of the claim and will determine its liability following payment, except that the plan shall be required to pay no more than it would have paid had it been the primary plan.

Facility of Payment

If another health plan provides or pays benefits that should have been provided or paid under this plan, the plan has the right to pay over to the other plan the amount the Plan Administrator determines is necessary to satisfy this coordination of benefit provision. These amounts are considered benefit payments under this plan and will operate to discharge the plan from liability to the extent of such payments.

Acts of Third Parties

When you or your covered dependent are injured, or become ill, because of the actions or inactions of a third party, the plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party, and you must follow special plan rules. This section describes the plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting plan benefits to pay for treatments, devices or other products or services related to such illness or injury, you agree that the plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf, or intervene in any pending lawsuit, against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as

a constructive trustee over the funds to the extent that the plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the plan back first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must pay the plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator.

- Execute a written agreement assigning your rights against a third party to the plan and/or authorizing the plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator.
- Cooperate with the plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the plan's subrogation or recovery rights outlined in this Summary.
- Notify the plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The plan may terminate your plan participation and/or offset your future benefits in the event that you fail to provide the information or authorizations, or to otherwise cooperate in a manner that the plan considers necessary to exercise its rights or privileges under the plan. If the plan must institute proceedings against you for not honoring the plan's recovery rights under this section, you will be responsible for the costs of collection, including reasonable attorney's fees.

If the "Acts of Third Party" provisions in this SPD conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this SPD will both apply, so that the plan has the maximum subrogation, reimbursement and recovery rights.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this plan, the plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Kaiser Mid-Atlantic HMO Grandfathered Plan Notice

Caltech believes that the Kaiser Mid Atlantic plan is considered a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to either Campus or JPL.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you are a subscriber in a non-grandfathered health plan, there is additional information regarding your right to external appeals that can be found in the applicable EOC. Please contact Campus or JPL for more information.

Claims and Appeals Rules for Kaiser

Claim-Related Definitions

Claim

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim" or "post-service claim," depending on when during the course of your care you file the claim. However, the plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the plan does not fully agree with your claim, you will receive an “adverse benefit determination” — a denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

Initial Claim Determination

For each of the plan benefits, the plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the plan has to evaluate and respond to a claim begins on the date the plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The time frames on the following pages apply to the various types of claims that you may make under the plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan’s review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse claim determination for a claim under health or disability benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability benefit claims only).

For medical claims, the notice will also include information sufficient to identify the claim involved. This includes:

- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the time frame for the expedited process, as long as written notice is provided no later than three days after the oral notice.

Time Frames for Initial Claims Decisions

Time frames generally start when the plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days.

For the Kaiser Mid-Atlantic Plan				
	Urgent Care Claims	Non-Urgent “Pre-Service” Claims	Non-Urgent “Post-Service” Claims	“Concurrent Care” Decision to Reduce Benefits
Time frame for Providing Notice	Notice of determination (whether adverse or not) must be provided by the plan as soon as	Notice of determination (whether adverse or not) must be provided by the plan within a	Notice of adverse determination must be provided within a reasonable period of time, but no later than	Notice of adverse determination must be provided by the plan enough in advance to give you an

For the Kaiser Mid-Atlantic Plan

	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits
	possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	30 days.	opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.
Extensions	If your claim is missing information, the plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The plan has up to 15 days, if necessary due to matters beyond the plan's control, and must provide extension notice before initial 15-day period ends.*	The plan has up to 15 days, if necessary due to matters beyond the plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A

For the Kaiser Mid-Atlantic Plan

	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the plan as soon as possible (no later than 24 hours after receipt of the claim by the plan).	Notice that your claim is improperly filed must be provided by the plan as soon as possible (no later than five days after receipt of the claim by the plan).	N/A	N/A

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart above. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the *Filing a Claim* section of this SPD.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will provide you with written notification of the plan's determination on review, within the time frames described in the Time Frames for Appeals Process section of this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health or disability benefit under the plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the above chart.

Unless the right to an external review applies under the medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.