Section 1: General Terms
GENERAL TERMS YOU SHOULD KNOW

The following are general terms used throughout this Handbook. Definitions of terms that are benefit-specific are defined in the applicable sections of this Handbook.

Actively At Work
For all benefits under the Caltech benefits program except for your medical, dental and vision coverage, you must be Actively At Work on the day your coverage under the Caltech benefits program or any election changes you have made to your benefits is to begin. Otherwise, coverage or election changes begin on the day you return to work as a Benefit-Based Employee.

Medical, dental and vision coverage or benefit election changes made during annual enrollment while you are on an unpaid leave of absence will not become effective until you return to work as a Benefit-Based Employee. However, if you are on an approved FMLA leave and your medical, dental and vision coverage is in effect and has not lapsed, any election changes made during annual enrollment will become effective while you are on your FMLA leave.

Refer to the EOCs for each benefit plan’s definition of Actively At Work. Generally, Actively At Work means any day that you are performing your duties as a Benefit-Based Employee.

Adopted or Adoption
Refers to legal Adoption or placement for Adoption.

Beneficiary
The person(s) you designate to receive death benefits provided under the Caltech Benefits program in the event of your death.

Benefit-Based Employees
Refer to page 2.3.

Caltech
Refers to California Institute of Technology, including the Jet Propulsion Laboratory (JPL) and all other off-campus facilities. See also “Institute.”

Campus or JPL Benefits Office
The Benefits Office on campus is a component of the Human Resources Department of the California Institute of Technology and is responsible for the administration of the Caltech benefits program. The Benefits Office at Jet Propulsion Laboratory (JPL) is responsible for the day-to-day administration of the Caltech benefits plans at JPL.

Change(s) in Status Events
Refer to page 6.3 for the list of qualifying Changes in Status and other IRS-approved events that allow you to add, cancel, or change your elections during the plan year.

COBRA
Under certain circumstances, if you or your covered Dependents lose Caltech medical, dental, vision, Health Care Spending Account coverage or EAP coverage you have a right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to a temporary extension of that coverage. See pages 2.22-2.32.

Deductible
The amount of covered expenses that must be paid each year before certain benefit plans will pay its portion of eligible expenses. Refer to each benefit plan’s EOC, if applicable, for a description of the deductible amount.
Dental Health Maintenance Organization (DMO)
A dental plan that provides, offers, or arranges for coverage of designated dental services needed by plan members for a fixed, prepaid premium. Services are provided by a participating dentist.

Dependents
Refer to pages 2.4. Dependent coverage eligibility is also subject to state and federal requirements.

Domestic Partners
Refer to Registered Domestic Partners and Same-Sex Domestic Partners, as defined in this section of the Handbook.

Employee Assistance Program (EAP)
The Institute offers an Employee Assistance Program (EAP) to assist employees and eligible dependents in handling personal or work related matters. EAP Services include counseling and referrals to appropriate resources.

Enrollment Period
A period during which a Benefit-Based Employee may add or drop certain benefits and add or drop Dependents without restriction, subject to each specific benefit plan’s limitation.

ERISA
The Employee Retirement Income Security Act of 1974. This law mandates, among other items, certain reporting and disclosure requirements for group life, health, and retirement plans. Your ERISA rights are summarized in Section 8, Plan Information. Non-ERISA plans are not subject to the same requirements and mandates. A list of the Caltech plans which shows ERISA/Non-ERISA status is also in the Plan Information Section on pages 8.24.

Evidence of Coverage (EOC)
Refers to the Evidence of Coverage certificates issued by insurance carriers or HMOs. The EOC provides you with a detailed summary of your benefits coverage. This Handbook provides eligibility features of each benefit plan and Caltech-specific policies and procedures. Start with the Handbook and then refer to the applicable EOC. These documents together constitute your Summary Plan Description (SPD) under ERISA. Any terms in the Handbook with respect to eligibility and Caltech-specific policies and procedures shall supersede any items in conflict with the EOC, with the exception of any terms that are required by law or the California regulatory agency with jurisdiction over the insurance carrier or HMO.

Applicable EOCs are posted on the Internet. Please refer to the medical section of the Caltech benefits website at www.benefits.caltech.edu.

Evidence of Insurability (EOI)
Proof presented through a written statement and/or a medical examination that an individual meets the minimum requirements of good health as defined by the individual plan. It is usually only required for late enrollments, certain increases in life coverage, or for coverage over certain limits but will not apply to Medical plan enrollment. Also known as Evidence of Good Health or a Statement of Good Health. Refer to the specific plan for a description of the plan’s EOI requirements, if applicable.

Health Maintenance Organization (HMO)
A Health Maintenance Organization (HMO) is an organized system of medical care providers who offer a wide range of medical care services (e.g., pediatrics, internal medicine, surgery, obstetrics, etc.) to its members. HMO members receive medical care for a fixed, prepaid monthly fee. Medical services are usually provided by a primary care physician who may
refer you to other physicians within the HMO network. Claim forms are not required but members pay a copayment for services received under the plan. Only services from providers in the HMO network are covered under the plan.

**Health Savings Account**

If you enroll in the High Deductible PPO, and you are not enrolled in Medicare parts A and/or B, you can open a Health Savings Account (HSA), which you can fund using employee pre-tax contributions. You can use money in your HSA to pay for your qualified health care expenses that are not otherwise covered. Your unused HSA balance rolls over to the next year and earns interest, so you can build tax-free savings over time.

**High Deductible PPO**

With the Anthem Blue Cross High Deductible PPO, you receive PPO-type coverage, including the option to seek care with any licensed provider. By using a participating (or in-network) PPO provider, you will not be required to pay for covered services at the time of service, and the claims will be submitted directly to the carrier by the provider. When using a non-participating provider (or out-of-network), the services will cost you more because you pay a higher percentage of covered charges than you would if you used participating providers since their fees may be greater than those negotiated with participating providers.

In addition, the plan includes a Health Savings Account (HSA) option that lets you save using employee tax-free contributions for current and future qualified health care expenses. Your unused HSA balance rolls over to the next year and earns interest, so you can build tax-free savings over time.

**HIPAA**

The Health Insurance Portability and Accountability Act of 1996. To protect your privacy, federal law sets rules about the proper use and disclosure of your personal health information and gives you certain rights. HIPAA also provides plan participants with special enrollment rights and other benefits-related protections that are applicable to the Caltech benefits program. Refer to pages 2.9 – 2.11 for information on Special Enrollment Events under HIPAA.

**Initial Enrollment**

The initial enrollment period is the first 31 days after you become eligible to enroll for coverage under the Caltech benefits program. If you wait until after 31 days, you may not enroll for medical or dental insurance or a Health Care or Dependent Care Spending Account until the next annual enrollment period unless you experience a HIPAA Special Enrollment Event or Change in Status Event (see pages 2.9 – 2.11 for information on HIPAA Special Enrollment Events or page 6.2 - 6.4 for information on Change in Status Events). Late enrollment for Supplemental Life and Supplemental Disability insurance will be subject to satisfactory Evidence of Insurability (EOI).

**Institute**

Refers to the California Institute of Technology, including the Jet Propulsion Laboratory (JPL) and all other off-campus facilities. See also “Caltech.”

**Jet Propulsion Laboratory (JPL)**

An operating division of the California Institute of Technology, and a Federally Funded Research and Development Center (FFRDC) under NASA sponsorship.

**Non-Benefit-Based Employees**

Refer to page 2.4.
Preferred Provider Plan (PPO)
A PPO stands for a Preferred Provider Organization. A type of medical plan, such as the Anthem Blue Cross PPO Plan, allows you to use a PPO provider or any non-participating provider each time you need care. By using a PPO provider, you will not be required to pay for covered services at the time of service, and the claims will be submitted directly to the carrier by the provider. When using a non-participating provider, the services will cost you more because you pay a higher percentage of covered charges than you would if you used participating providers since their fees may be greater than those negotiated with participating providers.

Personnel Memoranda (PM)
Personnel Memoranda outlining official Caltech policies with respect to staff employees.

Postdoctoral Scholar
Caltech or JPL Research appointees sponsored by professorial faculty for contractual terms reviewed annually.

Qualified Domestic Relations Order (QDRO)
An order, decree, judgment, or administrative notice (including a settlement agreement) which establishes the rights of another person (the “alternate payee”) to your pension benefits, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state and which meets the requirements of ERISA.

Qualified Medical Child Support Order (QMCSO)
An order, decree, judgment, or administrative notice (including a settlement agreement) requiring health coverage for a child, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state and which meets the requirements of ERISA.

Regular Salary
Your base wage or compensation for your regular hours of employment. Salary includes any salary reductions under IRC Section 125, but excludes bonuses, commissions, overtime, extended work week compensation, per diems, shift differential, field rate bonuses, flight bonuses, off-site service pay, and similar payments. With respect to the Institute Retirement Plans only, see page 7.5 for definition of earnings used for Retirement Plan purposes.

Registered Domestic Partner
Under the Caltech benefits program described in this Handbook, Registered Domestic Partners are two adults of the opposite sex, one of whom is at least age 62 and covered under Medicare, or Same-Sex Domestic Partners who have a Certification of Registered Domestic Partnership on file with the California Secretary of State, or other applicable state agencies. Registered Domestic Partners and their Dependents may be enrolled as Dependents in a Benefit-Based Employee’s medical, dental, vision, group life and personal accident insurance (PAI) plan, provided the general terms and conditions of coverage for the respective plans are met. Medical coverage payments for Registered Domestic Partners are exempt from taxation by the State of California. The Tax Savings Plan and spending accounts are available only for Registered Domestic Partners who are Tax-Qualified Dependents under the Internal Revenue Code. Employer-provided coverage for a Registered Domestic Partner who is not a Tax-Qualified Dependent, will be subject to “imputed income.” Contact the Campus or JPL Benefits Office for a tax information sheet.
Registered Domestic Partners and their covered Dependents are eligible for continuation of medical, dental and vision insurance benefits similar to COBRA and have similar conversion rights under medical, vision, group life and PAI coverage. Contact the Campus or JPL Benefits Office regarding Registered Domestic Partner certification, termination and rates.

**Same-Sex Domestic Partner**

Under the Caltech benefits program described in this Handbook, Same-Sex Domestic Partners are two adults of the Same-Sex who have a Certification of Domestic Partnership on file with the Campus or JPL Benefit Office and who have registered with the California Secretary of State, or other applicable state agencies. Same-Sex Domestic Partners and their Dependents may be enrolled as Dependents in a Benefit-Based Employee’s medical, dental, vision, group life and personal accident insurance (PAI) plans, provided the general terms and conditions of coverage for the respective plans are met. The Tax Savings Plan and spending accounts are available only for Same-Sex Domestic Partners who are Tax-Qualified Dependents under the Internal Revenue Code.

Spouse

Under the Caltech benefits program described in this Handbook a spouse refers to your husband or wife under a legally valid marriage. Spouses and their Dependents may be enrolled as Dependents in a Benefit-Based Employee’s medical, dental, vision, group life and personal accident insurance (PAI) plans, provided the general terms and conditions of coverage for the respective plans are met. The Tax Savings Plan and spending accounts are available only to spouses who are Tax-Qualified Dependents.

**Summary Plan Description (SPD)**

A description of a benefits plan or program available to persons covered by those plans as required by the Employee Retirement Income Security Act (ERISA). The SPD consists of the California Institute of Technology Benefits Handbook and the Evidence of Coverage certificates issued by the insurance carrier or HMO for your medical, dental and vision plans.

**Tax-Qualified Dependent**

A Dependent, Domestic Partner or child of your Domestic Partner, as applicable, who meets the requirements of Section 152 of the Internal Revenue Code.

Generally, this means all of the following requirements are met:

- The individual lives with you as a member of your household for the full tax year.
- He or she is citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or a child being adopted by a US citizen or national.
- He or she receives more than 50% of his or her financial support from you.
• He or she is not anyone else’s Section 152 dependent.

Subject to the terms of eligibility under this Plan, if coverage is provided to a Domestic Partner or child of your Domestic Partner, as applicable, who are not your Tax-Qualified Dependents, the amount of that coverage will be subject to imputed income and you will not be able to pay for their coverage on a pre-tax basis. You may wish to consult with your tax advisor to determine if your Dependent qualifies as a Tax-Qualified Dependent.

Contact the Campus or JPL Benefits Office if you have any questions or for more information.

**Total Disability or Disability**

Please refer to the medical Evidence of Coverage (EOC), and the group life and LTD sections in this Handbook for plan-specific definitions of Total Disability or Disability. Please refer to the medical section of the Caltech benefits website at [www.benefits.caltech.edu](http://www.benefits.caltech.edu) (under the health tab).
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INTRODUCTION

The Caltech benefits program is designed to provide quality, competitive benefits that are affordable for you and the Institute. The Caltech benefits program described in this Handbook includes the Consolidated Welfare Plan (Plan 601), consisting of health and welfare insurance coverages (see chart on page 8.24), and the Tax Savings and Spending Account Plan. The Defined Contribution Retirement Plan (Base Retirement Plan 002), the ERISA TDA (Plan 005) and the Prudential Pension Plan (Plan 004) are mentioned several times throughout this Handbook. The Prudential Plan’s SPD has already been distributed to the small group of employees who participate in the Prudential Plan.

Caltech shares the cost of most benefits with you, and gives you the opportunity to supplement your coverage with certain voluntary plans. The program provides a strong base of coverage for you and your Dependents, and the ability to choose the plan and the level of coverage that best meet your needs.

This Handbook, together with your evidence of coverage certificates, describes the benefits provided under the Caltech benefits program effective January 1, 2014 and constitutes the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA). The plans included in this SPD that are not subject to ERISA are so indicated.

The Institute expects and intends to continue the Caltech benefits program but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP for Business & Finance or Human Resources, as applicable.

The Benefits Handbook, together with the applicable plan documents, evidence of coverage (EOC) or summary of coverage (SOC), and TIAA-CREF materials, constitutes your summary plan description (SPD) under The Employee Retirement income Security Act (ERISA). The Benefits Handbook contains rules on eligibility and any Caltech-specific policies and details on the Flexible Spending Account. Refer to the EOC or SOC for a general description of your benefits and coverage. With respect to the Retirement Plans, the ERISA TDAs and the Non ERISA TDA Plan, in the event of a conflict between the legal plan documents and the Handbook, the legal plan document shall govern.

The most recent versions of the applicable Evidence of Coverage Certificates (EOCs) and the Handbook are available online via the Internet at www.benefits.caltech.edu
## WHEN YOU NEED INFORMATION

In addition to the Benefits Office (Campus: 626-395-6443 and JPL: 818-354-3760), you may call the Customer Service Numbers for the respective benefit plans when you have questions.

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When you call a carrier’s customer service with questions, have your Social Security or Member identification number ready, and make a note of the date, time, and name of the person with whom you spoke.

## Eligibility

With respect to eligibility for plan benefits, the terms of each plan designate certain individuals as eligible for benefits under the plan. Refer to each section for additional information regarding specific benefit plans.

### Benefit-Based Employees

To qualify for benefits, you must be a Benefit-Based Employee. This includes the following individuals:

1. Faculty;

2. Other Faculty and Non-Faculty Appointments (Including Postdoctoral Scholars with External Funded Appointments);

3. Postdoctoral Scholars and Senior Postdoctoral Scholars, as appointed by Caltech; and

4. Staff Employees including Key Staff Employees and Temporary Staff Employees.

### Other Faculty and Non-Faculty Appointments (Including Postdoctoral Scholars with External Funded Appointments)

Other Faculty and Non-Faculty Appointments (Including Postdoctoral Scholars with External Funded Appointments) are eligible to participate in the medical, dental and vision plans available to Benefit-Based Employees and their Dependents. However, premium cost sharing by the Institute for the medical, dental and vision plans is limited to individuals either receiving a monthly compensation of $1,000 paid by Caltech, or having designated external funding as an Institute allowance for this purpose. Refer to Section 7 for eligibility for the retirement plans.
Postdoctoral Scholars and Senior Postdoctoral Scholars

Postdoctoral Scholars and Senior Postdoctoral Scholars are eligible to participate in all plans available to Benefit-Based Employees and their Dependents. Premium cost sharing by the Institute is limited to individuals who are paid by Caltech. Refer to page 7.1 for eligibility for the retirement plans.

Key Staff Employees

For a definition of Key Staff Employees, see page 7.1.

Staff Employees

Staff Employees are employees who are regularly scheduled to work 20 or more hours per week. Employees with two or more part-time assignments whose combined regularly scheduled hours are equal to 20 or more hours per week qualify as Benefit-Based.

Temporary Staff Employees

Temporary Staff Employees are employees who are regularly scheduled to work 20 or more hours per week in an assignment that is expected to last at least four months. The date the Temporary Staff Employee was first regularly scheduled to work 20 or more hours per week will be used in determining coverage effective dates on page 2.7.

See page 7.20 for eligibility to participate in voluntary retirement savings under the ERISA TDA Plan.

Non-Benefit-Based Employees

The following are considered Non-Benefit-Based Employees:

1. Staff Employees hired on a temporary basis for less than four months;
2. Occasional employees;
3. Part-time employees regularly scheduled to work less than 20 hours per week; and
4. Any individual hired by JPL in the following employment classification:
   - Call Back Student;
   - High School Summer Teacher;
   - Interim Employee Program;
   - Minority Initiative Intern.

Non-Benefit-Based Employees are only eligible for Travel Accident Insurance, Extra-Hazardous Duty Insurance, and Worker’s Compensation coverage.

Affiliate Organizations

See Appendix I, page 9.1 for a list of affiliate organizations and the plans that apply to each organization. (Note: Your cost and eligibility structure may be different from those described in this document. Contact your affiliate organization regarding employee cost and enrollment rules.)

Dependent Eligibility

Certain plans provide coverage for eligible Dependents. Unless otherwise noted, for all plans except the spending account(s), your eligible Dependents include your:

- Spouse
- Domestic Partner
- Children (natural, step, adopted, foster children, and children for whom you are a court-appointed guardian) up to their 26th birthday regardless of eligibility for other group coverage subject to applicable state and federal requirements.
- Your children age 26 and over who are incapable of employment because of physical or mental disability (subject to carriers authorization/approval).
- Children who otherwise meet the Plan definition as defined above for whom you are required to provide coverage under a
“Qualified Medical Child Support Order (QMCSO).”

For the spending account(s), refer to page 6.8 for a description of eligible Dependents.

Caltech adopted the above definitions for dependents on the plan effective June 1, 2010.

**Important!!!** You must at all times give accurate information about your family status and your Dependents, regarding eligibility for benefits under the Caltech benefits program. Misrepresentation of information about your family status and/or your Dependents could result in disciplinary action, including immediate termination of employment from Caltech. Effective 3/1/2009, proof of Dependent eligibility will be required by the Institute for any dependents added or re-added to our plan(s). All family members must be covered under the same medical, dental and vision plans.

**When Two or More Family Members Work For Caltech**

Unless otherwise noted, when both Spouse, Domestic Partners, or any Dependent children work for Caltech, each may enroll in the Caltech plans as a Benefit-Based Employee and/or a Dependent. Children of parents who both work at Caltech may be covered as a Dependent under the plan of one or both parents.

A Benefit-Based Employee who is a Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a Caltech retiree must be covered as an active employee under the applicable benefit plans. Dependent children of a Benefit-Based Employee who is also a Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a Caltech retiree must also be covered as a Dependent under the plan for active employees. Upon loss of Benefit-Based Employee status, the Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a retiree and any Dependent children shall be covered under the retiree medical plan if the eligibility requirements for retiree medical plan coverage are satisfied. (See page 2.17 for retiree medical plan eligibility).
**General Plan Information**

**Enrollment and Making Changes**

**Initial Enrollment**
If you are a new Benefit-Based Employee, you will attend a new employee orientation meeting where you will have an opportunity to enroll. You must enroll within 31 days of your date of hire (or change to Benefit-Based Employee status). Subsequent enrollment opportunities may be limited.

If you are declining enrollment for yourself and/or your Dependent(s) because of other medical, dental and/or vision plan coverage, you may in the future be able to enroll yourself and/or your Dependents in a Caltech plan if you or your eligible Dependents lose eligibility for that other coverage (or another employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within 31 days after your or your eligible Dependents’ other coverage ends (or after another employer stops contributing towards the other coverage) and you must meet additional requirements described on page 2.9. In addition, if you have a new Dependent as a result of marriage, birth, or Adoption, you may be able to enroll yourself, your Spouse, your Domestic Partner and/or your Dependents, provided that you request enrollment within 31 days after the marriage, birth, Adoption or placement of a Foster Child. Please review page 2.9 before you elect to waive any coverage.

If you experience a special enrollment event, you must notify the Institute within 31 days in order to make change to your election. See HIPAA Special Enrollments section on page 2.9.

New faculty members must contact the Faculty Records Office regarding Initial Enrollment in benefit plans.

Except for coverage under the medical, dental and vision plans, you must be Actively At Work in order for any new benefits to go into effect. Otherwise, coverage begins on the day you return to work as a Benefit-Based Employee.

Your election must be made within the 31-day election period. If you do not submit a completed election form within the 31-day election period, you will lose your right to enroll (or make a change) until the next enrollment period or if you experience a Change in Status Event or other IRS recognized event. During this 31-day election period, you may revoke your initial election and make changes as long as it is within the original 31-day election period.

**Important!!!** You must at all times give accurate information about your family status and your Dependents, regarding eligibility for benefits under the Caltech benefits program. Misrepresentation of information about your family status and/or your Dependents could result in disciplinary action, including immediate termination of employment from Caltech. Effective 3/1/2009, proof of Dependent eligibility will be required by the Institute for any dependents added or re-added to our plan(s). All family members must be covered under the same medical, dental and vision plans.
When Participation *First* Begins

<table>
<thead>
<tr>
<th>PLAN</th>
<th>COVERAGE BEGINS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category I</strong></td>
<td>For all Benefit-Based Employees coverage begins on the first of the month (or first working day of the month) coincident with or next following the month you qualify as a Benefit-Based Employee.</td>
</tr>
<tr>
<td>Medical Plans</td>
<td></td>
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<tr>
<td>Dental Plans</td>
<td></td>
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<tr>
<td>Vision Plan</td>
<td></td>
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<tr>
<td>Tax Savings Plan</td>
<td></td>
</tr>
<tr>
<td>Group Life (Basic and Supplemental)</td>
<td></td>
</tr>
<tr>
<td>Group LTD (Basic and Supplemental)</td>
<td></td>
</tr>
<tr>
<td>Personal Accident Insurance Plan</td>
<td></td>
</tr>
<tr>
<td>Spending Account(s)</td>
<td></td>
</tr>
<tr>
<td><strong>Category II</strong></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>Coverage is effective on the first day of Employment.</td>
</tr>
<tr>
<td>Travel Accident Insurance Plan</td>
<td>Coverage is effective on the first day of Employment.*</td>
</tr>
<tr>
<td>International SOS Medical Access/International Referral Service</td>
<td>Service is available on the first day of Employment</td>
</tr>
<tr>
<td>Extra-Hazardous Duty Plan</td>
<td>Coverage is effective on the first day of Employment</td>
</tr>
<tr>
<td>Base Retirement Plan</td>
<td>Faculty members, except those excluded under the Plan (see page 7.1): On the first of the month (or first working day of the month) coincident with or next following the month you qualify as a Benefit-Based Employee.</td>
</tr>
<tr>
<td></td>
<td><strong>Postdoctoral Scholars:</strong> Postdoctoral Scholars participate on the first day of the month following two years of eligible Benefit-Based Employee service.</td>
</tr>
<tr>
<td></td>
<td><strong>Key Staff</strong>: On the first of the month (or first working day of the month) coincident with or next following the month you qualify as a Benefit-Based Employee.</td>
</tr>
<tr>
<td></td>
<td><strong>Staff</strong>: On the first day of the month following six months of eligible service.</td>
</tr>
<tr>
<td>Voluntary ERISA TDA Plan</td>
<td>First day of pay period following receipt of online Salary Deferral Agreement received prior to pay period cutoff date.</td>
</tr>
</tbody>
</table>

* If you have accepted in writing an employment offer with Caltech and travel on Institute-related business prior to your first day of employment, as a prospective employee, you will be covered by the Caltech Travel Accident Insurance Plan.

** For a definition of Key Staff and Staff, see page 7.1.
**Annual Enrollment Period**

During the Annual Enrollment Period in the fall, you may enroll or disenroll yourself and/or your Dependents in any medical plan, dental or vision plan; switch among medical plans; switch between dental plans; enroll or disenroll from the Tax Savings Plan; increase or decrease group life insurance coverage; enroll or disenroll your supplemental disability coverage; or enroll or re-enroll in the spending account(s).

If, in anticipation of a divorce, a Spouse’s coverage is dropped during annual enrollment or due to a change in status, under certain circumstances, your Spouse will be offered COBRA continuation coverage from the date of divorce. Caltech or JPL Benefits Office must be notified when the divorce becomes final in order for COBRA to be available. Coverage will not be available from the date the Spouse’s coverage was dropped until the date of divorce. This means there could be a lapse in coverage.

For group life insurance increases or supplemental LTD enrollment, you may be subject to Evidence of Insurability (EOI) determination. Elections not requiring EOI requested during the Annual Enrollment Period will be effective January 1 of the calendar year following the Annual Enrollment Period. Coverage subject to EOI will be effective after the carrier approves it.

If an Annual Enrollment Period occurs while you are on a FMLA or military leave, you will be able to change your elections under the same terms and conditions permitted for employees Actively At Work. Additionally, if an Annual Enrollment Period occurs while you are receiving COBRA coverage, you will be able to change your health plan elections under the same terms and conditions permitted for similarly-situated employees Actively At Work.

If you are on an unpaid leave and not Actively At Work during the Annual Enrollment Period due to other than FMLA or military leave, you will have an opportunity to change your benefits upon your return to work as a Benefit-Based Employee.

**Changes in Your Benefits “At Other Times”**

See the chart on page 2.10 for an explanation of allowable benefit changes during the plan year.
**HIPAA Special Enrollment**

If you decline enrollment for yourself or your Dependents in the medical, dental and/or vision plan because of other insurance or group plan coverage, you may be able to enroll yourself and/or your Dependents in the Caltech medical, dental and vision plan if you or your Dependents lose eligibility for that other coverage (or if another employer stops contributing towards your or your Dependents other coverage). However, you must request enrollment within 31 days after your or your Dependents other coverage ends (or after the employer stops contributing toward the other coverage). Loss of other medical, dental and/or vision plan coverage qualifies for special enrollment only if all three of the following conditions are satisfied:

1. You (or your Dependents) are otherwise eligible to enroll in the medical, dental and vision plan (see page 2.4 for eligibility provisions),

2. You (or your Dependents) were covered under a group insurance plan or insurance coverage when coverage under the Caltech plan was last offered, and

3. You lost that other coverage because you are no longer eligible for coverage or any benefits under that plan (or employer contributions to that other plan terminated) or, if the other coverage was COBRA, you (or your Dependents) lost other coverage due to the exhaustion of your rights to COBRA continuation coverage. Loss of eligibility for coverage includes but is not limited to, losing coverage as a result of i) divorce, legal separation, cessation of Dependent status (e.g., attaining the maximum age to be eligible as a Dependent child under a plan), death of an employee, termination of employment, and/or reduction in the number of hours of employment; ii) in the case of coverage offered through an individual or group HMO, an individual no longer residing or working in the HMO’s service area; and iii) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

In addition, if you gain a new Dependent as a result of marriage, birth, or Adoption, you may be able to enroll yourself and your Dependents for medical, dental and vision coverage. You may also switch between plans (for example from HMO to PPO). However, you must, request enrollment within 31 days after the marriage, birth, or Adoption.

If you are enrolling due to a new child, coverage will begin on the child’s date of birth, Adoption or Foster placement. If you are enrolling due to your marriage or loss of other health plan coverage, coverage will be effective on the first day of the month following the date of the qualifying event. If a court has ordered that coverage be provided for a Spouse, Domestic Partner or Dependent child, enrollment must be requested within 31 days from the date the court order was issued. For more information about Change in Status Events, please refer to page 6.2 or contact Campus or JPL Benefits Office.

Effective April 1, 2009, the Caltech benefit plan will allow a special enrollment event if you and/or your eligible dependents:

- lose Medicare or Children's Health Insurance Program (CHIP) coverage due to a change in eligibility, or
- later become eligible for a state's premium assistance program under Medicaid or CHIP.

You or your dependents will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in medical and/or dental coverage provided under the Caltech benefit plan. Note that the 60-day time period only applies to Medicaid/CHIP eligibility changes and not to any...
other HIPAA special enrollment event changes.

**HIPAA Special Enrollment Events**

These Special Enrollment events may enable you to add Dependents coverage and/or to enroll yourself as follows:

<table>
<thead>
<tr>
<th>IF YOU HAVE THIS EVENT</th>
<th>YOU MAY MAKE THE FOLLOWING CHANGE TO YOUR MEDICAL/DENTAL/VISION ELECTION WITHIN 31 DAYS OF THE EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>You gain an eligible Dependent through marriage, birth or Adoption</td>
<td>Enroll yourself and/or your Dependent(s) and/or change medical plans</td>
</tr>
<tr>
<td>You lose other health plan coverage and meet the requirements #1, #2 and #3 on page 2.9</td>
<td>Enroll yourself and/or your Dependent(s)</td>
</tr>
<tr>
<td>Your Dependent loses non-Caltech health plan coverage and meets the requirements #1, #2 and #3 on page 2.9</td>
<td>Enroll yourself and your Dependent(s) who lost coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF YOU HAVE THIS EVENT</th>
<th>YOU MAY MAKE THE FOLLOWING CHANGE TO YOUR MEDICAL/DENTAL/VISION ELECTION WITHIN 60 DAYS OF THE EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>You lose Medicaid or Children’s Health Insurance Program (CHIP) coverage due to a change in eligibility</td>
<td>Enroll yourself and/or your Dependent(s)</td>
</tr>
<tr>
<td>You later become eligible for a state’s premium assistance program under Medicaid or CHIP</td>
<td>Enroll yourself and/or your Dependent(s)</td>
</tr>
</tbody>
</table>
Changes in Your Benefits “At Other Times”

You may make the following changes to your benefits at any time during the year:

<table>
<thead>
<tr>
<th>PLAN(S)</th>
<th>CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical:</strong>&lt;br&gt;Anthem Blue Cross PPO&lt;br&gt;Anthem Blue Cross Advantage HMO&lt;br&gt;Anthem Blue Cross High Deductible PPO&lt;br&gt;Group Health Cooperative Plan&lt;br&gt;Kaiser Permanente&lt;br&gt;Kaiser Mid-Atlantic&lt;br&gt;<strong>Dental:</strong>&lt;br&gt;Delta Dental&lt;br&gt;MetLife DHMO (Safeguard)&lt;br&gt;Vision Service Plan (VSP)&lt;br&gt;Employee Assistance Program (EAP)</td>
<td>You may add or delete yourself and/or your Dependents within 31 days of a Change in Status or other IRS-recognized event. Enrollment in EAP is automatic.</td>
</tr>
<tr>
<td>Tax Savings Plan and Spending Account(s)</td>
<td>You may change your contributions within 31 days of a Change in Status or other IRS recognized event.* For the Spending Accounts, you must re-enroll each year to continue participation.</td>
</tr>
<tr>
<td>Group LTD (Core and Buy-up)</td>
<td><strong>Basic:</strong> Coverage is 100% employer paid and automatically provided to you. <strong>Supplemental:</strong> You may add or drop coverage at any time. Evidence of Insurability is required if you are a late enrollee.</td>
</tr>
<tr>
<td>Group Life (Basic and Supplemental)</td>
<td><strong>Basic:</strong> Coverage is 100% employer paid and automatically provided to you. <strong>Supplemental:</strong> You may add or drop coverage at any time. Any future increases in coverage following your initial enrollment may require Evidence of Insurability and a physical examination.</td>
</tr>
<tr>
<td>Group Life (Supplemental Spouse, Domestic Partner and Dependent Coverage)</td>
<td>Enrollment after 31 days for Spouses or Domestic Partners coverage and any future increases in coverage will require Evidence of Insurability.** Evidence of Insurability is not required for dependent children. See page 5.4.</td>
</tr>
<tr>
<td>Accidental Death &amp; Personal Loss (Non-ERISA)</td>
<td>You may add or drop coverage at any time. Coverage changes become effective on the first of the month following receipt of your application.</td>
</tr>
<tr>
<td>Travel Accident Insurance Plan Extra-Hazardous Duty Plan</td>
<td>Enrollment is automatic once you are eligible.</td>
</tr>
<tr>
<td>Base Retirement Plan</td>
<td><strong>Faculty/Key Staff:</strong> You must enroll immediately. <strong>Staff:</strong> You must enroll within six months of Eligible Service. (You become eligible after six months of Eligible Service.) <strong>Postdoctoral Scholars:</strong> You must enroll prior to completing two years of Eligible Service. (You become eligible after two years of Eligible Service.)</td>
</tr>
<tr>
<td>Voluntary ERISA TDA Plan</td>
<td>You may supplement the Base Retirement Plan with your own voluntary tax-deferred contribution up to the maximum allowable. You may enroll, change, or stop contributions at any time.</td>
</tr>
</tbody>
</table>

* See page 6.3 in the TSP and Spending Accounts Section for a list of Change in Status and other IRS-recognized events and a description of the consistency requirement for allowable mid-year election changes.

** After electing Group Life coverage for your Dependent children, coverage will be automatic for any new children.

Please note that except for medical coverage, you must be Actively At Work on the effective date in order for your new benefits or change in benefits to go into effect. Otherwise, they become effective on the day you return to work as a Benefit-Based Employee. Any benefit coverage changes related to salary increases will become effective on the first payroll period of your new salary.
COST OF COVERAGE

The employee portion of premiums for benefits is deducted from your paycheck during the month of coverage.* For monthly premium amounts, contact the Campus or JPL Benefits Office.

In months where there are three pay periods, deductions are taken twice.

*Your initial deduction may include a deduction for the previous month.

WHAT HAPPENS WHEN...?

This section addresses what happens to your benefits while you are on a leave of absence. This section does not address how your retirement benefits are affected by the following events. Please see Section 7 for more details on how your retirement benefits will be determined in the following situations. Contact the Campus or JPL Benefits Office for more information.

In order for your benefits to be reinstated, contact the Campus or JPL Benefits Office within 31-days of your return from leave.

What Happens to Your Benefits When You Are on a Paid Leave of Absence?

During a paid leave of absence, your payroll deductions for benefits and coverage will continue the same as if you are Actively At Work. If the Annual Enrollment period occurs during a paid leave of absence, you will be permitted to make all allowable election increases. However, any Life and/or LTD changes that you make will become effective upon your return to work subject to the carrier’s approval of your enrollment application. See rules below that apply when your paid leave becomes an unpaid leave. Dependent Care Reimbursements under DCSA may not be payable while you are off work due to illness.

Taking leave under Family and Medical Leave (FMLA) is recognized as a Change in Status Event, under which you may revoke or change your DCSA elections. For new enrollment in the DCSA plan, contact the Campus or JPL Benefits Office within 31-days of your return from leave.

What Happens to Your Benefits When You Are on an Unpaid Leave of Absence?

Unpaid Family and Medical (“FMLA”) Leave / California Family Rights Act (CFRA)

If you are on an unpaid Family and Medical Leave Act (FMLA) leave, you may continue the benefits in which you are enrolled for up to 12 weeks.¹ FMLA leave is measured on a rolling 12-month basis. During an approved FMLA leave of absence, Institute contributions for medical, dental, vision, basic life and basic LTD coverage continue as if you were an active employee for the 12 weeks¹ of FMLA leave.

If you decide to continue your medical, dental, vision, supplemental life, supplemental LTD, Health Care Spending Account (HCSA) coverage and/or Health Savings Account (HSA) you will be billed monthly for your portion of the cost and any payments will be made on an after-tax basis. Your other benefits except the Dependent Care Spending Account (DCSA) will also continue during the 12 weeks¹ of FMLA leave subject to the terms of each particular insurance contract and timely payment of your portion of the cost. You will be sent a bill monthly for your portion of the cost. See Unpaid Disability Leave below regarding continuation of your benefits during an unpaid disability leave beyond the 12 weeks of FMLA leave.

¹ FMLA is also available for up to 26 weeks for military caregiver leave (contact Human Resources for information).
Dependent Care Reimbursements under DCSA may not be payable while you are off work due to illness. Taking leave under Family and Medical Leave (FMLA) is recognized as a Change in Status Event, under which you may revoke or change your DCSA elections. For new enrollment in the DCSA plan, contact the Campus or JPL Benefits Office within 31-days of your return from leave.

If you take FMLA/CFRA leave, but your coverage under the plan is terminated, your coverage will be reinstated the first of the month following your return to work as a Benefit-Based Employee and you will not be subject to any exclusion or waiting period.

If you are on FMLA/CFRA leave, during the Annual Enrollment period, you may switch plans as if you were Actively At Work.

**Unpaid Disability Leave (Non-FMLA)/CFRA**

Institute contributions for your medical, dental, vision, basic life and basic LTD coverage continue as if you were an active employee for the first six months of leave. The six-month period is measured from the first day of leave, including FMLA/CFRA leave, paid or unpaid. During that time, if you decide to continue your medical, dental and vision coverage, you will be required to pay the employee portion of the cost. For any other benefit that you decide to continue, including supplemental life, supplemental LTD, Personal Accident Insurance (PAI), Health Care Spending Account (HCSA) and/or Health Savings Account (HSA) coverage, you will be required to continue to pay 100% of the cost. You will be billed monthly for any benefits you decide to continue. All payments will be made on an after-tax basis.

After the first six months of leave, you may be required to pay 100% of the cost for any benefits that you continue up to a maximum of 24 months from the first day of leave as long as premiums are paid.

If you are approved to continue your leave after exhausting your FMLA/CFRA leave

Institute contributions to your retirement account will continue through the end of your 6th month of leave or when sick leave is exhausted, whichever is later.

Note: the Institute retirement contribution rate will be the rate that was used in effect immediately prior to your Disability, unless your age or years of service changes the level of Institute contributions.

Your HCSA may continue on an after-tax basis, only for the Plan Year in which your leave began. The HCSA may be reinstated upon your return to work as a Benefit-Based Employee only for the Plan Year in which your leave began.

Your Dependent Care Spending Account (DCSA) will be suspended at the time you transition to unpaid status (if applicable). The DCSA may be reinstated upon your return to work as a Benefit-Based Employee only for the Plan Year in which your leave began.

Your HSA may continue on an after-tax basis, only for the Plan Year in which your leave began. The HSA may be reinstated upon your return to work as a Benefit-Based Employee only for the Plan Year in which your leave began.

While on an unpaid disability leave (non-FMLA/CFRA), you may not enroll in or switch medical, dental and vision plans. You may add or drop Dependents during the Plan Year if you have a Change in Status or other IRS-recognized event. If you have a HIPAA Special Enrollment Event, you and/or your new or existing Dependents may be able to enroll as described
on page 2.9. If you move outside of an HMO service area and lose coverage, you may be able to change your coverage within 31 days of your loss of coverage.

If you are on unpaid leave (non-FMLA/CFRA), during the Annual Enrollment period, your requested changes will not be effective unless you contact the Benefits Office upon your return to work as a Benefit-Based employee.

**Additional Information Regarding Long Term Disability (LTD) Insurance Benefits**

Once approved for LTD, the LTD carrier will determine if you are eligible for life insurance premium waiver for your own life insurance, spousal life and dependent life.

If you are approved for LTD benefits, you may continue your existing benefits, up to a maximum of 24 months from the first day of leave, by paying your portion of premium. The Institute will continue paying the employer premium.

If you do not qualify for LTD benefits after the first six months of your Disability, you are required to pay the full cost of benefits (Institute plus employee contributions) and are subject to the time limitations of 24 months maximum. You will be billed monthly.

Refer to Section 4 for further details on LTD.

**Personal Leave**

You may continue benefits for the first 12 months of an approved unpaid leave of absence, subject to the terms of each particular insurance contract (see page 7.4 for regular retirement contributions during an unpaid leave). However, eligibility for LTD and DCSA (if applicable) coverage will terminate at the beginning of the leave. You will become eligible for LTD and DCSA (if applicable) coverage the first of the month following the date that you returned to work as a Benefit-Based Employee. If other benefits are continued, you are required to pay the full cost of coverage (Institute and employee portion) during the period of an unpaid leave. You will be billed monthly for your cost. Subject to the terms of each contract, changes or increases in coverage may not take effect until the date you return to active work as a Benefit-Based Employee. If you do not return to work at the end of your approved leave and you have continued your medical, dental, vision and life insurance coverage, COBRA and Conversion will be available (see COBRA and Conversion sections beginning on page 2.21).

**If You Take a Military Leave (USERRA)**

Under the Uniform Services Employment and Reemployment Rights Act (USERRA), if you take a military leave, whether for active duty or for training, you are entitled to continue medical, dental, vision and Healthcare Spending Account (HCSA) coverage for up to 24 months (as long as you give the Institute advance notice, with certain exceptions, of the leave), and provided that your total cumulative leave, when added to any prior periods of military leave from the Institute, does not exceed five years (with certain exceptions).

If the entire length of the leave is 44 days or less, you will not be required to pay any more for your medical, dental and vision coverage than the portion you paid before the leave.

If the entire length of the leave is greater than 44 days but less than six months, you will not be required to pay any more for your medical, dental and vision coverage than you paid before the leave.

For the first six months of military leave, the Institute will pay the employer portion of your medical, dental, vision, basic life and basic LTD coverage. If you elect to continue those coverages, you will be required to pay the employee portion for those coverages.

After six months, you may be required to pay up to 102% of the entire amount (including both
Institute and employee contributions plus 2% necessary to cover an active employee.

If you take a military leave, but your coverage under the plan is terminated — for instance, because you do not elect the extended coverage, an exclusion or waiting period will not apply in the event you are reinstated back into the Caltech benefits program plan. However, an exclusion or waiting period may apply to any illness or injury incurred or aggravated during military service.

Continuation of coverage under your military leave and coverage available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) will run concurrently. That means that if you experience a COBRA qualifying event during your military leave, any continuation of coverage that you took while on military leave will count toward the maximum allowable COBRA coverage period. If COBRA and USERRA give you (or your Spouse Domestic Partner or Dependent children) different rights or protections, the law that provides the greater benefit will apply. See page 2.21 for the rules on COBRA coverage.

During your military leave, all of your other benefits including life, PAI and LTD may continue as long as you pay 100% of the cost of the coverage (refer to page 5.13 for PAI exclusions and page 4.9 for LTD exclusions).

Your DCSA will be suspended during your military leave and your HCSA may only continue if you pay after-tax for the duration of leave protected under USERRA (e.g. 24 months).

Please refer to page 7.5 for information regarding your participation in the Base Retirement Plan.

**Unpaid Non-military, Non-FMLA /CFRA Leave in General**

You have the option of suspending coverage under your benefit plans during a leave of absence (subject to the rules set forth on page 6.3 regarding Changes in Status). You may reinstate your coverage effective **the first of the month** following your return to work as a Benefit-Based Employee. In order to reinstate coverage, you must contact the Campus or JPL Benefits Office within 31 days of your return from leave.

When you go on an unpaid leave of absence, Institute contributions for partial months will be paid as follows:

- If you are paid for at least one working day during the month you go on unpaid leave, the Institute will pay its contributions toward coverage through the end of the month provided that you pay the employee portion.*

- If you are paid for at least 10 working days during the month you return to work, the Institute will pay its contributions towards coverage for that same month provided that you pay the employee portion.*

*An exception to this rule occurs when you are on an approved FMLA leave or USERRA military leave. Refer to page 2.15 for details.

Pre-tax contributions to the ERISA TDA Plan stop during an unpaid leave of absence.

Refer to Caltech Personnel Memoranda or JPL’s leave of absence policies for further information regarding leaves of absence.

**What Happens When You Return From a Leave of Absence?**

When you return from an unpaid leave of absence as a Benefit-Based Employee, your benefit elections will generally be reinstated and you may commence payment of your benefit
elections on a pre-tax basis. USERRA and FMLA/CFRA require immediate reinstatement upon reemployment. If you missed the Annual Enrollment Period while you were on an unpaid leave, you will have the opportunity to change plan elections for yourself and your Dependents upon your return to work. If you waived any benefits while on your unpaid leave of absence, you will need to re-enroll upon your return to work.

You may be required to re-pay any military pay received while you were on a military leave if the combined military pay and Caltech’s pay exceeds your regular base wages or salary.

Contact the Campus or JPL Benefits Office within 31 days of your return from leave in order for your benefits to be reinstated.

What Benefits Are Available if You Are Assigned to Work on a Job Assignment Outside of California at the Request of the Institute?

If you are temporarily assigned to work outside of California at the request of the Institute, you and your Dependents may be able to enroll in coverage under the Blue Card Plan with Anthem Blue Cross. If you had coverage under one of the Institute’s medical plans prior to the commencement of the job assignment and waived Caltech medical coverage, including coverage under the Blue Card Plan with Anthem Blue Cross, you and your Dependents may be eligible for an out-of-area medical premium reimbursement to cover a portion of the cost to purchase individual medical coverage. Before you leave, contact the Campus or JPL Benefits Office for further details.

What Happens When You Transfer Between Campus and JPL or Other Areas of the Institute?

If you transfer within the calendar year, your insurance and retirement benefits and costs remain the same assuming your status, salary and/or hours do not change. Please contact Campus or JPL Benefits Office for details.

What Happens To Your Benefits When You Terminate Employment?

Upon termination of employment from the Institute, except for termination due to gross misconduct, you and your Dependents may be eligible to continue your medical, dental, vision, and Health Care Spending Account coverage under COBRA.

Refer to page 2.21 for further details of your COBRA rights.

For information on converting your group life insurance coverage, refer to page 2.30 or contact the Campus or JPL Benefits Office.

What Happens if You Are Rehired? (Non-Retiree Staff Only)

Rehire — If you are a Benefit-Based Employee and leave the Institute and are rehired as a Benefit-Based Employee, the following rules on your coverage will apply:

- termination — if rehired within 12 months of termination, eligibility for benefits will resume on the first of the month coinciding with or following the month you are rehired. Your pre-tax medical, dental, vision and spending account elections will be reinstated unless you have a Change in Status or other IRS-recognized event as described on page 6.2. If your return crosses an Annual Enrollment period, you may make new
elections and must re-enroll to participate in a spending account. Campus employees refer to Personnel Memoranda 14 and 31, and JPL employees refer to the JPL Termination policy and JPL’s Service Date Policy.

- **layoff** — if rehired within 12 months (or possibly up to 24 months depending on the length of your service), benefits will resume on the first of the month coinciding with or following the month you are rehired. Your pre-tax medical, dental, vision and spending account elections will be reinstated unless you have a Change in Status or other IRS-recognized event as described on page 6.4. If your return crosses an Annual Enrollment period, you may make new elections and must re-enroll to participate in a spending account. Campus employees refer to Personnel Memorandum 14, and JPL employees refer to JPL Termination policy and JPL’s Service Date Policy.

All other rehire situations require that you meet the waiting periods of the individual plans if you return to the Institute after a 12 month period. In either case, you must re-enroll for all plans in the same manner as for any newly hired employee.

Refer to page 7.4 regarding participation in the retirement plan upon re-employment for a description of how combining periods of service affects your Retirement Plan contributions.

See page 2.19 for the rules applicable to a rehired retiree.

**What Happens When You Retire?**

You and your Dependents are eligible for Caltech retiree benefits, as described below, when you are at least 55 years old and have at least 10 continuous years of service as a Benefit-Based Employee immediately prior to retirement or death.

In addition, you are eligible for Caltech retiree benefits

1. if you are at least 55 years old, and
2. have more than 20 years of service as a Benefit-Based Employee, and
3. have a minimum of 12 months benefit based service immediately prior to retirement.

**Retiree Medical Eligibility** — If you are eligible for medical coverage under one of the retiree medical plans offered by Caltech, the Institute pays a portion of the cost as follows:

- **Group I:** If you were at least 55 years of age and had 10 or more continuous years of service as of April 1, 1991*, Caltech will contribute towards coverage for you and your Dependents.

- **Group II:** If you do not qualify under Group I, for every year of service as a Benefit-Based Employee, including non-consecutive periods of service, Caltech will contribute 3.8% of the average cost of the HMO plans, up to a combined maximum of 95% of the cost. So, for example, if you retire with 25 years of service, Caltech will contribute 95% (25 x 3.8) of the cost of the average cost of the HMO plans offered. If you choose a higher priced medical plan, you will pay the difference between the Caltech contribution as determined under the Group II formula and the price of that medical plan.

* See Appendix I, page 9.1, for special transition rules.

**Rate information** — To find out the rate information that applies to you, contact the Campus or JPL Benefits Office. Caltech will bill you monthly for the premium due. Timely
payments are required to keep your coverage in effect.

If at the time you retire you are not enrolled in one of the medical plans available to employees, you may enroll in a retiree medical plan offered during the next Annual Enrollment period (see below).

If you are enrolled in a Caltech active health plan at the time you retire, you can continue current coverage until next open enrollment.

If you retire following a layoff, contact the Campus or JPL Benefits Office for further information.

For retirees and/or dependents over 65, Medicare is primary and the Caltech medical plan will pay the difference, if any, up to the maximum current benefit allowable.

Retirees may elect to waive Caltech medical coverage and receive cash reimbursement for medical premiums paid to a non-Caltech medical plan through the Retiree Reimbursement Program. The Retiree Reimbursement Program is limited to a scheduled monthly amount or the actual premium paid, whichever is less. Premiums paid for Dental and Medicare Part A & B or by another entity or employer are not eligible for reimbursement. Contact the Campus Benefits Office at 626-395-6443 or hrbenefits@caltech.edu or the JPL Benefits Office at 818-354-3760 or benefits@jpl.nasa.gov for information about this retiree medical benefit option.

Extension of medical, dental, vision, and Health Care Spending Account Coverage — At times like retirement, extended benefits under COBRA may be available. See pages 2.23-2.31 for information about COBRA coverage.

Retiree Life/PAI Insurance — As a retiree, you are eligible for the basic non-contributory life insurance amount of $5,000 ($5,000 if retired prior to January 1, 1992). Within 31 days following your retirement, you may convert the difference between the amount of group life insurance you had as an active employee and the retiree life insurance amount of $5,000 to an individual life policy. PAI may also be converted to an individual policy within 31 days of retirement. See page 2.31 for details.

Information and conversion application forms for both plans may be obtained from the Campus or JPL Benefits Office.

Long Term Disability Insurance — Eligibility for coverage under the LTD plan ends on your last day of work. You may not convert or extend this coverage.

Sick Leave Credit—Employees who are retiree eligible and have accrued sick leave hours will receive a credit based on a percentage of unused hours. The sick leave credit will be paid in a lump sum payment at retirement. Please refer to the Caltech sick leave personnel memoranda, 15-3, section 8.3 or JPL’s paid time off policy located on the JPL HR policy page.

Rules for Surviving Spouses and Domestic Partners

Upon the death of a Benefit-Based Employee or a retiree who is eligible for or receiving retiree medical benefits, the surviving Spouse or Domestic Partner may receive benefits under a retiree medical plan and make most allowable plan changes permitted to similarly-situated retirees. A surviving Spouse or Domestic Partner will not be allowed to add a new Spouse or Domestic Partner to the plan.

If the surviving Spouse or Domestic Partner is a Benefit-Based Employee of the Institute, he or she and any eligible Dependents will be covered under the medical, dental and vision plans available to active employees. Coverage will continue under the plan for actives as long as he or she remains a Benefit-Based Employee.
Changes In Your Medical Benefits — At times other than the Annual Enrollment Period, retirees may add or delete Dependents within 31 days of a corresponding Change in Status such as birth, adoption, legal guardianship, marriage, legal separation, beginning or ending a domestic partnership, divorce, annulment, death, loss or gain of other coverage due to a change in employment, change in residence, and Dependent loss of eligibility.

Annual Enrollment Period — During the Annual Enrollment Period in the fall, retirees may enroll themselves and/or their Dependents in a medical plan, or switch among medical plans. Participation or de-selection requested during the Annual Enrollment Period will be effective on January 1st of the calendar year following the Annual Enrollment Period.

What Happens if You Are Rehired After You Retire?

If you are rehired as a Benefit-Based Employee after you have qualified for retiree health benefits, you and your Dependents will be covered under the Institute medical, dental and vision plans available to active employees. Coverage will be effective the first of the month coincident with or next following your rehire date.

If you are rehired as a non-Benefit Based Employee after you have qualified for retiree health benefits, you and your Dependents may be covered under the Institute health plans offered to retirees.

For Group I, you will be allowed back into the retiree plan with no change in benefits coverage.

For Group II retirees, when your service as a rehired retiree ends and you again terminate from the Institute, your contributions for retiree coverage will be recalculated and you will receive credit for every year of service as a Benefit-Based Employee, including those earned as a rehired retiree.

Refer to page 7.4 regarding participation in the retirement plan upon re-employment.

WHEN OTHER COVERAGE ENDS

Your coverage under all plans, except, LTD, Travel Accident, and Extra-Hazardous Duty, will end on the earliest of the following dates, except as described during leaves of absence (please refer to pages 2.12-2.16):

- The date you stop making any required contributions;
- The date the plan is terminated;
- The end of the month in which you are no longer a Benefit-Based Employee.

Medical, Dental, Vision, and/or EAP coverage may be extended through COBRA. Travel Accident and Extra-Hazardous Duty coverage will end on your last day of work.
YOUR RIGHT TO CONTINUE COVERAGE (COBRA)

Under a federal law commonly known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your Spouse and Dependent children may elect to temporarily continue medical, EAP, dental, or vision coverage in certain instances where such coverage otherwise would be reduced or terminated.* Individuals entitled to COBRA continuation (i.e., "qualified beneficiaries") are you, your Spouse and your Dependent children who are covered at the time of a "qualifying event". Although not required to cover Domestic Partners by law, the Institute will offer COBRA-like coverage to Domestic Partners. In addition, a child who is born to you or placed for Adoption with you during the COBRA coverage period is also a qualified beneficiary. Generally, to elect COBRA coverage, you must notify the Institute of your intent to continue within 60 days after you (and/or your Dependents) would otherwise lose coverage or the date you receive notice, if later. If you are contributing to a Health Care Spending Account, you can continue those contributions through the end of the year your participation began subject to the amount left in the HCSA.

* Any continuation coverage during a military leave will count toward the maximum COBRA period allowable. Any election you make pursuant to COBRA will also be an election under USERRA, and vice versa, and both CORBA and USERRA will apply with respect to continuation coverage if elected.

Who is Covered?

Employee: You may enroll for COBRA coverage if your Caltech medical, EAP, dental, or vision coverage stops because you terminate employment (other than for gross misconduct) or reduce your work hours to Non-Benefit-Based Employee status. Contact the Campus or JPL Benefits Office if your termination of employment is due to a layoff.

Your Spouse or Domestic Partner may enroll for COBRA coverage if his or her medical, EAP, dental or vision coverage stops because of the following qualifying events:

- Your termination of employment (other than for gross misconduct) or substantial reduction of work hours to Non-Benefit-Based Employee status;
- Divorce or legal separation, or termination of Domestic Partnership;
- Your entitlement to Medicare benefits as a retiree or due to disability; and
- Your death.

Children: Your Dependent children may enroll for COBRA coverage if their medical, EAP, dental, or vision coverage stops because of the following qualifying events:

- Your termination of employment (other than for gross misconduct) or substantial reduction of work hours to a Non-Benefit-Based Employee status;
- Your divorce, legal separation, or termination of Domestic Partnership;
- Your death;
- Child’s loss of Dependent eligibility; and

Your entitlement to Medicare benefits as a retiree or due to disability. FMLA: If you take a leave of absence that qualified under the Family Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your Spouse, Domestic Partner and Dependent children, if any) will have the right to elect COBRA if:

- They were covered under the group health plan on the day before FMLA leave began (or became covered by the group health plan during FMLA leave);
• They lose group health coverage under the plan because you do not return to work at the end of the leave. COBRA coverage will begin on the earliest of the following to occur: i) when you definitively inform Caltech that you are not returning at the end of the leave; or ii) the end of the leave, assuming you do not return to work and you’ve continued coverage while on leave.

Newly Eligible Children: If you, the former employee, elect COBRA coverage and then have a child (either by birth or Adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the plan’s eligibility and other requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage by providing Caltech (see contact information below) with notice of the new child’s birth or Adoption. This notice must be provided within 31 days of birth or Adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or Adoption of new qualified beneficiary, and birth certificate or adoption decree.

Newly acquired Dependent child(ren) (other than children born to or Adopted by the employee) will not be considered qualified beneficiaries, but may be added to the employee’s continuation coverage, if enrolled in a timely fashion, subject to the plan’s rules for adding a new Dependent. If you fail to notify Caltech within the required timeframe, you will not be offered the option to elect COBRA coverage for the newly acquired child.

QMCSO: Your child who is receiving benefits under the program pursuant to a Qualified Medical Child Support Order (QMCSO) received by Caltech during your period of employment with Caltech is entitled to the same rights to elect COBRA as an eligible Dependent child covered under the Caltech benefits program.

When is COBRA Coverage Available?

When the qualifying event is the termination of employment, reduction in hours or death of the employee, COBRA coverage will be offered to qualified beneficiaries. You do not need to notify Caltech of any of these three events. You and your covered Dependents will be provided with instructions for continuing your health coverage.

If, in anticipation of a divorce, a Spouse’s coverage is dropped during annual enrollment or due to a change in status, under certain circumstances, your Spouse will be offered COBRA continuation coverage from the date of divorce. HR must be notified when the divorce becomes final in order for COBRA to be available. Coverage will not be available from the date the Spouse’s coverage was dropped until the date of divorce. This means there could be a lapse in coverage.

It is your legal responsibility to inform Caltech within 60 days of the date the qualified beneficiary loses coverage when divorce or a legal separation results in your Spouse’s, Domestic Partner’s or Dependents’ loss of eligibility for coverage, or when a child loses Dependent status under the program or there is a termination of a relationship with your Domestic Partner. You must supply Caltech with a current address for your former Spouse or Domestic Partner. Caltech will then notify you, your Spouse, your Domestic Partner, or your children of their rights under COBRA, supplying coverage, cost, and enrollment information.

The notice must include the following information:
The name of the employee who is or was covered under the program;

The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the program due to the qualifying event;

The qualifying event giving rise to COBRA coverage;

The date of the qualifying event; and

The signature, name and contact information of the individual sending the notice.

For other qualifying events (e.g., if your employment ends, your hours are reduced, or you become entitled to Medicare), you and your covered Dependents will be provided with instructions for continuing your health coverage.

In the event of your death, Caltech will notify your covered Dependents how to continue their medical, EAP, dental and/or vision coverage.

In addition you must provide documentation supporting the occurrences for the qualifying event if Caltech requests it. Acceptable documentation includes a copy of the divorce decree or Dependent child(ren)’s birth certificate(s), driver’s license or marriage license.

You must mail or hand deliver this notice to Caltech at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to Caltech within the 60-day notice period, all rights to COBRA will be waived. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the program for any claims mistakenly paid.

COBRA also requires that continuation of coverage rights similar to those described above may apply to retirees, Spouses, Domestic Partners and Dependents if Caltech commences a Title 11 bankruptcy proceeding. In such case, qualified beneficiaries include you, your Spouse, your Domestic Partner and your Dependents who have retiree coverage under the medical plan on the date the proceeding commenced or have had retiree coverage for one year before or after the proceeding commenced or have had retiree coverage substantially eliminated within one year before or after the date the proceeding commenced, regardless of whether you and/or your Spouse or Domestic Partner are enrolled in Medicare. Retiree coverage under the program for you and your Dependents may be continued for the rest of your (the retiree’s) life. After your death, if bankruptcy proceedings have already commenced, your surviving Spouse or Domestic Partner and Dependent children may continue to receive retiree health coverage for an additional 36 months.

**How to Elect COBRA**

To elect COBRA coverage, you must complete the election form that is included with your COBRA notice and mail it to the COBRA Administrator at the address on page 2.29 under Contact Information. (An election notice and form will be provided to qualified beneficiaries at the time of the qualifying event.)

You must elect COBRA coverage within the 60 day from the later of the day:

- You receive notification of COBRA rights;
- Coverage is lost due to the qualifying event.

Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA. If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA.
coverage as long as it is within the original 60-day election period.

Coverage. If you elect COBRA continuation coverage, you are entitled to the same coverage you had as a Benefit-Based Employee. This includes the right to switch plans during the Annual Enrollment Period. Any benefit changes in active employee programs apply to your continuation coverage too. (For example, if the medical plan for active employees is switched to a new insurance carrier, coverage for those on COBRA will also switch to the new carrier.)

Separate Election. Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect to be covered under COBRA, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse, Domestic Partner or Dependent child may elect different coverage than the employee elects.

A covered employee, Spouse or Domestic Partner can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Medicare and Other Coverage. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary’s COBRA coverage will terminate automatically if after electing COBRA, he or she becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When you complete the election form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Once you elect COBRA coverage, you have 45 days to pay initial premiums to Caltech. You should send your payment with your COBRA election form to ensure prompt enrollment. The Institute must receive your premium before your claims will be paid. All other premiums are due the first day of each month; however, you have a 30-day grace period in which to pay premiums before COBRA coverage is canceled. Coverage which has been terminated cannot be reinstated.

Duration of COBRA
You and/or your Dependents may continue medical, EAP, dental and/or vision coverage for a maximum of:

- 18 months in the case of your termination of employment or substantial reduction in work hours;
- 36 months for Dependents for termination of coverage for any qualifying event listed on the previous page other than your termination or reduction in work hours.

If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered Dependents because their coverage was not lost or reduced) and then they lose coverage due to your termination of employment or reduction in hours of work within 18 months, your Dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare. This COBRA coverage period is
available only if the covered employee becomes entitled to Medicare within 18 months before termination or reduction of hours.

You may also continue HCSA coverage on an after-tax basis through the end of the calendar year in which the qualifying event occurs. HCSA coverage is described in Section 6. COBRA coverage for the HCSA, if elected, will consist of the HCSA coverage in force at the time of the qualifying event (i.e. the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply. All qualified beneficiaries who were covered under the HCSA will be covered together for COBRA coverage.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

**Second Qualifying Event**

If your Dependents experience a second qualifying event (except for your entitlement to Medicare) within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

Second qualifying events include an employee’s death, divorce, or child losing Dependent status (if such qualifying event would have resulted in a loss of coverage under the program for an active employee or dependent). If you experienced a second qualifying event, COBRA coverage for a Spouse, Domestic Partner or Dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event or the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event. Acceptable documentation includes copy of the divorce decree, death certificate or Dependent child(ren)’s birth certificates, driver’s license or marriage license.

You must mail this notice to the COBRA Administrator at the address on page 2.31 under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

**Disability Extension**

If the qualifying event that resulted in your COBRA election was your termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled.
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after your termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

If you or your Dependents want to extend coverage for up to 29 months due to disability (described above), you must notify the COBRA administrator within 60 days after the latest of:

- the date the Disabled individual receives his or her Social Security Disability determination;
- the date your employment ends or hours are reduced; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the program as a result of your termination of employment or reduction of hours.

You must also provide this notice before the end of the initial 18-month COBRA continuation period. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration’s determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

You must also notify the COBRA administrator within 30 days after Social Security determines that you or your Dependent no longer is Disabled. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Note that if a second qualifying event (such as divorce, loss of Dependent status) occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a Spouse or Dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of
employment or reduction in hours of employment.

**Cost of COBRA**

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost of group health plan coverage (including both Institute and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. **If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the program.** Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). **If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the program.**

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator at the address on page 2.29 under Contact Information.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the program would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it and make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

The cost of coverage for the 19th through 29th months of coverage under the disability extension is:

- 150% of the full cost of coverage for all family members if the disabled individual is among those continuing coverage;
- 102% if the disabled individual is not among those family members extending coverage.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the rate for the 19th through 36th months of the COBRA continuation period is

- 150% for all family members if the disabled individual is among those continuing coverage;
- 102% if the disabled individual is not among those family members extending coverage.
Early Termination of COBRA

Eligibility for COBRA coverage will end sooner than the 18, 29 or 36 months if:

- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by Caltech that does not contain an exclusion or limitation affecting the person’s preexisting condition, or the other plan’s preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA coverage if bankruptcy is the qualifying event.)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children Adopted by you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- The date Caltech no longer provides group health coverage to any of its employees.

COBRA coverage may also be terminated for any reason the program would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Caltech reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan’s pre-existing condition rule does not apply to you by reason of HIPAA’s restrictions on pre-existing condition clauses, the program may terminate your COBRA coverage.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage (after exhaustion or satisfaction of any pre-existing condition limitation). Caltech, the insurance carriers and/or HMOs may require repayment to the program of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

When COBRA coverage ends, you may be able to convert your medical coverage to an individual policy (see Conversion).
Extended Cal-COBRA Coverage Period

You and/or your Dependents may be eligible for an extension of your medical plan coverage under Cal-COBRA beyond the date federal COBRA continuation coverage is scheduled to end. Cal-COBRA extends medical coverage to qualifying individuals entitled to less than 36 months of federal COBRA (e.g., federal COBRA coverage due to termination of employment or reduction in work hours).

Health service plans and health insurers are required to extend the term of their continuation coverage from the date of the original COBRA event.

This extension applies to the medical plan only. The carrier is required to notify COBRA participants within the notice of pending termination of COBRA coverage. The carrier may charge up to 110% of the premium during the Cal-COBRA extension period.

You should contact the applicable HMO or insurance carrier for additional details.

Please examine your options carefully before declining Cal-COBRA coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher costs or you and/or your Dependents could be denied coverage entirely.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

Campus Benefits Office:
California Institute of Technology
399 S. Holliston, MC 161-84
Pasadena, CA 91125
626-395-6443

Lab Benefits Office:

Jet Propulsion Laboratory
4800 Oak Grove Drive, T1720-B
Pasadena, CA 91109
818-354-3760

You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

Keep The Program Informed of Address Changes

In order to protect your and your family’s rights, you should keep Caltech informed of any changes in your and your family members’ addresses. You should also keep a copy, for your records, of any notices you send to Caltech.

CONVERSION TO AN INDIVIDUAL POLICY

Medical Coverage

If your group medical coverage stops, you may be eligible to convert to an individual medical insurance policy from the carrier. The Caltech benefits program plan must be in force and the coverage has to stop for any of the following reasons:

- Your employment ends;
- You are no longer a Benefit-Based Employee;
- Your COBRA (and Cal-COBRA, if applicable) continuation coverage has expired.

The new conversion policy may be for yourself and any Dependents covered under the plan. Proof of good health is not required.

If your group medical coverage stops because the plan ends or you’ve not paid your required
premiums, you will not have the right to convert coverage.

If you die, your Spouse, Domestic Partner or the guardian of your Dependent children may convert to an individual policy for the covered Dependents.

If your marriage or domestic partnership ends, your former Spouse or Domestic Partner may convert to an individual policy within 31 days of either of the following times:

- When your marriage or domestic partnership ends;
- At the end of any period of COBRA or Cal-COBRA (only if the plan is in force).

Any of your covered Dependents may convert to an individual policy if the Dependent:

- Stops being eligible; or
- Is 19 or older when you convert your policy. (Only Dependents under 19 can be covered under your new family conversion policy.)

How to Apply: You must elect conversion coverage within 31 days after COBRA coverage stops.

Call the Customer Service numbers to obtain a conversion application from your medical plan. See page 2.2. Your carrier will explain the coverage and cost for the conversion coverage. You must pay the first premium to the carrier before the insurance will be effective.

If you die within the 31-day conversion period, your Spouse or any guardian of your Dependent children may apply for the individual policy for your covered Dependents.

The benefit amounts for the new policy will be governed by the following:

- The rules of the insurance policy;
- The laws of the state where you live when you apply.

A copy of the policy may be obtained from the insurance carrier.

Other Limitations: The insurance carrier may limit the benefits of the individual health policy because you or a Dependent has other insurance coverage. In some cases, the insurance carrier may even refuse to issue a policy. You will be advised of the rules when you apply.

Employee Assistance Program (EAP)

Employees will have the option to extend EAP coverage under certain circumstances for yourself and/or your covered dependents if coverage would otherwise end due to termination of employment or another COBRA “Qualifying Event”.

Group Life Insurance

If you or your Dependent’s group life coverage is reduced or you are no longer eligible for coverage under the group life policy, you may be able to convert to an individual policy. Depending on your coverage, you may be able to port or convert your Voluntary Life coverage. Your coverage under the group life policy will cease at the end of the month in which you are no longer eligible. You have 31 days from the day your group life coverage ends or is reduced, to convert to an individual policy. The policy will go into effect the day following loss of coverage. Applications for conversion policies are available from the Campus or JPL Benefits Office.

Your individual policy can equal up to the face amount of the coverage you had while eligible, less the amount of any retiree coverage, if applicable. The individual policy does not include disability or any other supplementary
benefits. You will not be required to provide Evidence of Insurability.

If you die during the 31-day conversion period, your Beneficiary will be paid the death benefit that you were entitled to convert, whether or not you have applied for an individual policy.

If your coverage ends because the plan is terminated entirely or for your employee group, and you are totally Disabled at that time, you will be eligible to convert the amount of the terminated policy up to a maximum of $10,000. You will not be eligible to convert any replacement coverage that may be offered.

When you apply, you will be told the cost of your coverage. (Rates for an individual are based on age.) You must apply in writing and pay the first premium for coverage to take effect. If your group life insurance is canceled for any reason, you should contact the Campus or JPL Benefits Office at once.

Accidental Death & Personal Loss You and your insured family members may apply to Port or convert your voluntary Accidental Death coverage with your Life port or conversion coverage to an individual policy if your coverage under this policy terminates for any reason except:

- Nonpayment of premium; or

- When the terminated policy is replaced within 31 days by similar coverage sponsored or arranged by the Institute.

- The converted policy cannot exceed the lesser of your elected benefit when the policy ceases, or $250,000. The conversion coverage will be at the premium rate on the form then being made available for such conversion.
TERMS YOU SHOULD KNOW

Basic Services
Procedures necessary to restore teeth (other than crowns or cast restorations), oral surgery, endodontics (root canal therapy), and periodontics.

Crowns and Cast Restorations
Caps, veneers, inlays, and onlays.

Diagnostic Services
Procedures, such as X-rays, to help the dentist evaluate your dental health and determine necessary treatment.

Endodontics
Treatment of the tooth pulp.

Orthodontia
Treatment for the correction of dental malocclusion.

Periodontic Services
Treatment of gums and bones that support the teeth.

Preventive Services
Procedures, such as cleanings, to help prevent dental disease.

Prosthodontic Services
Procedures involving bridges, dentures and implants to replace missing teeth.

Usual, Reasonable, and Customary Charges
Charges for a particular service that fall within the parameters of the average or commonly charged fee for that service within the community where treatment is received.
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YOUR CALTECH MEDICAL PLANS

The Institute offers you the choice of several medical plans, described in this section of the Handbook.

PPO Plans

⇒ The Anthem Blue Cross PPO and the Anthem Blue Cross High Deductible PPO
   (http://www.anthem.com/ca/caltech)

Below are some highlights of the Anthem Blue Cross PPO and the Anthem Blue Cross High Deductible PPO.

For specific details on the Anthem Blue Cross PPO and the Anthem Blue Cross High Deductible PPO, please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu (under the Health tab).

Health Maintenance Organizations (HMOs)

⇒ Anthem Blue Cross Advantage HMO (http://www.anthem.com/ca/caltech)
⇒ Kaiser Permanente (http://www.kp.org)

For specific details on the HMOs’ benefits, please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu (under the Health tab).

Refer to benefits.caltech.edu for the costs of coverage (see the Costs section under the Health tab). If you need any of the Evidence of Coverage (EOC) medical plan booklets, please visit the insurance company’s website or call the insurance company’s customer service phone number. You can find this contact information at benefits.caltech.edu (under Plan Contacts).
ANTHEM BLUE CROSS PPO AND HIGH-DEDUCTIBLE PPO PLANS

This section highlights some of the important provisions of the Anthem Blue Cross PPO and High Deductible PPO. Please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu (under the Health tab) or call Anthem Blue Cross Customer Service at 1-866-820-0765 to determine specific plan provisions as they apply to you and your covered Dependents. All information contained in this Handbook relating to eligibility and other Caltech-specific policies shall supersede any items in conflict with the Anthem Blue Cross Evidence Of Coverage (EOC) Plan Booklet. You should refer to the EOC for information related to applicable co-pays, Deductibles, benefits coverage and exclusions. Copies of the booklet are available from Anthem Blue Cross and the Campus or JPL Benefits Office.

HOW THE ANTHEM BLUE CROSS PPO PLAN WORKS

The Anthem Blue Cross PPO Plan allows you to use an Anthem Blue Cross PPO participating provider, or any other non-participating provider each time you need care. By using an Anthem Blue Cross PPO participating provider, you will not be required to pay for covered services at the time of service, and the claim will be submitted to Anthem Blue Cross directly by the provider. When using non-participating providers, the services will cost you more because you pay a higher percentage of covered charges than you would if you use participating providers since their fees may be greater than those negotiated with participating providers. Non-participating providers will be reimbursed based on “eligible charges” at the customary and reasonable rate as determined by the Plan. Employees will be responsible for paying any amounts in excess of the “eligible charges.” For the most current directory of Anthem Blue Cross PPO participating physicians and hospitals, refer to the Anthem Blue Cross custom website at http://www.anthem.com/ca/caltech.

Most covered charges are subject to an annual Deductible, applicable copayments, and benefit maximums. The plan pays 100% for your in-network preventative care. Refer to the current plan comparison chart for a summary of specific information on each medical plan.

HOW THE ANTHEM BLUE CROSS HIGH-DEDUCTIBLE PPO WORKS

The Anthem Blue Cross High-Deductible PPO allows you to use an Anthem Blue Cross PPO participating provider, or any other non-participating provider each time you need care. By using an Anthem Blue Cross PPO participating provider, you will not be required to pay for covered services at the time of service, and the claim will be submitted to Anthem Blue Cross directly by the provider. When using non-participating providers, the services will cost you more because you pay a higher percentage of covered charges than you would if you use participating providers since their fees may be greater than those negotiated with participating providers. Non-participating providers will be reimbursed based on “eligible charges” at the customary and reasonable rate as determined by the Plan. Employees will be responsible for paying any amounts in excess of the “eligible charges.” For the most current directory of Anthem Blue Cross PPO participating physicians and hospitals, refer to the Anthem Blue Cross custom website at http://www.anthem.com/ca/caltech.

Most covered charges are subject to an annual Deductible, applicable copayments, and benefit maximums. Refer to the current Comparison of Health Plan Benefits for a summary of specific information on each medical plan.
In addition, the plan includes a Health Savings Account (HSA) option that lets you save tax-free money for current and future qualified health care expenses. Your unused HSA balance rolls over to the next year and earns interest, so you can build tax-free savings over time.

**WHEN YOU NEED CARE**

The plan pays 100% for your in-network preventative care. Once the annual Deductible is satisfied, you will be paid the higher option percentage when you receive services from a participating provider. When you use a non-participating provider, you will be paid at the lower percentage. Only qualified, licensed providers of medical care are covered under the Anthem Blue Cross PPO plan (contact Anthem Blue Cross for a definition of covered physicians). In most cases, your out-of-pocket expenses will be lower when you select participating physicians from your Anthem Blue Cross provider network. You will save in two ways: you will be reimbursed at the higher level, and, because participating providers have agreed to negotiated fees, you will generally pay lower rates for services rendered.

You may receive certain prescription drugs (especially certain preventative care medications) for just a copay, even before you meet the plan’s annual deductible. See the preferred Rx Drug List under Guides & Forms.

**Filing Claims**

Claim forms can be obtained from Anthem Blue Cross and the Campus or JPL Benefits Office. When filing claims for non-participating providers, be sure to follow the instructions on the back of the form, and fill out the form completely. For your own records, you should also make a copy of the form and any bills or other information you attach.

**Covered Services**

The Anthem Blue Cross PPO Plan covers the following types of services subject to certain limitations:

- Hospital services
- Skilled Nursing Facilities
- Physician services
- Home Health Care
- Mammograms and Pap tests
- Ambulance services
- Diagnostic services
- Durable medical equipment
- Pregnancy and maternity care (see page 8.23)
- Mastectomy and reconstructive surgery (see page 8.23)
- Mental health and substance abuse treatment
- Organ tissue and transplants
- Prescription drugs
- Preventive care
- Well baby/child care

Contact Anthem Blue Cross for more details on cost-containment procedures.
COST-CONTAINMENT PROCEDURES

The Anthem Blue Cross Plan has built-in provisions designed to keep the costs down while continuing to provide you and your family with appropriate and adequate medical care. These cost-containment provisions will help control your out-of-pocket expenses as well.

Benefits are provided only for medically necessary services. When cost-containment provisions are used properly, you will know in advance whether specific services are determined to be medically necessary and, therefore, eligible for benefits coverage.

Please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu

COORDINATION OF BENEFITS

You or any Dependent may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program. This does not include Medicare or Medicaid. Health benefits payable under the Anthem Blue Cross PPO Plan and the Anthem Blue Cross High-Deductible PPO Plan will be coordinated with benefits payable under other plans.

Whenever there is more than one plan, the total amount of benefits paid in a calendar year under all plans cannot be more than the total charge or reasonable expenses charged. The expenses must be covered, in part, under at least one of the plans.

How Coordination Works

One of the plans involved will pay the benefits first. The other plans will pay benefits next.

(under the Health tab) especially if you or a covered Dependent needs surgery, a hospital stay, or has a lengthy, ongoing illness. There are significant penalties for not complying with the procedures established by Anthem Blue Cross.

There are three Anthem Blue Cross cost-containment programs, which are designed to work together.

1. Utilization Review
2. Prior Authorization (some outpatient and diagnostic procedures may require prior authorization)
3. Personal Case Management.

If the Caltech benefits program is primary, it will pay benefits first. Benefits will not be reduced due to benefits payable under other plans.

If the Caltech benefits program is secondary, benefits may be reduced due to benefits payable under other plans primary to the Caltech benefits program.

The amount of reasonable expenses will be determined first. Then the amount of benefits paid by the primary plan will be subtracted from this amount. The secondary plan will pay the difference but no more than the amount it would have paid if it were primary.
Which Plan Is Primary?

In order to pay claims, the insurance carrier must determine which plan is primary and which plan is secondary. You will have to give information about any other plan coverage available when you file a claim with the Anthem Blue Cross PPO Plan or the Anthem Blue Cross High-Deductible PPO Plan.

There are rules to determine which plan is primary and which plan is secondary. The rules are used until one is found that applies to the situation. They are always applied in the following order:

1. A plan which has no coordination of benefits provision will be primary to a plan which does have a coordination of benefits provision.

2. A plan which covers the person as an employee or retiree will generally be primary to a plan which covers the same person as a Dependent.

3. When a person is covered as a Dependent under two or more plans of parents who are either married, not separated, or have a court decree which awards joint custody without specifying that one parent has the responsibility to provide health care coverage the following applies:
   - The plan which covers a Dependent child of the person whose birthday is earlier in the calendar year will generally be primary to a plan which covers a Dependent child of a person whose birthday is later in the calendar year. For example, if your birthday is in May and your spouse’s birthday is in October, your plan is considered primary for your Dependent child, regardless of which spouse is older in actual years.
   - If both parents have the same birthday, the plan which covered one of the parents longer will be primary to the plan which covered the other parent for a shorter period of time.
   - If the other plan does not have a rule based on birthdays similar to this rule, then the rule in the other plan will determine which plan is primary.

4. The rules that are used to find out which plan is primary and which plans are secondary when a person is covered as a Dependent under two or more plans of divorced or separated parents are as follows:
   - The plan of the parent with custody will be primary to a plan of the parent without custody. Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:
     - The plan of the parent with custody will pay benefits first.
     - The plan of the stepparent with custody will pay benefits next.
     - The plan of the parent without custody will pay benefits next.
     - The plan of the stepparent without custody will pay benefits next.
   - There may be a court decree which has specific terms giving one parent financial responsibility for the medical, dental or other health expenses of the Dependent child. The plan of the parent should have actual knowledge of the court decree. The plan which covers the parent with financial responsibility is primary to any other plan which covers that Dependent child.
• A plan may cover a person as an active employee, or as a Dependent of that employee. This plan will be primary to any plan which covers the person as a laid-off or retired employee or as a Dependent of that employee. The other plan may not have a rule for laid-off or retired employees similar to this rule. In this case, this rule will not apply.

5. If none of the above rules apply, the plan which has covered the person for the longest time will be primary to all other plans.

6. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Coordination of benefits also applies if both Spouses or Domestic Partners are covered as Employees under the Caltech benefits program. Children of two Caltech employees may be covered as a Dependent by one or both parents.

COORDINATION WITH MEDICARE

Benefits for Individuals Who are Entitled to Medicare

If you (or one of your Dependents) are entitled to Medicare benefits, the following rules apply:

The Caltech benefits program is the primary payer — in other words, your claims go to the Caltech plan first — if either of the following applies:

• You are currently working for Caltech; or are enrolled as a Dependent of an active employee, or

• You (or your Dependent) first become entitled to Medicare benefits because you or your Dependent have end-stage renal disease (ESRD); in this case, the Caltech plan is the primary payer for the first 30 months of Medicare entitlement due to ESRD; at the end of the 30-month period, Medicare will become the primary payer.

The Caltech benefits program pays secondary and Medicare is the primary payer if you (or your Dependent) are covered by Medicare, do not have ESRD, and you are not currently working for Caltech.

If you (or your Dependent) are over age 65 and the Caltech benefits program would otherwise be the primary payer because you are still working, you or your Dependent may elect Medicare as the primary payer of benefits; if you do, benefits under the Caltech benefits program will terminate.

If you are disabled but do not qualify for Medicare, the Caltech benefits program is the primary plan. If you are disabled and you qualify for Medicare and you are still working, the Caltech benefits program is the primary plan. If you are disabled and qualify for Medicare due to your disability in some instances Medicare is the primary payer and you will submit your claims to Medicare first before submitting them to the Caltech benefits program (see rules above for ESRD).

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

In addition to the Anthem Blue Cross PPO Plans, the Institute also offers you the choice of medical coverage through one of two Health Maintenance Organizations (HMOs):

• Anthem Blue Cross HMO (Advantage network) — a network of Participating Medical Groups (PMGs). Some are privately-owned medical groups which have contracted with Anthem Blue Cross, and others are Independent Practice Associations (IPAs). An IPA is an association of independent physicians and other providers who have contracted with Anthem Blue Cross HMO as a group. When
you enroll in the Anthem Blue Cross HMO, you must choose a PMG, and in some cases, you must also choose a “primary care physician” for yourself and each member of your family from your PMG’s provider listing.

You can find Anthem Blue Cross HMO providers at http://www.anthem.com/ca/caltech (search the Advantage HMO network).

- Kaiser Permanente — a group model HMO, which means you receive all service from Kaiser providers at Kaiser facilities.

Please keep in mind that these HMOs, for the most part, only offer services in the Southern California area. When making your HMO plan selection, you should check your zip code with the specific HMOs to find out what is available in your area, and consider the proximity to your home when selecting an HMO.

HMOs provide comprehensive medical coverage. For a complete description of how each HMO works and what expenses are covered by each HMO, see the Medical section at benefits.caltech.edu (under the Health tab).

**HOW THE HMOs WORK**

In an HMO, you generally pay no Deductibles and only copayments for most covered expenses. In most cases, you receive no coverage for treatment from providers who are not in the HMO.

**Specialist Referrals**

In general, both HMOs require that you be referred to an HMO specialist by your primary care physician. Further treatment by the specialist is also coordinated through your primary care physician.

With all HMO plans, treatment obtained without the authorization of your primary care physician is generally not covered. HMOs are not required to reimburse a member for expenses incurred with a provider outside of the HMO network unless a referral has been made by the HMO for specific services.

**Emergency Services**

Emergency treatment is covered under the HMOs, although each has its own rules for coverage and definitions of an emergency. You are advised to seek treatment from your primary care physician, or at your HMO facility, unless you are outside the service area. See Out-of-Area Treatment, below.

If a life-threatening emergency occurs, go directly to the nearest emergency facility. In any case, you should notify your HMO within 48 hours to request authorization for emergency treatment and follow-up care.

Contact your HMO for specific details on emergency services.

**Out-of-Area Treatment**

In general, except for circumstances when an outside specialist is authorized, the HMOs do not offer coverage for treatment received from non-HMO facilities. However, coverage may be provided for out-of-area treatment in the case of an emergency, provided that required authorization is received from the HMO prior to treatment.

It is critical that you call your HMO prior to receiving medical care. If prior notification is impossible due to the nature of the emergency, you should notify the HMO within 48 hours to request authorization for emergency treatment and follow-up care.

Refer to the HMO booklets for specific details about out-of-area treatment.

Note: HMOs are not required to cover out-of-area care except for services which are authorized by the HMO.
This is just a brief description of the benefits offered by the various Caltech medical plans. Please refer to the HMO booklets (also called Evidence of Coverage or EOC) for specific information on the benefits offered by each HMO. Together with this Handbook, they constitute the SPD as required by ERISA.
YOUR CALTECH DENTAL PLANS

The Institute offers you the choice of two dental plans, described in the following sections.

**PPO Plan**
- Delta Dental ([http://www.deltadentalins.com/caltech](http://www.deltadentalins.com/caltech))

You may choose any dentist, but will receive greater benefits by using Delta Dental PPO dentists.

**Dental Health Maintenance Organization (DHMO)**
- MetLife DHMO (Safeguard) ([http://www.metlife.com/mybenefits](http://www.metlife.com/mybenefits))

You must use Safeguard dentists. For routine services you pay nothing. A scheduled copayment applies to most major services.
HOW THE PLAN WORKS

You may choose any dentist and receive coverage, but your benefits will be greater if you choose a Delta Dental PPO or Premier dentist. You will receive the highest level of coverage if you receive services from a Delta Dental PPO provider. Most dentists in California are members of the Delta Dental network. This means that Delta dentists have agreed to accept the Delta approved fees as payment for services. You can still receive coverage for services from a non-Delta dentist, but you are responsible for the difference if your dentist charges more than Delta’s approved fees.

Your Delta Dental Plan benefits are summarized in the following chart:

DELTA DENTAL PLAN BENEFITS

<table>
<thead>
<tr>
<th>PLAN PROVISION</th>
<th>PLAN COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>You pay $50 per covered family member</td>
</tr>
<tr>
<td>Preventive/Diagnostic Services</td>
<td>Plan pays 100% with no Deductible</td>
</tr>
<tr>
<td>Basic Services</td>
<td>Plan pays 80% after Deductible</td>
</tr>
<tr>
<td>Crowns, Cast Restorations, and Prosthodontics*</td>
<td>Plan pays 50% after Deductible</td>
</tr>
<tr>
<td>Annual Maximum Benefits</td>
<td>$1,500 per covered family member ($1,750 if services are provided by a Delta Dental PPO provider). Maximum waived for Diagnostic &amp; Preventive Benefits</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Plan pays 50% up to $1,000 lifetime benefit for Dependent Children to age 26. Orthodontia for employees and spouses is not covered.</td>
</tr>
</tbody>
</table>
PAYMENT OF BENEFITS

If you are treated by a Delta PPO or Premier Dentist, Delta will pay the dentist directly. You are only responsible for your portion of the cost. Your Delta PPO or Premier dentist will file a claim with Delta for you or your covered family member.

If you are treated by a non-Delta Dentist, you must pay the dentist and then submit a claim to Delta. Delta will determine what portion of the dentist’s fees is covered and reimburse you. You may not assign your benefits directly to the dentist.

If you have any questions about claims, contact Delta Dental Customer Service.

Pre-Determination

If your dentist recommends treatment that is extensive (such as bridges or crowns) or likely to cost greater than $300, Delta recommends you obtain a pre-determination for the treatment.

A pre-determination does not guarantee payment. It is an estimate of the amount Delta will pay if you are eligible and meet all the requirements at the time the treatment you have planned is completed.

This involves your dentist submitting an Attending Dentist’s Statement to Delta for the services you need. Delta will inform the dentist how much of the treatment will be covered by Delta and how much you will be responsible for. If you have any questions about payment of benefits, you should settle them with Delta before you begin receiving the treatment. You have the right to appeal any decision about your benefits. See Plan Information in Section 8 for details.

For further information on your Delta Dental benefits, please refer to the Delta Dental PPO Evidence of Coverage (EOC), available at http://www.deltadentalins.com/caltech.
**METLIFE DHMO (SAFEGUARD)**

Caltech also offers you coverage through the MetLife DHMO, benefits provided by Safeguard, Inc., a MetLife Company. Highlights of the MetLife DHMO (Safeguard) plan are provided in this section. For a summary of dental plan benefits, refer to the *Dental section at benefits.caltech.edu (under the Health tab).* For specific plan details, refer to the Safeguard booklet (also known as the “Evidence of Coverage certificate” or “EOC”).

**HOW THE PLAN WORKS**

The MetLife DHMO (Safeguard) is a managed-care dental program. There are no Deductibles and many of your routine dental expenses are fully paid by the plan. Other treatments require set copayments. When you enroll, you select a Safeguard network dentist. In order to receive benefits, you must see your selected dentist. Except for limited emergency situations, Safeguard pays no benefits for dental services received outside its network.

You choose your dentist from the Safeguard directory, available online at https://www.metlife.com/mybenefits. Each family member may choose a different dentist. If necessary, your dentist will refer you to a Safeguard specialist for certain types of care, such as Endodontics, Periodontics, oral surgery, and Orthodontia.

**METLIFE DHMO (SAFEGUARD) BENEFITS**

You can find a summary of your out-of-pocket costs for certain dental services in the Dental section at benefits.caltech.edu (under the Health tab). For a complete list of costs, see the Safeguard Evidence of Coverage and disclosure form, available online at http://www.metlife.com/mybenefits or from the Campus or JPL Benefits Office.

The procedures and materials recommended by your dentist may exceed the limitations of this dental plan, and could result in substantial additional charges for treatment. Discuss all options carefully with your dentist prior to treatment.

**Second Opinions**

If you wish to obtain a second opinion for a benefit covered under the plan, contact the Safeguard Benefit Services Department at 1-800-880-1800. Safeguard will make arrangements for this service to be provided at no cost to you. Once the consultation is completed and you have been informed of the diagnosis, you must return to your assigned Safeguard provider for treatment.

**PAYMENT OF BENEFITS**

Safeguard contracts directly with your dentist. You pay the dentist for your portion of the cost, if any. There are no claim forms to complete. **You should bring your Safeguard Evidence of Coverage (EOC) booklet** (available online at http://www.metlife.com/mybenefits) **with you to each appointment to ensure you pay the correct copayment, if any, for services rendered.**

The copayment for orthodontia will be prorated over the course of 24 months’ treatment.

Remember, there is no coverage for treatment received from a non-Safeguard dentist unless you have received a referral and prior approval from Safeguard.

**Please refer to the Safeguard EOC for further information on your Safeguard benefits.**

**VISION**
Caltech offers you vision coverage through Vision Service Plan (VSP). You can select Vision Service Plan (VSP) to receive coverage for eye exams, glasses or contact lenses. Discounts are available on frames and lenses and some other services when you use VSP signature network providers. For details about the vision plan or to search for a vision signature network provider go to the Caltech benefits website at www.benefits.caltech.edu or visit VSP at www.vsp.com or call 800-877-7195.
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YOUR CALTECH DISABILITY BENEFITS

Disability insurance coverage is designed to protect you against the loss of income that can accompany a Disability.

**Short Term Disability (for Employees in the State of California only)**

Employees may be covered for a short-term disability through the California State Disability Insurance (SDI) program. Cost for this coverage is paid by employees through a special state tax. There is a seven-calendar-day waiting period before benefits are paid. SDI benefits may be integrated with accrued sick leave and/or vacation pay. Payments under SDI are capped at 52 weeks.

For more information, contact State Disability Insurance at 1-800-480-3287 for English or at 1-866-658-8846 for Spanish. Their website is http://www.edd.ca.gov/Disability

**Paid Family Leave (for Employees in the State of California only)**

Disability compensation may be provided to individuals who take time off work to care for a seriously ill child, spouse, parent, domestic partner, sibling, grandparent or to bond with a new child. This program is known as Paid Family Leave (PFL) and is being administered by the California State Disability Insurance (SDI).

The cost for PFL coverage is paid by employees through their State Disability Insurance (SDI) deductions. There is a waiting period of seven calendar days before benefits are paid. PFL benefits are paid at the same rate as SDI benefits, and may also be integrated with accrued sick leave and/or vacation pay. Payments under PFL are capped at 6 weeks over a 12-month period.

For more information, contact the Paid Family Leave program at 1-877-BE-THERE for English or at 1-877-379-3819 for Spanish. Their website is http://www.edd.ca.gov/disability/paid_family_leave.htm.

**Long Term Disability (LTD)**

The following section summarizes the Basic and Supplemental LTD Plan. For more information, contact the Campus Disability & Leave Administration Unit or JPL Benefits Office.
YOUR BASIC LONG TERM DISABILITY AND SUPPLEMENTAL LONG TERM DISABILITY PLAN BENEFITS

You become eligible for the Basic Long Term Disability (LTD) and Supplemental LTD Plan coverage on the first of the month coincident with or next following the date of your hire or change to Benefit-Based Employee status. Caltech pays for your Basic LTD plan. You have the option to purchase additional coverage by enrolling in the Supplemental LTD plan. If you enroll in the Supplemental LTD plan after the first 31 days of your eligibility, you will be subject to Evidence of Insurability.

LTD coverage is designed to protect you against the loss of income that can accompany a long-term disability. The LTD plan provides you with a portion of your pay after the Elimination Period of 180 consecutive days of a Total Disability due to illness or injury, or when you have depleted all your sick leave, whichever is later.

Once you become eligible, you will be automatically enrolled in the Basic LTD plan. The Basic Plan provides you with 40% of your Basic Monthly Earnings minus other income benefits in effect on the day before your Disability to a maximum monthly benefit of $10,000 minus other income benefits. If you enroll and have been approved for participation in the Supplemental Plan, your combined Basic plus Supplemental Plan Benefits provide you with 60% of your Basic Monthly Earnings minus other income benefits in effect on the day before your Disability to a maximum monthly benefit of $17,500 minus other income benefits. Maximum Basic Monthly Earnings are covered up to $25,000 for Basic Long Term Disability. Maximum Basic Monthly earnings are covered up to $29,167 for Supplemental Long Term Disability.

QUALIFYING FOR BENEFITS

Pre-Existing Conditions Limitation – Newly Eligible Employees and Late Applicants

A Pre-Existing Condition means you received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the 3 months immediately prior to your effective date of coverage, and the Disability caused or substantially contributed to by the condition begins in the first 12 months after the effective date of coverage.

You are not covered for a disability caused or substantially contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition.

Mental Illness, Alcoholism or Drug Abuse Limitations

When you are totally disabled due to Mental Illness, Alcoholism or Drug Abuse, and confined to a hospital or institution, the Monthly Benefit will be payable up to the end of Your Hospital, Mental Health Facility, or recovery program facility confinement, but in no event to exceed the Maximum Benefit Duration shown in the table on page 4.7.

While you are totally disabled due to Mental Illness, Alcoholism or Drug Abuse and not confined in a hospital or institution, the Monthly Benefit will be payable the lesser of:

1. 24 months; or
2. the Maximum Benefit Duration shown in the table on page 4.7. The maximum benefit duration for M&N for faculty and staff is 24 months unless
hospitalized at the end of the 24 month period. If the inpatient confinement last greater than 30 days following the 24 month period the benefit can be extended up to 90 days in any 12 month period.

But in no event will the Monthly Benefit be payable for longer than the Maximum Benefit Duration during of 24 months during a period of continuous Total Disability due to Mental Illness, Alcoholism or Drug Abuse, whether or not you are confined in a hospital or institution.

**Evidence of Disability**

You must obtain and submit medical documentation of your Disability from your doctor in order to receive benefits, and you must remain under a doctor’s care to continue to receive benefits.

You will not receive any LTD benefits until the insurance carrier has received and approved evidence of your Disability. The insurance carrier may request proof of your Disability at any time.

**Recurrent Disabilities**

1. If, after a period of Disability for which a Monthly Benefit has been paid under This Plan, you:
   a. resume your regular job on a full-time basis; and
   b. perform all the material duties for less than six consecutive months;

   any Recurrent Disability will be a part of the same period of Disability. The liability for the entire period will be subject to the terms of This Plan for the prior Disability.

2. If, after a period of Disability for which a Monthly Benefit has been paid under This Plan, you:
   a. resume your regular job on a full-time basis; and
   b. perform all the material duties for six consecutive months or more;

   any Recurrent Disability will be treated as a new period of Disability. You must complete a new Elimination Period before Monthly Benefits are payable.

3. If you become eligible for coverage under any other group long term disability policy, this Recurrent Disability provision will not apply.

**Benefit Reductions**

Your LTD benefits will be reduced by any amounts paid or payable from other sources, such as:

1. Any disability benefits for you, your spouse or child(ren) under Federal Social Security Act, Canadian Pension Plan, Quebec Pension Plan, Railroad Retirement Act or any similar plan or Act.

2. Temporary disability benefits under a workers’ compensation law.

3. Amounts received under any other occupational disease law, Longshoremans’ Harbor Workers’ Act, Maritime Doctrine of Maintenance, Wages and Cure or similar act.

4. Any disability benefits under the Jones Act, any state compulsory/statutory benefit law, any government retirement system (including but not limited to the California State Teachers Retirement System (Cal STRS) and/or the California Public Employee Retirement System (CalPERS) or the Employers Retirement plan.

5. Any retirement benefits under federal Social Security Act, Canadian Pension Plan, Quebec Pension Plan, Railroad Retirement Act, the employer’s retirement plan or any similar plan or act.
6. Third party liability payments made by judgment, settlement or otherwise (minus attorney fees).

7. Sick pay.

8. Amounts received by compromise or settlement of any claim for permitted offsets (minus attorney fees).

9. Any salary continuation, personal time off, and annual leave pay.

10. Compensation earned during Rehabilitation Employment as set forth in the rehabilitative employment benefit provision of the EOC.

If there is reasonable good faith that you are entitled to disability benefits under the following sources, you must apply for such benefit.

1. Federal Social Security Act (primary and/or family benefits.)

2. Any state compulsory/statutory benefit law including California State Disability Insurance (SDI).

To apply for the benefits referenced above means to pursue such benefits with reasonable diligence until you receive the respective approval from the Social Security Administration and/or the appropriate state agency.

You must submit proof that you have applied for the benefits referenced above. If your application for such benefits is approved, your monthly benefit will be reduced by the amount actually paid to you from such sources. If you fail to apply for any of the benefits referenced above and to pursue such benefits with reasonable diligence and if there is a reasonable means of estimating the amount of such benefits payable, your monthly benefit will be reduced by the amount of such benefits estimated that you, your spouse and or child(ren) are eligible to receive because of your Disability. This estimate will start with the first monthly benefit coincident with the date you were eligible to receive such benefits unless you have submitted proof that you have applied for and are pursuing these benefits with reasonable diligence, approval of your claim for these benefits or a notice of denial for these benefits.

When you do receive approval or notice of denial of the above referenced benefits you must submit this information immediately. The amount of your monthly benefit will be adjusted and you must promptly repay any overpayment.

**Minimum Monthly Benefit**

10% of the monthly benefit before reduction for other income benefits or $100, whichever is greater.

**Maximum Monthly Benefit**

- Basic Plan - $10,000
- Supplemental Plan - $17,500

**Additional LTD Information**

While approved for LTD benefits, you may be eligible for life insurance premium waiver for yours, dependent and spousal coverage.

While on LTD, you will not have the option of electing to enroll or switch your medical or dental plans. You may disenroll Dependents as of the first day of any month. If you have a HIPAA special enrollment as described on page 2.9, you may enroll yourself or newly acquired Dependents or Dependents who have lost other coverage. If you are enrolled in an HMO plan, contact your plan prior to any change in residence. Refer to page 2.9 if you move outside of the HMO service area while on a disability leave of absence.
COST OF COVERAGE

The Institute provides Basic LTD coverage for all Benefit-Based Employees. The Institute pays premiums for coverage under The Basic Plan. Participation in the Supplemental LTD plan is voluntary. You pay premiums for coverage under the Supplemental LTD Plan. Your contribution to the LTD premium is $0.19 per each $100 of your Basic Monthly Earnings.

Example: If your Basic Monthly Earnings are $2,000, your monthly premium is:

\[
\frac{($2,000 \times 0.19)}{100} = $3.80
\]

Employee Monthly Premium = $3.80

Monthly LTD premiums are waived while receiving benefits under the plan.

Cost of Living Adjustment

A cost of living adjustment will be calculated for you on January 1 following 12 months of continuous disability.

You will be eligible for additional cost of living adjustments on each anniversary of the first adjustment, provided you have been continuously receiving Disability Benefits under This Plan. However, no more than 5 annual adjustment calculations will be made during a continuous period of Disability for which you are receiving Disability Benefits under This Plan.

Changes In Coverage

Your LTD benefit is based on a percentage of your Basic Monthly Earnings. If your Basic Monthly Earnings change, your level of coverage will change on the date which your new Basic Monthly Earnings are effective. Your premium will change during the payroll period in which your new Basic Monthly Earnings are effective. Increases in coverage will go into effect on that date only if you are Actively At Work; if you are not, they will go into effect on the date you return to active work. These changes will apply only to disabilities commencing thereafter.

Taxation of LTD Benefits

If benefits are received under a plan to which the employee has contributed, the portion of the disability income attributable to the employee’s after-tax contributions is tax-free. Treas. Reg. Sec. 1.105-1(c).

FILING CLAIMS

After approximately 4 months of disability, the LTD insurance carrier will contact you to initiate your LTD claim. Written proof of a claim by you must be given to the insurance carrier not later than 90 days following the end of the 180 day Elimination Period. As part of your evidence of Disability, the insurance carrier may require you to give proof that you have applied for any of the income benefits described on page 4.4 to which you may be entitled.

Payment of benefits will begin only after your claim is received and approved. Benefits are paid to you at the end of each month that you are disabled.

WHEN BENEFITS BEGIN

LTD benefits begin when you have been disabled with the same condition for the later of 180 days or when you have exhausted your sick leave.

WHEN BENEFITS END

LTD benefits will end on the earliest of the following dates:

- The date you are no longer disabled.
- The date you fail to furnish proof that you are continuously disabled.
- The date you fail to have a medical exam, if requested by the insurance carrier.
- The date of your death.
- The completion of the maximum duration as shown in the table below the date that benefits end in the section titled Mental...
Illness, Alcoholism, and Drug Abuse Limitations

RECOVERY FROM A DISABILITY

If You Return to Active Work Before Completing Your Elimination Period

- If you return to Active Work before completing the Elimination Period for a period of 30 days or less, and then you become Disabled again due to the same or related Sickness or accidental injury, the LTD insurance carrier will not require you to complete a new Elimination Period. We will count those days towards the completion of your Elimination Period.

- If you return to Active Work for a period of more than 30 days, and then become Disabled again, you will have to complete a new Elimination Period.

If You Return to Active Work After Completing Your Elimination Period

- If you return to Active Work after completing your Elimination Period for a period of 6 months or less, and then become Disabled again due to the same Sickness or accidental injury, the LTD insurance carrier will not require you to complete a new Elimination Period. For the purpose of determining your benefit the LTD insurance carrier will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

- If you return to Active Work for a period of more than 6 months and then become Disabled again, you will have to complete a new Elimination Period.

<table>
<thead>
<tr>
<th>AGE WHEN DISABLED</th>
<th>DURATION OF LTD BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Faculty</td>
</tr>
<tr>
<td>Younger than 61</td>
<td>To end of month in which you turn age 68 (Minimum 24 months)</td>
</tr>
<tr>
<td>61-62</td>
<td>To end of month in which you turn age 68 (Minimum 24 months)</td>
</tr>
<tr>
<td>63</td>
<td>To end of month in which you turn age 68 (Minimum 24 months)</td>
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<tr>
<td>64</td>
<td>To end of month in which you turn age 68 (Minimum 24 months)</td>
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<tr>
<td>65</td>
<td>To end of month in which you turn age 68 (Minimum 24 months)</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
</tbody>
</table>
SURVIVOR BENEFIT

If you die after satisfying the 180- -day elimination period and while a Monthly Benefit is payable, the insurance carrier will pay to your Eligible Survivor a lump sum amount equal to six times (effective 1/1/2011) your last Monthly Benefit. Proof of your death must be provided to the LTD insurance carrier before any benefit under this section would be payable. For the purpose of this section, a certified copy of a death certificate will establish proof.

Upon your death, the LTD insurance carrier will pay the amount due to your eligible survivor. If you die while totally disabled, a single, lump sum benefit will be paid under this provision if there is an Eligible Survivor as defined below:

• Your legally married spouse or domestic partner at the date of your death.
• If there is no such spouse, your biological or legally adopted child who, when you die:

  is not married; and

  is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

Please note that the benefit amount will be reduced by any overpayment the LTD carrier is entitled to recover.

REHABILITATION BENEFIT

While you are disabled, you are encouraged to work or participate in a rehabilitation program during your elimination period or while receiving monthly benefits. When you work while disabled you will receive the sum of the following amounts:

1. your monthly benefit (including your Rehabilitation Incentive when applicable),
2. the amount of your earnings for working while disabled,
3. the amount of Child care expenses for which you are eligible.

During the 24-month period following your elimination period, your monthly benefit will be reduced if the total amount you receive from the above sources and other sources listed on page 4.4 exceeds 100% of your Basic Monthly Earnings, including any adjustment to such earnings as provided for in the definition of partial disability listed on page 4.10. Your monthly benefit will be reduced by that portion of the amount you receive which exceeds 100% of such Basic Monthly Earnings or Adjusted Basic Monthly Earnings.
After the 24-month period following your return to work, your monthly benefit will be reduced by 50% of your earnings from working while disabled. Your monthly benefit will be further reduced if the total amount you receive from the above sources and other sources listed on page 4.4 exceeds 100% of your Basic Monthly Earnings, including any adjustment to such earnings as provided for in the definition of partial disability listed on page 4.10. Your monthly benefit will be reduced by that portion of the amount you receive which exceeds 100% of such Basic Monthly Earnings or Adjusted Basic Monthly Earnings.

While Disabled, if you participate in a rehabilitation program approved by the insurance carrier, your monthly benefit percentage is increased by 10% up to a maximum of $500, for 6 consecutive months while in the approved Rehabilitation program.

If your monthly benefit is reduced as a result of receiving earnings from any work or service while disabled, the Minimum Monthly Benefit will not apply.

EXCLUSIONS

No benefits will be paid for a Disability or physical loss if:

- You are not under continuing medical supervision and treatment by a physician to the satisfaction of the insurance carrier.

- The Disability is caused by an intentionally self-inflicted injury, illness or attempted suicide.

- The Disability is caused by a bodily injury resulting directly or indirectly from:
  - insurrection, rebellion, war (e.g., acts of war, whether declared or undeclared), service in the armed forces of any country unless while on a paid leave of absence where premiums for coverage have been paid; or
  - participation in a riot.

- The Disability is as a result of the commission of a felony.

YOUR OTHER BENEFITS DURING DISABILITY

There are special rules regarding continuation of your group life insurance and other coverage while you are on a disability leave of absence. These rules are described in the General Information Section 2.
TERMS YOU SHOULD KNOW

Active Work
You are performing all of your usual and customary duties of your job for your regularly scheduled hours.

Basic Monthly Earnings
Your monthly rate of pay excluding overtime and other extra pay you receive. The amount of Basic Monthly Earnings in effect on the date of your Disability will be used to compute your Monthly Benefit.

Eligible Survivor
Your lawful Spouse, Same-Sex Domestic Partner or Registered Domestic Partner, if living, otherwise your children who are under age 26. The term “children” also includes stepchildren and legally Adopted children.

Disability or Disabled
As a result of Sickness or Injury, you are either Totally Disabled or Partially Disabled.

Total Disability or Totally Disabled
During the elimination period and the next 24 months, you are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue your Usual Occupation in the usual and customary way.

After such period, you are not able to engage with reasonable continuity in any occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life and physical and mental capacity that exists within any of the following locations:

1. a reasonable distance or travel time from your residence in light of the commuting practices of your community,
2. a distance of travel time equivalent to the distance or travel time you traveled to work before becoming disabled,
3. the regional labor market, if you resided prior to becoming disabled in a metropolitan area.

Partial Disability or Partially Disabled
As a result of Sickness or Injury while actually working in an occupation, you are unable to earn 80% or more of your Basic Monthly Earnings.

If you are partially disabled and have been continuously receiving monthly benefits under the plan, your Basic Monthly Earnings will be adjusted only for the purposes of determining whether you continue to be partially disabled. We will make the initial adjustment by adding to your Basic Monthly Earnings an amount equal to your Basic Monthly Earnings times the annual rate of increase in the Consumer Price Index for the prior calendar year.

This first adjustment will take place on the date the 13th disability benefit payment is payable. Subsequent adjustments will take effect on each anniversary of the first increase.

You must be under the Regular Care of a doctor unless Regular Care will not improve the condition(s) causing the disability or will not prevent a worsening of the condition(s) causing your disability.

Elimination Period
The period of your Disability in which the LTD insurance carrier does not pay benefits. The Elimination Period lasts for the later of 180 days or the end of a period in which you are receiving sick leave.

Regular Care
You personally visit a Doctor(s) as frequently as is medically required to effectively manage and treat the condition(s) causing your disability and you are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing your disability.

Prior to the initial payment of benefits, provided you are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing your disability, if the time period between your visits to a Doctor(s) is reasonable, you will be deemed to have satisfied the Regular Care of a doctor requirement, even if this results in a visit to a Doctor(s) occurring after the end of the Elimination Period.

*Substantial and Material Acts*

The important tasks, functions and operations generally required by employers from those engaged in your Usual Occupation that cannot be reasonably omitted or modified. In determining what Substantial and Material acts are necessary to pursue your Usual Occupation, first the specific duties required by your job are looked at. If you are unable to perform one or more of these duties with reasonable continuity, then it will be determined whether those duties are customarily required of other employees engaged in your usual occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other employees engaged in your usual occupation, then those duties will not be considered in determining what Substantial and Material acts are necessary to pursue your Usual Occupation.

*Usual Occupation*

Any employment, business, trade or profession and the Substantial and Material acts of the occupation you were regularly performing for your employer when the disability began. Usual Occupation is not necessarily limited to the specific job that you performed for your employer.

*Injury*

Physical harm that is not a sickness. The injury must occur and disability must begin while you are covered under the plan.
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YOUR CALTECH SURVIVOR BENEFIT PLANS

No one wants to think about the death, injury or prolonged illness of yourself or a loved one, but in reality, these situations must be planned for in case the unthinkable occurs. That’s why Caltech provides protection for you and your family members in the form of the following basic and supplemental coverages:

- Group Life Insurance
- Accidental Death & Personal Loss Travel Accident Insurance
- International SOS Medical Assistance/International Referral Service
- Extra-Hazardous Duty Insurance

The following sections summarize your survivor benefits. For more information, contact the Campus or JPL Benefits Office.
GROUP LIFE INSURANCE PLAN

BASIC BENEFIT

The Group Life Insurance Plan provides a basic group life insurance coverage amount of one times your Annual Salary up to $50,000 of coverage at no cost to you. If you die from any cause, your Beneficiary(ies) will be paid a benefit equal to your basic group life benefit amount. You also have the opportunity to supplement your basic group life insurance coverage amount with optional supplemental group life insurance coverage.

If you retire from the Institute, your basic group life insurance benefit will be reduced to $5,000.

SUPPLEMENTAL BENEFIT

You may enroll in optional supplemental group life insurance. Your coverage amount will be paid to your Beneficiary(ies) in the event of your death.

COVERAGE OPTIONS

The table on page 5.3 shows the optional supplemental group life insurance coverage amounts available to you.

Your coverage is based on your Annual Salary. If your salary increases, coverage will be adjusted on the payroll period in which your new salary becomes effective.

Reduction at Ages 65 and 70

Basic and supplemental group life benefits for Employees, and supplemental group life benefits for your Spouse are reduced on the first of the month in which you turn age 65 to 65% of your original amount, and on the first of the month in which you turn age 70 to 40% of your original amount. At that time, you have 31 days to convert the difference to an individual plan. See page 2.31 for additional conversion information.
ENROLLMENT

New Employees may enroll within 31 days of becoming a Benefit-Based Employee. When initially hired as a Benefit-Based Employee, you may select up to three times your Annual Salary, up to a maximum of $500,000 of supplemental group life insurance coverage for yourself without Evidence of Insurability. You may enroll at any time after the initial 31 days, but your coverage will be subject to satisfactory Evidence of Insurability.

You may enroll a new Spouse within 31 days of the date of the marriage. You may enroll your Domestic Partner within 31 days of formation of partnership, provided the eligibility requirements listed on page 2.4 are met. You can also enroll a child up to age 26. Adopted or new Dependent children acquired through marriage must be enrolled for Dependent coverage within 31 days of Adoption or your marriage. Enrollment of a Spouse or Domestic Partner after these deadlines requires satisfactory Evidence of Insurability. After electing supplemental group life insurance for a Dependent child, coverage for any new Dependent children shall be automatically provided.

If your dependent is currently serving in the military of any country or subdivision of any country, they are not eligible to be covered for supplemental life benefits.

If you file an application for supplemental group life insurance more than 31 days after the eligibility period, your coverage will not take effect until the carrier approves your Evidence of Insurability. Prior to the date that Evidence of Insurability is approved, you will be enrolled in the highest coverage amount that does not require Evidence of Insurability. Any increase in your coverage following approval of Evidence of Insurability will become effective the first of the month following receipt of the carrier’s approval.

If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until you return to full-time work for one full day. This rule also applies to an increase in your coverage. Any increases in your coverage due to an increase in your Annual Salary will become effective on the first payroll period of your new salary.

Changes to Your Coverage Amount

During future Annual Enrollment Periods, you may increase your existing supplemental group life insurance coverage for yourself equal to one times your Annual Salary without providing Evidence of Insurability.

You may request a change in your group life insurance election at any time. However, Evidence of Insurability will be required for any of the circumstances listed on page 5.4.

<table>
<thead>
<tr>
<th>SUPPLEMENTAL GROUP LIFE COVERAGE</th>
<th>Type of Coverage</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental group life coverage for yourself</td>
<td>1, 2, 3, 4, or 5 times your Annual Salary rounded to next higher $10,000, up to $1,000,000 maximum*</td>
<td></td>
</tr>
<tr>
<td>Supplemental group life coverage for your Spouse or Domestic Partner</td>
<td>Units of $10,000, up to 100% of the total of the employees (basic and supplemental) amount or $200,000, whichever is less</td>
<td></td>
</tr>
<tr>
<td>Supplemental group life coverage for your Dependent children From live birth to age 26.</td>
<td>$10,000 per child</td>
<td></td>
</tr>
</tbody>
</table>

*You are limited to 3 times your Annual Salary up to a maximum of $500,000 of coverage as a new Benefit-Based Employee without evidence of insurability
When is Evidence of Insurability Required?

**Within 31 Days of Initial Eligibility**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Amounts over 3x Annual Salary or in excess of $500,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental group life insurance for yourself</td>
<td></td>
</tr>
</tbody>
</table>

**Future Annual Enrollment Periods**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Any increases greater than 1x Annual Salary more than current multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental group life insurance for yourself</td>
<td></td>
</tr>
<tr>
<td>You only have basic group life coverage</td>
<td></td>
</tr>
<tr>
<td>Spouse or Domestic Partner Life coverage</td>
<td></td>
</tr>
<tr>
<td>Child life coverage</td>
<td>Not required</td>
</tr>
</tbody>
</table>

**Changes at Other Times**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Any amount of supplemental group life insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental group life insurance for yourself or your Spouse, or Domestic Partner after 31 days of eligibility, marriage or formation of partnership</td>
<td></td>
</tr>
<tr>
<td>Supplemental group life insurance for your new dependent child up to age 26</td>
<td>Not required</td>
</tr>
</tbody>
</table>

**COST**

The basic group life insurance benefit of one times annual salary up to $50,000 is fully paid by the Institute.

Premiums are based on the employee’s age. The table below shows the monthly supplemental group life insurance rates by age group. The insurance carrier may change the rates charged for each age group. Your benefit cost will automatically be recalculated on the first of the month of a change in your age group.

The premium to cover Dependent children is $.84 per month, regardless of how many children you have. Once one child is insured, coverage for other new Dependent children is automatic. Dependent children are covered up to age 26 providing they are not in the military of any country.

<table>
<thead>
<tr>
<th>Employee Age</th>
<th>Monthly Rate Per $1,000 of Coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 to 29</td>
<td>$0.04</td>
</tr>
<tr>
<td>30 to 34</td>
<td>$0.05</td>
</tr>
<tr>
<td>35 to 39</td>
<td>$0.07</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$0.09</td>
</tr>
<tr>
<td>45 to 49</td>
<td>$0.13</td>
</tr>
<tr>
<td>50 to 54</td>
<td>$0.18</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$0.314</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$0.53</td>
</tr>
<tr>
<td>65 to 69</td>
<td>$0.99</td>
</tr>
<tr>
<td>70 and older</td>
<td>$1.61</td>
</tr>
</tbody>
</table>

* Premiums for both Employee and Spouse or Domestic Partner coverage are calculated based on the Employee’s age.
GROUP LIFE INSURANCE PLAN

YOUR BENEFICIARY

The Group Life Insurance Plan provides a benefit to your Beneficiary in the event of your death. You are the Beneficiary for the Spouse, Domestic Partner and/or Dependent child group life insurance you elect. You may name anyone as your Beneficiary(ies), and you may name one or more contingent beneficiaries if you wish. You should note that if you name a Beneficiary other than your Spouse or Domestic Partner or designate more than 50% to someone other than your Spouse or Domestic Partner, they may be required to sign a waiver form. You may not name the Institute as your Beneficiary. You may change your Beneficiary at any time by submitting a new Beneficiary Designation form in writing to the Campus or JPL Benefits Office. Beneficiary Designation forms may be obtained online at http://cit.hr.caltech.edu/Benefits/Beneficiary Form.pdf or at the Campus or JPL Benefits Office.

If you do not name a Beneficiary or your Beneficiary does not survive you, your group life insurance benefits will be paid out in full to the following individuals in this order:

1. Your surviving Spouse or Domestic Partner
2. Your surviving children, equally
3. Your surviving parents, equally
4. Your surviving siblings, equally
5. Your estate.

IF YOU ARE NO LONGER AN ACTIVE BENEFIT-BASED EMPLOYEE

If you are no longer an active Benefit-Based Employee because of retirement, disability, leave of absence or other reasons, there are special rules regarding continuation of your life insurance and other coverage. These rules are described on page 2.30.

CONVERSION TO AN INDIVIDUAL POLICY

If you or your Dependents lose coverage under the Caltech benefits program because of your termination of employment, total disability, retirement, or reduction of hours to Non-Benefit-Based Employee status, or if the amount of coverage is reduced due to attainment of age 65 or 70, you have the right to continue all or part of your coverage without having to provide Evidence of Insurability. Refer to page 2.31 for information on converting to an individual policy.

PORTABILITY

For purposes of this subsection the term “Portability” refers to Supplemental Life in effect.

1. If your Supplemental Life coverage ends because your employment ends or You cease to be in an eligible class that is eligible for such insurance, you will have 31 days from the date coverage ends to port your coverage.
2. You may elect to continue your dependent life insurance and Accidental Death coverage under the Portability provision only if you elect to continue your own life insurance coverage.

3. The Portability coverage applications are available from the Campus or JPL Benefits Office. The amount that you can port for yourself and your covered dependents can equal up to the face amount you had while eligible, less any amount of retiree coverage, if applicable.

**FILING CLAIMS**

The Campus or JPL Benefits Office will submit the initial claim to the life insurance carrier.

**Payment of Benefits**

Benefits will be paid to your Beneficiary(ies) in one lump sum.

**ACCELERATED DEATH BENEFIT (ADB)**

The Accelerated Death Benefits (ADB), often referred to as a living benefit, provides an early payment of up to 80% of the life insurance amount in force under your Group Life Insurance, in the event you or your covered Spouse or Domestic Partner are diagnosed with a terminal illness. The ADB feature does not apply to children.

An employee, Spouse or Domestic Partner is considered terminally ill if he or she suffers from an incurable, progressive, and medically recognized condition; and, to a reasonable probability and based on generally accepted prognostic protocol, will not survive more than 24 months. The insurance company will make the final determination based on medical documentation submitted by your physician.

You may apply through the Caltech or JPL Benefits Office for any amount up to 80% of your, your Spouse’s or your Domestic Partner’s group life insurance amount. The minimum ADB that can be requested is $5,000 and the maximum is $500,000. The benefit is payable in a lump sum. You should consult your tax professional to determine the consequences of this benefit payment.

Upon payment of the ADB, the employee’s group life insurance coverage will be reduced by the amount of the benefit received.

**Requirements for Payment of an Accelerated Benefit**

Subject to the conditions and requirements of this section, the life insurance carrier will pay an accelerated benefit to you or your legal representative if:

- The amount of each ADB Eligible Life Insurance benefit to be accelerated equals or exceeds $5,000; and
- The ADB Eligible Life Insurance to be accelerated has not been assigned; and
- The insurance carrier has received Proof that you are Terminally Ill.

The insurance carrier will only pay an accelerated benefit for each ADB Eligible Life Insurance benefit once.

**Proof of your Terminal Illness**
The insurance carrier will require the following Proof of Your Terminal Illness:

- A completed accelerated benefit claim form;
- A signed Physician’s certification that You are Terminally Ill; and
- An examination by a Physician of the insurance carrier's choice, at the insurance carrier's expense, if they request it.

You or Your legal representative should contact Caltech to obtain a claim form and information regarding the accelerated benefit.

Upon the insurance carrier’s receipt of your request to accelerate benefits, the insurance carrier will send you a letter with information about the accelerated benefit payment you requested. The letter will describe the amount of the accelerated benefit.

**TERMS YOU SHOULD KNOW**

**Annual Salary**

Your base wage or compensation for your regular hours of employment. Annual Salary includes any salary reduction amounts under IRC Section 125 (Tax Savings Plan and spending account contributions), but excludes bonuses, commissions, overtime, extended work week compensation, per diems, shift differentials, field rate bonuses, flight bonuses, off-site service pay and similar payments.
ACCIDENTAL DEATH & PERSONAL LOSS INSURANCE PLAN

The Accidental Death & Personal Loss (AD&PL) plan provides a benefit to you if you suffer a specific loss or loss of use, or to your Beneficiary if you die as the result of an accident. You may also enroll your eligible Dependents (including your Spouse or your Domestic Partner) for coverage under the Caltech benefits program. Benefits will be paid to you in the event of their accidental death. This coverage is totally voluntary and you pay the full amount of the premium.

Eligible Benefit-Based Employees may enroll at any time. Coverage will take effect on the first day of the month coincident with or next following the date your signed enrollment form is received by the Campus or JPL Benefits Office.

After you have enrolled, you may increase or decrease your coverage amount or change your coverage category at any time.

To make a change, contact the Campus or JPL Benefits Office to obtain an enrollment form. If you are Actively At Work, your change in coverage will go into effect on the first day of the month coinciding with or next following the month in which you elected the change.

COVERAGE OPTIONS AND COSTS

You may purchase coverage in 14 different amounts, from a minimum of $10,000 to a maximum of $500,000, as shown below. The current schedule is:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee Coverage Amount</th>
<th>I. Employee Only (cost per month)</th>
<th>II. Employee &amp; Children (cost per month)</th>
<th>III. Family Coverage* (cost per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$10,000</td>
<td>$0.26</td>
<td>$0.30</td>
<td>$0.38</td>
</tr>
<tr>
<td>B</td>
<td>$25,000</td>
<td>$0.64</td>
<td>$0.74</td>
<td>$0.96</td>
</tr>
<tr>
<td>C</td>
<td>$50,000</td>
<td>$1.26</td>
<td>$1.46</td>
<td>$1.90</td>
</tr>
<tr>
<td>D</td>
<td>$75,000</td>
<td>$1.90</td>
<td>$2.18</td>
<td>$2.86</td>
</tr>
<tr>
<td>E</td>
<td>$100,000</td>
<td>$2.50</td>
<td>$2.90</td>
<td>$3.80</td>
</tr>
<tr>
<td>F</td>
<td>$125,000</td>
<td>$3.14</td>
<td>$3.64</td>
<td>$4.76</td>
</tr>
<tr>
<td>G</td>
<td>$150,000</td>
<td>$3.76</td>
<td>$4.36</td>
<td>$5.70</td>
</tr>
<tr>
<td>H</td>
<td>$200,000</td>
<td>$5.00</td>
<td>$5.80</td>
<td>$7.60</td>
</tr>
<tr>
<td>I</td>
<td>$250,000</td>
<td>$6.26</td>
<td>$7.26</td>
<td>$9.50</td>
</tr>
<tr>
<td>J</td>
<td>$300,000</td>
<td>$7.50</td>
<td>$8.70</td>
<td>$11.40</td>
</tr>
<tr>
<td>K</td>
<td>$350,000</td>
<td>$8.76</td>
<td>$10.16</td>
<td>$13.30</td>
</tr>
<tr>
<td>L</td>
<td>$400,000</td>
<td>$10.00</td>
<td>$11.60</td>
<td>$15.20</td>
</tr>
<tr>
<td>M</td>
<td>$450,000</td>
<td>$11.26</td>
<td>$13.06</td>
<td>$17.10</td>
</tr>
<tr>
<td>N</td>
<td>$500,000</td>
<td>$12.50</td>
<td>$14.50</td>
<td>$19.00</td>
</tr>
</tbody>
</table>

* Employee plus Spouse (or Domestic Partner) or Employee plus Spouse (or Domestic Partner) and Dependent Children.
Coverage For You
Your coverage amount is based on the plan option chosen (Plans A-N). Refer to the chart on page 5.8.

If you elect more than $150,000, your benefit cannot be more than 10 times your annualized salary amount, rounded to the next higher benefit level.

For example: If your Annual Salary is $30,500, your maximum coverage amount is:

10 times $30,500 = $305,000

Next higher coverage = $350,000

Employee and Children Coverage
The coverage amount for your Dependent children is based on the plan option chosen (Plans A-N) as reflected in the table below:

<table>
<thead>
<tr>
<th>Dependent Children Coverage</th>
<th>Plans A and B</th>
<th>$5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans C, D, E, F, G, H, I and J</td>
<td>20% of the employee coverage amount</td>
<td></td>
</tr>
<tr>
<td>Plans K, L, M and N</td>
<td>$60,000</td>
<td></td>
</tr>
</tbody>
</table>

Spouse/Domestic Partner and Dependent children) as reflected in the tables below:

<table>
<thead>
<tr>
<th>Family Coverage</th>
<th>Plans A, B, C, D, E, F, G, H, I and J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Children</td>
<td>60% of the employee coverage amount if no Dependent children covered</td>
</tr>
<tr>
<td>Plans K, L, M and N</td>
<td>$180,000 if no Dependent children covered</td>
</tr>
<tr>
<td>$150,000 if Dependent children covered</td>
<td></td>
</tr>
</tbody>
</table>

YOUR BENEFICIARY
The plans provide a benefit to your Beneficiary in the event of your death, and to you in the event of a specific loss. If you elect employee and children or family coverage, you are the Beneficiary for your covered Dependents.
You may name anyone as your Beneficiary. You may change your Beneficiary at any time by sending the change, in writing, to the Campus or JPL Benefits Office.

If you do not name a Beneficiary or your Beneficiary does not survive you, benefits will be paid out in full to the following individuals in this order:

1. Your surviving Spouse or Domestic Partner
2. Your surviving children, equally
3. Your surviving parents, equally
4. The executors or administrators of your estate.

**PLAN BENEFITS**

**Death Benefit**

The plan pays 100% of the applicable benefit amount if you, your covered Spouse or Domestic Partner and/or covered Dependent children die as the result of a covered accident. The loss must occur within 365 days of the date of the accident.

**Common Disaster Benefit**

If you and your Spouse or Domestic Partner suffer loss of life within 90 days of the same accident, your Spouse’s or Domestic Partner’s benefit will be increased to be equal to your benefit (maximum $500,000).

**Specific Loss Benefits**

If you suffer certain specific losses in or as the result of any accident, you may receive a percentage of your benefit as shown in the table below.

To receive benefits, you must have been injured in or as the result of an accident that occurred while you were covered and the loss must have occurred within 365 days of the accident.

The maximum benefit payable for multiple losses from any one accident is 100% of your coverage amount.

“Loss” used with reference to hand or foot means the actual and complete severance through or above the wrist or ankle joint; as used with reference to eye means irrecoverable loss of entire sight; as used with reference to arm or leg means actual or complete severance at or above the elbow or knee; as used with reference to speech means complete and irrecoverable loss of speech; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears; and as used with respect to thumb and index finger means the complete severance through or above the metacarpophalangeal joints.

A benefit is not payable for both loss of thumb and index finger of same hand, loss of one hand or loss of one arm for an injury to the same hand/arm as a result of any one accident.

**Loss of Use**

“Loss of Use” means total paralysis of a limb or limbs which is determined by competent medical authority to be permanent, complete and irreversible.

<table>
<thead>
<tr>
<th>Loss</th>
<th>Percent of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life; both hands or both feet; sight of both eyes; both arms or both legs; both hearing and speech; and a</td>
<td>100</td>
</tr>
</tbody>
</table>
### Life, Accident, and Travel Benefits

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>third degree burn covering 75% or more of the body.</td>
<td></td>
</tr>
<tr>
<td>One arm or one leg</td>
<td>75</td>
</tr>
<tr>
<td>One hand or one foot; sight in one eye; speech; hearing in both ears; or a third degree burn covering 50% - 74% of the body</td>
<td>50</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss of Use</th>
<th>Percent of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Use of 4 Limbs</td>
<td>100</td>
</tr>
<tr>
<td>Loss of Use of 3 Limbs</td>
<td>75</td>
</tr>
<tr>
<td>Loss of Use of 2 Limbs</td>
<td>67</td>
</tr>
<tr>
<td>Loss of Use of 1 Limb</td>
<td>50</td>
</tr>
</tbody>
</table>
Extended Dependent Coverage

Coverage for your Spouse or Domestic Partner and/or Dependent child will end when your coverage ends. However, if you die as the result of a covered accident, coverage will continue for your covered Spouse or Domestic Partner and/or Dependent child, at no cost to them, until the earliest of the following events/dates:

- Remarriage of your Spouse;
- Termination of the policy;
- Adding a new Domestic Partner;
- A covered Dependent child ceases to be a Dependent child as defined in the Caltech benefits program; or
- 12 months after your death.

Spousal Education Benefit

If you elected family coverage and you die as the result of a covered accident, and if your surviving Spouse or Domestic Partner was not employed on the date of your death, the plan will pay for your Spouse or Domestic Partner to be trained for an occupation for which he or she would not have otherwise been qualified. The benefit is equal to the lesser of:

- 5% of the death benefit, or
- $5,000

The training must occur within one year of your death. Your Spouse or Domestic Partner must enroll on a full-time basis in a school for higher learning or vocational training for the purpose of preparing for gainful employment.

Day Care Benefit

If you have elected family coverage and you or your Spouse or Domestic Partner die as the result of a covered accident, a day care benefit will be payable on behalf of each of your Dependent children under age seven, if they were or become enrolled in an accredited day care center within one year of your death or the death of your Spouse or Domestic Partner. The benefit, which can be paid each year for up to four years, will equal the lesser of:

- 5% of the total amount of your or your Spouse’s or Domestic Partner’s death benefit, or
- $5,000 per year.

If you have no Dependent children who meet the requirements of this benefit, one lump sum payment equal to the lesser of 5% of the death benefit or $5,000 will be paid to your Beneficiary.

This benefit is in addition to the death benefit paid under this plan.

Education Benefit For Dependent Children

If you have elected family coverage and you or your Spouse or Domestic Partner die within one year of a covered accident, the plan will pay an education benefit for your Dependent children if the following conditions are met: they are currently attending a school for higher learning as a full time student or they are in the twelfth grade and will attend a school for higher learning as a full time student. Full time student determination will be made by the institution the student is attending. The education benefit will be paid within one year of your, or your Spouse’s or Domestic Partner’s death. It can be paid each year for up to four consecutive years (if the child...
remains an enrolled student) and will equal 5% of the covered person's benefit.

If, at the time of your or your Spouse's or Domestic Partner's death, there are no Dependent children eligible for the education benefit, the plan will pay one lump sum amount up to lesser of 5% or $5,000 payable annually up to 4 years.

This benefit is in addition to the death benefit paid under this plan.

**Seatbelt and Airbag Benefit**

An additional benefit will be payable if you or your Spouse or Domestic Partner or Dependent Child suffers loss of life as the result of an accident which occurs while:

- Driving or riding in a vehicle driven by a driver who is not under the influence of drugs or alcohol (as determined by the legal jurisdiction where the accident occurs), and either
- Wearing a seat belt, or
- Wearing a seat belt while driving a vehicle with a driver-side air bag or riding as a passenger in a seat protected by a passenger air bag.

The Seat Belt benefit, which is paid in addition to death or specific loss benefits is the lesser of $50,000 or 15% of the covered person’s benefit. The Air Bag benefit, which is paid in addition to death or specific loss benefits including the Seat Belt benefit is the lesser of $2,500 or 5% of the covered person’s benefit.

A child restraint device means a seat belt that meets the standards of the National Safety Council and is properly secured and utilized in accordance with applicable state law and the recommendations of its manufacturer for children of like age and weight.

**Continuation of Medical Coverage Funding Benefit**

If you suffer loss of life in a covered accident and your eligible family members are covered under the plan on the date of the accident, the plan will pay a benefit toward the cost of medical coverage premiums for continuation coverage for your covered Dependents. The benefit is equal to the lesser of:

- 5% of the death benefit, or
- $5,000 for up to 3 years

This benefit will be paid each year for a maximum of three years to your insured Spouse or Domestic Partner or on behalf of your insured Dependent children, as long as proof is provided that the benefit is being used for continuation of medical coverage premiums. If proof is not provided for a particular payment, no further payments under this benefit will be made.

If your Dependents cannot provide proof for the first payment, one lump sum payment of the lesser of 5% of the death benefit or $5,000 will be provided to your Beneficiary. No other payments under this benefit will be made.

**Coma**

1% of the benefit amount is payable for 11 months following a period of 30 days. On the 12 month the balance of the principal sum would be payable.

**Exposure and Disappearance**

If you or an insured Spouse, Domestic Partner or Dependent child suffers loss due to exposure to the elements, the plan will presume that the loss was due to an injury. If you or an insured Spouse or Domestic Partner or Dependent child suffers a loss of life within one year of a disappearance related to a forced landing, sinking or
wrecking of any land or water vehicle, transport or vessel or aircraft, the plan will presume that a related accident caused the loss of life. Loss of life will be presumed in the event your, or your insured Spouse’s, Domestic Partner’s or Dependent child’s body is not recovered within one year of a disappearance related to a forced landing, sinking or wrecking of any land or water vehicle, transport or vessel or aircraft.

CONVERSION PRIVILEGE

If your coverage ends, you have the option to convert to an individual policy when you convert your Life insurance. More details on converting coverage are on page 2.31 of the General Information section.

WHAT IS NOT COVERED?

Coverage for losses due to aircraft travel under the plan is limited as follows:

- Benefits will be paid only if you are riding as a passenger (and not as a pilot or crew member) in any aircraft or device used for aerial navigation.* The aircraft must be used for the transportation of passengers and licensed to carry passengers and piloted by a qualified licensed pilot.

  *A device for aerial navigation includes, but is not limited to, parachutes, hang gliders, parasails, and water kites.

Also, no benefits will be paid for a death or injury if it results from any of the following:

- Losses that occur more than 365 days after the accident
- Suicide, a suicide attempt, self-destruction or an attempt to self-destroy while sane or insane
- War or act of war, whether declared or undeclared
- An accident sustained while on active military duty for more than two months unless during a paid leave of absence and premiums have been paid for coverage
- Sickness or disease, except pyogenic infections which occur through an accidental cut or wound
  - Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo.)
  - Bodily or mental infirmity.*
  - Commission of or attempting to commit a criminal act.
  - Illness, ptomaine or bacterial infection.*
  - Inhalation of poisonous gases.
  - Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
  - Ligature strangulation resulting from auto-erotic asphyxiation.
  - Intentionally self-inflicted injury.
  - Medical or surgical treatment*.
  - 3rd degree burns resulting from sunburn.
  - Use of alcohol.
FILING CLAIMS

To file a claim for benefits, your Beneficiary (or you, in case of specific loss) must submit proof of your death or specific loss (within 30 days of the death or loss, or as soon as reasonably possible) and complete the required claim form, available at the Campus or JPL Benefits Office.

TERMINATION OF COVERAGE

Coverage will terminate when the policy is terminated, when you cease to be associated with Caltech in a capacity making you eligible, or on the date any insured person attains an age which would make him or her no longer eligible, whichever is earliest.

TERMS YOU SHOULD KNOW

Injury
Bodily injury caused by an accident and resulting in a covered loss.

Permanent Residence
A Country where an insured individual resides or is regularly employed in for three or more months.

Seat Belt
Belts that form a restraint system, including infant and child restraint systems when properly used with a seat belt.

School For Higher Learning
An educational institution above the twelfth grade level. It includes, but is not limited to, a state university, community college, private college, or trade/vocational school.

Vocational Training
Any educational, professional, or trade training program which prepares your covered spouse for an occupation for which he or she would not otherwise have been qualified.
TRAVEL ACCIDENT INSURANCE PLAN

All Institute employees are automatically covered by Travel Accident Insurance beginning on their date of hire. In addition, Emeriti Faculty and prospective new employees (who have accepted Caltech’s employment offer in writing but before the official start date) are covered by Travel Accident insurance for Institute business-related travel. It provides benefits for loss as a result of covered accidental injury for death, dismemberment or loss of movement while Traveling on Institute Business.

COVERAGE OPTIONS AND COST

COST OF COVERAGE
The Institute pays the full cost of your coverage.

WHEN COVERAGE BEGINS
Coverage begins when you leave your residence or regular employment site, whichever occurs last, to Travel on Institute Business. You are not covered when traveling between home and work on a daily basis*.

WHEN COVERAGE ENDS
Coverage ends when you return to your residence or regular employment site, whichever occurs first, from Traveling on Institute Business.

PLAN BENEFITS

DEATH BENEFIT
If you die as the result of an accident while Traveling on Institute Business (not including to and from work and home*), your Beneficiary(ies) will receive a benefit of up to $250,000.

SPECIFIC LOSS BENEFITS
If you are injured while Traveling on Institute Business, you will receive all or a percentage of your benefit if you suffer certain specific losses from an injury sustained in the accident, as shown below.

To receive benefits, you must have been injured in or as the result of an accident that occurred while you were covered by the plan, and the loss must occur within 365 days of the accident.

The maximum benefit payable for multiple losses from any one accident is 100% of your coverage amount.

“Loss” as used below, with reference to hand or foot, means complete severance through or above the wrist or ankle joint and as used with reference to eye, speech and hearing means the entire and irrecoverable loss thereof.

*See Commutation Coverage on page 5.17.
Loss of Movement

“Loss of Movement” means total paralysis of limbs which is determined by competent medical authority to be permanent, complete and irreversible.

<table>
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<td>Thumb and index finger of same hand</td>
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Commutation Coverage

If you suffer a covered injury resulting from an accident that occurs while you are commuting directly between your residence and place of regular employment in a conveyance not normally used for commuting, due to a breakdown of public transportation used regularly by you, you will receive all or a percentage of your benefit. The breakdown must be caused by a strike, power failure, or similar event.

Safe Driving Benefit

An additional benefit will be paid to you or, if applicable, your Beneficiary, if you suffer a covered specific loss, or loss of movement as the result of an accident which occurs while:

- Driving or riding in a vehicle driven by a driver who is not under the influence of drugs or alcohol (as determined by the legal jurisdiction where the accident occurs), and either
- Wearing a seat belt, or
- Driving a vehicle with a driver-side air bag or riding as a passenger in a seat protected by a passenger air bag.

The Seat Belt benefit, which is paid in addition to death, specific loss or loss of movement benefits is the lesser of $50,000 or 15% of the coverage amount. The Air Bag benefit, which is paid in addition to death, specific loss or loss of movement benefits, including the Seat Belt benefit, is the lesser of $10,000 or 5% of the coverage amount.
Adaptive Home and Vehicle Benefit

If you suffer a covered loss, other than loss of life, and a benefit is payable under the Accidental Death and Dismemberment benefit, a one-time cost for alterations to your principal residence and/or private automobile will be paid. The alterations must be incurred within two years from the date of the accident. Payable will be the lesser of 10% of your benefit or the actual cost to a maximum of $25,000.

Bereavement Counseling Benefit

If you suffer a covered loss of life, bereavement counseling expenses incurred by your Spouse or Domestic Partner or Dependent child will be payable up to $100 per visit with a $500 maximum per covered person per accident. The counseling expenses must be incurred within 90 days of your death.

Coma Benefit

1% of your benefit amount is payable for a maximum of 100 months if you become comatose within 31 days of the accident and remain so for at least 30 days. The benefit is payable beginning with the 2nd month that you remain in a coma.

Rehabilitation Benefit

Training expenses equal to the lesser of the expense for training, 10% of your benefit, or $25,000 is payable. The expense must be incurred within two (2) years of the date of the accident.

Therapeutic Counseling Benefit

A benefit is payable equal to the lesser of reasonable expenses incurred, excess of any other plan; 10% of your benefit, or $25,000.

Exposure and Disappearance

If you suffer loss due to exposure to the elements, the plan will presume that the loss was due to an injury. If you suffer a loss of life within one year of a disappearance related to a forced landing, sinking or wrecking of any land or water vehicle, transport or vessel or aircraft, the plan will presume that a related accident caused the loss of life. Loss of life will be presumed in the event your body is not recovered within one year of a disappearance related to a forced landing, sinking or wrecking of any land or water vehicle, transport or vessel or aircraft.
MAXIMUM AGGREGATE BENEFIT
The maximum benefit payable for all Institute employees injured or killed in any one accident is $5 million.

WHAT IS COVERED?
You are covered for injuries or loss of life sustained during authorized business travel of the Institute. Coverage includes injuries or loss of life sustained while:

- At a business destination
- A passenger in any vehicle
- Boarding, exiting, or riding as a passenger (but not as a pilot or crew member), in any aircraft that:
  - is operated on a regular, special, or chartered flight by a scheduled airline
  - has a current and valid air worthiness certificate and is piloted by a person holding current and valid licensing.

WHAT IS NOT COVERED?
You are not covered for any injuries or loss of life resulting from:

- Everyday travel to and from work
- Flying as a pilot or a crew member of an aircraft, except for JPL employees performing work while aboard military aircraft, NASA aircraft or other aircraft requiring special permits or waivers
- Suicide or self-destruction
- War or any act of war (except hijacking), whether declared or undeclared, within the United States, Canada, or other named Countries, subject to change from time to time, or in an insured individual’s Country of Permanent Residence
- Service in the armed forces of any nation.

FILING CLAIMS
To file a claim for benefits, your Beneficiary (or you, in case of specific loss) must submit proof of your death or specific loss (within 30 days of the death or loss, or as soon as reasonably possible) and complete the required claim form, available at the Campus or JPL Benefits Office.

TERMINATION OF COVERAGE
Coverage will terminate when the policy is terminated or when you are no longer employed by the Institute.

TERMS YOU SHOULD KNOW
Permanent Residence
A Country where an insured individual resides or is regularly employed in for three or more months.

Traveling on Institute Business
Travel with the authorization of the Institute for the purpose of furthering Institute Business, including a personal trip of up to seven (7) days immediately preceding, following, or during an authorized trip.
YOUR BENEFICIARY

Your Beneficiary for the Travel Accident Insurance Plan will be the same Beneficiary named for your basic life insurance, unless otherwise specified.
EXTRA-HAZARDOUS DUTY INSURANCE PLAN

Institute employees are automatically covered by Extra-Hazardous Duty Insurance beginning on their date of hire. It provides benefits to you or your Beneficiary due to a covered accidental injury for death or dismemberment as a result of certain Testing activities performed by the Jet Propulsion Laboratory (JPL) in connection with any Caltech contracts.

COVERAGE OPTIONS AND COST

COST OF COVERAGE
The Institute pays the full cost of your coverage.

WHEN COVERAGE BEGINS
Coverage begins on the day you are hired.

WHEN COVERAGE ENDS
Coverage ends when you are no longer employed by the Institute.

PLAN BENEFITS

DEATH BENEFIT
If you die due to a covered accidental loss as the result of Testing activities performed in connection with Caltech contracts, your Beneficiary(ies) will receive a benefit of $25,000.

SPECIFIC LOSS AND ILLNESS BENEFITS
If you are injured, you will receive all or a percentage of your benefit if you suffer certain specific losses from an injury sustained in the accident, as shown in the table below.

To receive benefits, you must have been injured in or as the result of a covered accident that occurred while you were covered by the plan, and the loss must have occurred within 365 days of the accident. You may also receive benefits if you become Disabled within 30 days of a covered accidental loss that results from Testing activities performed in connection with any Caltech contracts, if you are wholly and continuously Disabled and you are prevented from performing each and every duty pertaining to your occupation.

The maximum benefit payable for multiple losses from any one accident is 100% of your coverage amount.

“Loss” as used below, with reference to hand or foot, means complete severance through or above the wrist or ankle joint and as used with reference to eye, speech and hearing means the entire and irrecoverable loss thereof.
**EXTRA-HAZARDOUS DUTY INSURANCE PLAN**

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**Loss of Movement**

“Loss of Movement” means total paralysis of limbs which is determined by competent medical authority to be permanent, complete and irreversible.

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<tr>
<td>Loss of Movement of Upper and Lower Limbs</td>
<td>100</td>
</tr>
<tr>
<td>Loss of Movement of both Lower Limbs</td>
<td>75</td>
</tr>
<tr>
<td>Loss of Movement of Upper and Lower Limbs of one side</td>
<td>50</td>
</tr>
</tbody>
</table>
MAXIMUM AGGREGATE BENEFIT

The maximum benefit payable for all Institute employees injured or killed in any one accident is $2.50 million.

Exposure and Disappearance

If you suffer loss due to exposure to the elements, the plan will presume that the loss was due to an injury. If you suffer a loss of life within one year of a disappearance related to a forced landing, sinking or wrecking of any land or water vehicle, transport or vessel or aircraft, the plan will presume that a related accident caused the loss of life. Loss of life will be presumed in the event your body is not recovered within one year of a disappearance related to a forced landing, sinking or wrecking of any land or water vehicle, transport or vessel or aircraft.

WHAT IS COVERED?

All Institute employees are covered in the event of:

• Injuries or loss of life sustained in the course of employment and as the sole and direct result of Testing activities performed by the Jet Propulsion Laboratory (JPL) in connection with any Caltech contracts.

• Injuries or loss of life sustained during the course of employment while boarding, exiting, or riding as a passenger in any civilian or military aircraft being used for transportation purposes only, provided the pilot has a valid and current pilot’s certificate or its military equivalent. (This benefit is not payable in addition to benefits payable under the Travel Accident Insurance Plan.)

• Injuries or loss of life sustained by JPL employees performing work while aboard military aircraft, NASA aircraft or other aircraft requiring special permits or waivers.

WHAT IS NOT COVERED?

You are not covered for any injuries or loss of life resulting from:

• Flying as a pilot or crew-member of an aircraft, except for JPL employees performing work while aboard military aircraft, NASA aircraft or other aircraft requiring special permits or waivers.

• Suicide or self-destruction while sane or insane

• War or any act of war, whether declared or undeclared

• Service in the armed forces of any nation.

FILING CLAIMS

To file a claim for benefits, your Beneficiary (or you, in case of specific loss or disease) must submit proof of your death, specific loss, or disease (within 30 days of the death, loss, or diagnosis of disease, or as soon as reasonably possible) and complete the required claim form, available at the Campus or JPL Benefits Office.

YOUR BENEFICIARY

Your Beneficiary for the Extra-Hazardous Duty Insurance Plan will be the same Beneficiary named for your basic group life insurance, unless otherwise specified.
TERMINATION OF COVERAGE

Coverage will terminate when the policy is terminated or when you cease to be associated with Caltech or JPL in a capacity making you eligible, whichever is earlier.

TERMS YOU SHOULD KNOW

Testing

Means activity directly involving certain extra-hazardous propellants and radiation in connection with the Jet Propulsion Laboratory (JPL).
International SOS is your very own personal and medical assistance advisor for emergencies, as well as routine advice when outside your home country. Reach out to International SOS if you need a routine referral, lose your medication, or have a medical crisis.

Your membership card contains your membership number and phone numbers to access International SOS 24/7/365.

Visit www.internationalsos.com and enter your membership number to learn more about your benefits.

Before you travel outside your home country, prepare yourself:

- Access accurate, real-time information on www.internationalsos.com. View country guides, online medical reports, and sign up for medical e-mail alerts

- Call an Assistance Center for pre-travel information (i.e., vaccination, required medication)

While abroad, contact ISOS if you:

- Seek health and safety advice

- Need to speak with an experienced, Western-trained doctor

- Need a local doctor or other provider credentialed by our medical staff

- Require supplies of medication or equipment

- Need travel advice on loss of travel documents or legal assistance

In an emergency, call ISOS to:

- Arrange medical transportation or care

- Coordinate medical fees, when approved

- Monitor your condition and advise

- Seek health and safety advice

- Need to speak with an experienced, Western-trained doctor

- Need a local doctor or other provider credentialed by our medical staff

- Require supplies of medication or equipment

- Need travel advice on loss of travel documents or legal assistance

* Please keep in mind: International SOS is not insurance coverage and, therefore, participants may be held accountable for any charges that are not part of the referral plan (e.g., medical treatment or travel expenses). For more information regarding referral services offered by International SOS, please contact the Campus or JPL Benefits Office.
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TAX SAVINGS PLAN /SPENDING ACCOUNTS OVERVIEW

TAX SAVINGS PLAN OVERVIEW

The Tax Savings Plan (TSP) allows participants to pay for their portion of Caltech medical and dental plan premiums with pre-tax dollars. Paying with pre-tax dollars means your contributions are taken from your pay before any Federal – and, in most cases state – income and FICA taxes are withheld.

Your actual tax savings will depend on several factors, such as your:

- Gross salary
- Taxable income
- Medical and dental plan elections
- Level of coverage.

SPENDING ACCOUNTS OVERVIEW

The spending accounts provide you with an opportunity to set aside pre-tax dollars to pay for certain eligible health and/or dependent day care expenses. There are two spending accounts available:

- **Health Care Spending Account (HCSA)** allows you to set aside pre-tax dollars for you and your Tax-Qualified Dependent(s) to cover allowable health care expenses not covered under the Caltech medical plan or any other medical plan including: out-of-pocket medical, dental, and vision care expenses such as deductibles, copayments, eyeglasses, orthodontia or prescription drugs. For a more detailed list of allowable expenses for reimbursement, see page 6.7.

- **Dependent Care Spending Account (DCSA)** allows you to set aside pre-tax dollars to pay for child care for children under 13 or day care expenses for an incapacitated Spouse, Domestic Partner or other individual (e.g., a disabled parent) who is your Tax-Qualified Dependent under the Internal Revenue Code that allow you and your Spouse, Domestic Partner\(^1\) to work or look for work.

You may choose to participate in one or both of the accounts. Based on your estimate for health care and/or dependent day care expenses for the plan year, you designate an annual amount which is pro-rated and taken from your salary each pay period to fund your account(s). Then, when you incur an eligible expense, you submit a Flexible Spending Account claim form with proof of your expense. Once your request has been processed, the expenses will be deducted from the appropriate account(s) and a reimbursement check will be sent to your home or deposited to your Bank Account.

**Estimate Expenses Carefully**

It is important that you estimate your expected eligible expenses accurately, because the Internal Revenue Service has certain requirements that affect you and your spending account(s).

Claims for expenses must be for services you receive when your spending account is in effect. For example, if you begin a spending account on September 1 and continue your participation until December 31, only expenses incurred from September 1 through December 31 are eligible for reimbursement. You will forfeit any unused amounts remaining in your account at the end of the calendar year. This is commonly known as the “use-it-or-lose-it” rule. All claims incurred during the plan year must be submitted within 3 months after the close of the year (e.g., claims must be postmarked by March 31 for services incurred in the prior calendar year).

Amounts reimbursed from your spending account(s) cannot also be claimed as federal income tax deductions or credits. This is because these amounts are already being reimbursed with pre-tax dollars.

Amounts in your HCSA cannot be used to reimburse DCSA expenses and vice versa.

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\(^1\) Only applies if your Domestic Partner is your Tax-Qualified Dependent.
EFFECT ON SOCIAL SECURITY AND OTHER BENEFITS

Your participation in the TSP and/or in a spending account may have a slight effect on your Social Security benefits. This is because your pre-tax contributions lower the amount of your taxable earnings, which is the amount on which your Social Security benefits are based. Your Social Security benefits may be reduced, but in most cases this reduction (if any) will be very small. If your taxable income (after the reduction for your spending account contribution) is greater than the Social Security Taxable Wage Base, there will be no effect on your future Social Security retirement benefits.

Your other pay-based benefits (such as retirement, vacation, group life insurance and LTD) will still be based on your Regular Salary.

Tax Laws

The terms and provisions of the Tax Savings Plan and the spending accounts are based on current tax laws. Tax laws or regulations could reduce some of the tax savings and/or may require modification to the plans by the Plan Administrator (see page 8.23).

ENROLLMENT

Tax Savings Plan

Benefit-Based Employees automatically participate in the Tax Savings Plan when they enroll in either medical or dental coverage provided under the Caltech benefits program sponsored by the Institute. This means any contributions will automatically be deducted from your pay on a pre-tax basis. Benefit-Based Employees may elect to waive participation in the TSP and make contributions on an after-tax basis. The waiver of participation in the TSP must be made within 31 days of becoming a Benefit-Based Employee or during the annual Enrollment Period. If you participate in the TSP, you may not make a change in election until the next Annual Enrollment Period unless you have a qualifying Change in Status or other IRS-recognized event permitting a mid-year election change (see below).

Please note that you cannot pay for coverage on a pre-tax basis for Domestic Partners who are not otherwise your Tax-Qualified Dependents as defined under Internal Revenue Code Section 125. Contributions for their medical and dental coverage can be made pre-tax for the State of California but after-tax for Federal taxation. Any employer provided coverage for a non-IRS tax dependent is subject to imputed income.

Spending Accounts

In order to participate in one or both of the spending accounts, you must enroll within 31 days of becoming a Benefit-Based Employee, during the Annual Enrollment Period or within 31 days of a Change in Status or other IRS recognized event (see page 6.3). You may not submit claims for reimbursement under the spending accounts for a Domestic Partner who is not your Tax-Qualified Dependent.

CHANGE IN STATUS EVENTS

Outside of Annual Enrollment period, you may add or delete Dependents to your current medical, dental and vision plans, start or stop contributions under the medical, dental and vision plans, and start, stop or change your contributions under one or both of the spending accounts during the plan year only within 31 days of a Change in Status Event or other IRS-recognized event or if you experience a different event permitting a new mid-year election change. The effective date of any changes is subject to individual plan provisions. Read each section carefully to determine election changes that are permitted following a Change in Status Event.
The following Change in Status Events and other IRS events are recognized under the plan:

- **Change in legal marital status** — marriage, death of Spouse or Domestic Partner, divorce, legal separation, termination of Domestic Partnership or annulment.

- **Change in the number of your Dependents** — birth, Adoption, placement for Adoption, death, or change in legal custody or a change in your relationship with your Spouse or Domestic Partner.

- **Change in your or your Spouse’s, or Domestic Partner’s employment status that impacts eligibility for benefits** — termination or beginning employment, beginning or returning from an unpaid leave of absence, or other event (e.g., salaried to hourly, full time to part time, change in worksite).

- **Change in Dependent’s eligibility** — age, Tax-Qualified Dependent status or other similar eligibility criteria.

- **Change in residence that impacts benefit eligibility** — you move outside of an HMO/DMO service area [NOTE: This does not apply to an election change with respect to the HCSA or DCSA.]  

- **Judgment, decree, court order, or Qualified Medical Child Support Order (QMCOSO)** — court-ordered medical and dental coverage for your legal Dependent children. You may also make a corresponding election change for HCSA.

- **HIPAA special enrollment events** — adding group medical or dental plan coverage following loss of other medical or dental coverage or acquiring a new Spouse, Domestic Partner or Dependent through marriage, formation of Domestic Partnership, birth or Adoption (see page 2.9).

- **Significant cost or coverage changes** — increase or decrease in cost charged to Benefit-Based Employees; new benefit option introduced during the plan year; substantial decrease or change in network providers; significant reduction in a benefit plan option. Also includes an open enrollment period of your Spouse’s or Domestic Partner’s employer plan, if applicable, that is at a different time than this plan. [NOTE: This does not apply to an election change with respect to the HCSA (or on account of a change in cost or coverage under the HCSA).]

- **Change due to entitlement (or loss of entitlement) to Medicare or Medicaid** — If you, your Spouse, Domestic Partner or a covered Dependent becomes entitled to Medicare or Medicaid (i.e., becomes enrolled), you may drop or reduce coverage for that individual. If you are participating in the health care spending account (HCSA), you may stop making contributions to your HCSA account. If you, your Spouse, Domestic Partner or a Dependent loses entitlement to Medicare or Medicaid, you may enroll or increase coverage for that individual (and yourself) in the plan. [NOTE: This does not apply to an election change with respect to the DCSA.]  

- **Changes consistent with taking leave under the Family and Medical Leave Act (FMLA)** — If you take leave under the FMLA, you may revoke your election under the plan and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.
If applicable, the events listed on the previous page qualify as Change in Status Events or other IRS recognized events permitting mid-year election changes only if they result in your or your Spouse’s, Domestic Partner’s or Dependent’s gain or loss of eligibility under the Caltech or other employer plan. Note that financial hardship is **not** a qualified Change in Status event. You cannot use financial hardship as a basis to request a change in your election.

In addition, if applicable any changes you wish to make to your coverage must be on account of **and** correspond with the Change in Status Event (such as requesting Dependent coverage for your Spouse if you get married), **and** must be made within 31 days of the Change in Status Event. You will **not** be permitted to switch from one plan to another, unless the switch is required due to a change in residence or unless you make an election change under a HIPAA Special Enrollment Event. A Change in Status Event becomes effective on the first of the month coincident with or next following the date of the event except that additions to medical coverage due to a birth or Adoption will become effective as of the date of birth or Adoption (see page 2.9).

If you have a Change in Status Event or other IRS-recognized event that permits you to make a change in coverage, you should contact the Campus or JPL Benefits Office immediately to obtain the appropriate forms and determine allowable coverage changes you can make.

If you waived participation in the Tax Savings Plan and pay for your coverage on an after-tax basis, the rules in this section do not apply to your election changes. For example, you may cancel medical and/or dental coverage at any time but reenrollment in these plans is limited to annual enrollment or in the case of HIPAA Special Enrollment Event described on page 2.9. Contact the Campus or JPL Benefits Office for more information.
HEALTH CARE SPENDING ACCOUNT ELIGIBILITY

Benefit-Based Employees are eligible to use the HCSA. You may submit eligible expenses incurred by any of your Tax-Qualified dependents as long as the expenses are not covered or reimbursed by the Institute’s or any other medical or dental plans.

**Automatic Reimbursement Feature For Anthem Blue Cross Members**

Because our Spending Account Administrator, UniAccount, is part of the Anthem Blue Cross family, certain eligible health care expenses can be automatically reimbursed without submitting claim forms:

- Anthem Blue Cross PPO participants who elect to participate in a HCSA can be reimbursed automatically for most out-of-pocket medical expenses, including office visit copays, deductible and coinsurance payments, and prescription drug copays;

- Anthem Blue Cross HMO participants can be reimbursed automatically for prescription drug copays.

You will still need to submit a claim for reimbursement of Anthem Blue Cross HMO office visit copays and all other eligible expenses.

CONTRIBUTION LIMITS

If you choose to participate in the HCSA, you will decide how much to contribute, subject to the HCSA plan minimum, $120; or a maximum, $2,500 per year.

You will be reimbursed from the HCSA for eligible expenses up to your annual elected contribution (minus any prior reimbursements), even if this exceeds your account balance at the time of the reimbursement.

FILING SPENDING ACCOUNT CLAIMS FOR REIMBURSEMENT

Claim forms are available in the Campus or JPL Benefits Office. Include appropriate receipts with the claim form and mail to UniAccount for reimbursement. (See claim form for filing and mailing instructions.)

For HCSA claims, expenses must be incurred while you are a plan participant and during the calendar year. Expenses paid for or reimbursed by another employer or program are not eligible for reimbursement through the spending account(s).

All claims for health care and/or dependent care expenses incurred prior to the end of the calendar year must be postmarked by March 31 of the following year or they will not be reimbursed. You will receive a statement prior to the end of the year showing your reimbursements and your account balance.

If you have any questions about the status or filing of your claims, call UniAccount at 1-888-209-7976.
HOW TO ESTIMATE YOUR HCSA CONTRIBUTION

Consider your family’s recent and future expected health care expenses. Use the worksheet below to help you estimate your calendar year expenses and the amounts to be deposited into your HCSA. Review the list of eligible expenses on page 6.7 and identify any expenses you anticipate for the year. Review your and your Dependent’s medical and dental plans to determine what will be covered and what you might expect to pay yourself.

Planning Your Health Care Expenses Worksheet

Here is a worksheet to help you estimate what your eligible health care expenses would be for the plan year. See page 6.7 for a list of eligible health care expenses.

<table>
<thead>
<tr>
<th>OUT OF POCKET EXPENSES*</th>
<th>ANNUAL AMOUNT**</th>
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<tbody>
<tr>
<td>Deductibles and Copayments (medical and dental)</td>
<td>__________________</td>
</tr>
<tr>
<td>Routine Physical Exams (covered at 100% in-network)</td>
<td>__________________</td>
</tr>
<tr>
<td>Well Baby Care (covered at 100% in-network)</td>
<td>__________________</td>
</tr>
<tr>
<td>Vision Exams</td>
<td>__________________</td>
</tr>
<tr>
<td>Purchase of Glasses/Contact Lenses</td>
<td>__________________</td>
</tr>
<tr>
<td>Hearing Care</td>
<td>__________________</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>__________________</td>
</tr>
<tr>
<td>Dental/Orthodontia</td>
<td>__________________</td>
</tr>
<tr>
<td>Other</td>
<td>__________________</td>
</tr>
<tr>
<td><strong>ANNUAL TOTAL</strong></td>
<td></td>
</tr>
</tbody>
</table>
# HCSA Eligible Expenses

## Examples of Eligible Health Care Expenses

The following list identifies some of the common medical and health related expenses that the Internal Revenue Service considers to be reimbursable medical expenses. These expenses are eligible for reimbursement through your HCSA provided that you have not been reimbursed from any other benefits plan. Expenses are deemed to be incurred on the date you (or your Dependent) receives the medical care, not on the date you are billed or charged for it, or pay for it. Allowable HCSA expenses include, but are not limited to:

<table>
<thead>
<tr>
<th>Eligible Expense</th>
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<th>Eligible Expense</th>
</tr>
</thead>
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<td>Eye examination</td>
<td>Prescription drugs, legal</td>
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<td>Eye glasses</td>
<td>Prostheses</td>
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<td>Guide dog and its upkeep</td>
<td>Rental of medical equipment</td>
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<td>Birth control pills</td>
<td>Hearing exams, aids or batteries</td>
<td>Smoking cessation programs</td>
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<td>Capital expenses for:</td>
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<td>Substance abuse treatment</td>
</tr>
<tr>
<td>Home improvements*</td>
<td>Laboratory fees and diagnostic testing</td>
<td>Surgery</td>
</tr>
<tr>
<td>Special equipment installed in the home or car* *(if the main reason for the</td>
<td>Laser eye surgery</td>
<td>Special schooling and equipment for physically or mentally handicapped (if</td>
</tr>
<tr>
<td>improvement or equipment is for medical care, but only to the extent the</td>
<td>Mental health treatment</td>
<td>recommended by a doctor</td>
</tr>
<tr>
<td>expenditure exceeds any increase in the improved property’s value)</td>
<td>Nursing services</td>
<td>Wheelchair</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Nursing home (for medical reasons)</td>
<td>X-ray fees</td>
</tr>
<tr>
<td>Christian Science practitioners (for medical care)</td>
<td>Organ transplant expenses</td>
<td></td>
</tr>
<tr>
<td>Contact lenses</td>
<td>Prescription drugs for a normal, healthy newborn baby</td>
<td></td>
</tr>
<tr>
<td>Crutches</td>
<td>Marriage counseling</td>
<td></td>
</tr>
<tr>
<td>Dental treatment (including orthodontia)</td>
<td>Over-the-counter drugs used to promote general wellness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over-the-counter drugs used to treat a specific illness or injury, if not</td>
<td></td>
</tr>
<tr>
<td></td>
<td>prescribed by a physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal use items like cosmetics, toiletries, and items for personal hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schooling or tuition for scholastic improvement or discipline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social activities like dancing or swimming lessons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special foods or dietary supplements like vitamins, minerals, bottled water,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teeth whitening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transportation for nonmedical reasons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trips or vacations</td>
<td></td>
</tr>
</tbody>
</table>

Refer to the IRS Publication 502, Medical and Dental Expenses for more specific information on eligible health care expenses. However, some expenses that are considered allowable medical expenses in Publication 502 are not reimbursable under the HCSA (e.g., long term care expenses and any insurance premiums). To request IRS Publication 502, call 1-800-829-3676, or go on line to [http://www.irs.gov/pub/irs-pds/p502.pdf](http://www.irs.gov/pub/irs-pds/p502.pdf).
DEPENDENT DAY CARE SPENDING ACCOUNT

ELIGIBILITY

Benefit-Based Employees are eligible to use the DCSA. If you are married, your Spouse or Domestic Partner must either work, be a full-time student, or be physically or mentally Disabled in order for expenses to be eligible for reimbursement from the DCSA. Expenses must be incurred to enable you and your Spouse or Domestic Partner (if applicable) to work or look for work, or for your Spouse or Domestic Partner to attend school full-time (i.e. at least 5 months during the year) while you work. Additionally, eligible dependent day care expenses include expenses that you incur to allow you to work while your Spouse or Domestic Partner is mentally or physically disabled and is in need of care or is unable to provide care for a Dependent. Your and your Spouse’s or Domestic Partner’s work can be done for others or in your own business. It can be either full-time or part-time. However, it doesn’t include volunteer work.

You must also have “qualifying individuals” for whom you will incur eligible dependent care expenses. Qualifying individuals include:

- A child under the age of 13* (a “qualifying child” under the Internal Revenue Code) who meets all of the following requirements:
  I. Is either your child (including a step, adopted and foster child) or grandchild, or your brother, sister, stepbrother, stepsister or a descendant of any such relative (e.g., niece or nephew);
  II. Resides with you for more than one-half of the taxable year, and
  III. Does not provide over one-half of his or her own support for the calendar year.

- Your disabled Spouse or Domestic Partner who meets all of the following requirements:
  I. Is physically or mentally unable to care for himself or herself and;
  II. Lives with you for more than one-half of the calendar year.

- Any other relative or household member of any age or any other tax Dependent of any age (e.g., an elderly parent, your Spouse, Domestic Partner or older child) who receives more than half their support from you, who is not the “qualifying child” of yours or any other individual and who meets all of the following requirements:
  I. Is physically or mentally unable to care for himself or herself; and
  II. Lives with you for more than one-half of the calendar year.

*If your child turns 13 during the year, you can stop your contributions within 31 days following the child’s 13th birthday.

CONTRIBUTION LIMITS

If you are single, or married filing a joint return, you can set aside up to $5,000 in pre-tax dollars each calendar year into your DCSA. If you are married and file separate returns, you can set aside up to $2,500 a year.

If you choose to participate in the DCSA, you will decide how much to contribute, subject to the DCSA plan minimum, $120; or a maximum, $5,000 per year and IRS limits on what you can defer.

Your annual contribution can never be more than your earned income for the year if you are single or the lesser of your or your Spouse’s or Domestic Partner’s earned income for the year if you are married. In addition, if your Spouse or Domestic Partner is not employed, but is Disabled or a full-time student, your Spouse’s or Domestic Partner’s presumed earned income for each month during which he or she is Disabled or a full-time student is:

- $250 per month if you have one qualifying individual; and
• $500 per month if you have two or more qualifying individuals.

EXPENSES

Only certain expenses are eligible through the DCSA. You should refer to the following list when estimating the amount of your eligible expenses for the year.

Expenses That Are Eligible For Reimbursement

Here is a partial list of IRS-approved Dependent care expenses for which you can seek reimbursement through the DCSA when incurred for qualifying individuals:

• A day care (includes before/after school) center that meets local regulations, provides care for more than six non-residents and receives a fee for such services, whether or not for profit
• Elder/dependent care facility
• Housekeeper, maid, or cook, as long as he/she is also responsible for the well-being and protection of a qualifying individual (including meals and lodging expenses)*
• Babysitters or companions, including your children who have attained age 19 at the end of the calendar year, and other individuals for whom you (or your Spouse or Domestic Partner) cannot claim as exemptions on your federal income tax return*
• Nursery school or preschool (expenses are limited to care of your child and not your child’s education)
• Day camp
• Dependent care services provided outside your home for a Dependent child under age 13, or for any other qualifying individual (e.g., a disabled Spouse, Domestic Partner or older child, an elderly parent), but only if such other qualifying individual spends at least 8 hours a day in your home

*Eligible expenses can include wages and Social Security taxes paid to or on behalf of a caretaker.

Expenses That Are Not Eligible For Reimbursement

• Dependent care provided by your Spouse, Domestic Partner, your children who will be under age 19 at the end of the calendar year (regardless of tax-dependent status), or any other individual who could be claimed as a dependent on your (or your Spouse’s or Domestic Partner’s) federal income tax return
• Dependent care obtained for reasons not related to gainful employment (e.g., a babysitter for you and your Spouse or Domestic Partner to attend a social event; also note that volunteer work is not considered gainful employment)
• Overnight camp
• Any expense for which you deduct or for which you take the Dependent care tax credit on your (or your Spouse’s or Domestic Partner’s) federal income tax return
• Transportation to and from a dependent care location
• Dependent care if your Spouse or Domestic Partner is not employed or is not Disabled or a full-time student
• Dependent care if your Spouse or Domestic Partner is employed, but could provide care because his or her work hours do not coincide with yours
• Dependent care while you are off work because of illness (if applicable)
• Food, clothing, education, entertainment (unless these are small amounts that are incident and cannot be separated from the cost of caring for the qualifying individual),
or transportation to and from the Dependent care location

- Care provided in full-time residential institutions, such as nursing homes and homes for the mentally Disabled

- Education expenses in the first grade or higher. Kindergarten expenses are reimbursable only to the limited extent the expense is for the care of your child, and not your child’s education.

**Maximum Reimbursement**

Under the DCSA, you may be reimbursed for expenses only up to the amount of money you have in your account. If your requested reimbursement exceeds your account balance, the excess will be pended until you make additional contributions.

Here is an example: Let’s say $200 is withdrawn from your paycheck for deposit in a Dependent Care Spending Account (DCSA) in January, and you submit a claim for $300 in January. Only $200 will be reimbursed until additional deposits are made available in the DCSA account.

**ADDITIONAL MID-YEAR CHANGES TO YOUR DCSA ELECTION**

In addition to the Change in Status Events and other IRS-recognized events on page 6.3, the plan allows mid-year changes to your DCSA election if you are already participating in the DCSA as follows:

- Increase/decrease in day care provider fees (except for increases by a day care provider who is related to you)

- Choosing a different day care provider that impacts your cost

- A change in your or your Spouse’s or Domestic Partner’s regular work schedule that increases or decreases the amount paid to a day care provider
DCSA OR TAX CREDIT

The current tax laws provide two means of saving on dependent care expenses: dependent care assistance plans (such as the DCSA) and the federal dependent care tax credit. The tax credit would apply to the same expenses that are eligible for reimbursement through your DCSA. You can take a tax credit on your federal income tax return of 20% to 35% of your eligible dependent care expenses, depending on your adjusted gross income. The amount of the credit offsets your tax liability dollar for dollar. The expenses covered by the credit are limited to a maximum of $3,000 for one qualifying individual and $6,000 for more than one qualifying individual. The credit equals a percentage of your dependent care expenses up to the maximum limit on expenses. The percentage is determined under the chart shown below:

Thus, if your adjusted gross income is $30,000 and you have $5,000 in dependent care expenses for one child, your tax savings under the tax credit method would be 27% of $3,000, or $810 (see chart below). The $3,000 figure is the maximum amount of dependent care expenses that may be taken into account under the tax credit method if you have one child.

You may be able to use both approaches, but you cannot take a deduction for the same expenses twice. In addition, each dollar you contribute to the DCSA reduces the total amount of expenses that are eligible for the tax credit (i.e., reduces the $3,000 and $6,000 maximum eligible expense amount). You may want to consult a tax expert for help in determining whether the DCSA is more advantageous than the tax credit, as individual circumstances must be considered.

Refer to IRS Publication 503 for further information, available by request from the IRS by calling 1-800-829-3676 or online at http://www.irs.gov/pub/irs-pdf/p503.pdf. Please note, however, that this plan’s definition of when an expense is “incurred” will control, not the definition in IRS Publication 503. For purposes of this plan, expenses are deemed to be incurred on the date the dependent care is received, not on the date you are billed or charged for it or pay for it.

### Federal Dependent Care Tax Credit

<table>
<thead>
<tr>
<th>Adjusted Gross Income</th>
<th>Percentage of Eligible Dependent Care Expenses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 0 – $15,000</td>
<td>35%</td>
</tr>
<tr>
<td>$15,001 – $17,000</td>
<td>34%</td>
</tr>
<tr>
<td>$17,001 – $19,000</td>
<td>33%</td>
</tr>
<tr>
<td>$19,001 – $21,000</td>
<td>32%</td>
</tr>
<tr>
<td>$21,001 – $23,000</td>
<td>31%</td>
</tr>
<tr>
<td>$23,001 – $25,000</td>
<td>30%</td>
</tr>
<tr>
<td>$25,001 – $27,000</td>
<td>29%</td>
</tr>
<tr>
<td>$27,001 – $29,000</td>
<td>28%</td>
</tr>
</tbody>
</table>
## DEPENDENT DAY CARE SPENDING ACCOUNT

### Adjusted Gross Income vs. Percentage of Eligible Dependent Care Expenses*

<table>
<thead>
<tr>
<th>Adjusted Gross Income</th>
<th>Percentage of Eligible Dependent Care Expenses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$29,001—$31,000</td>
<td>27%</td>
</tr>
<tr>
<td>$31,001—$33,000</td>
<td>26%</td>
</tr>
<tr>
<td>$33,001—$35,000</td>
<td>25%</td>
</tr>
<tr>
<td>$35,001—$37,000</td>
<td>24%</td>
</tr>
<tr>
<td>$37,001—$39,000</td>
<td>23%</td>
</tr>
<tr>
<td>$39,001—$41,000</td>
<td>21%</td>
</tr>
<tr>
<td>$43,001 and over</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Maximum of $3,000 for one qualifying individual, $6,000 for more than one qualifying individual.

### FILING SPENDING ACCOUNT CLAIMS FOR REIMBURSEMENT

Claim forms are available in the Campus or JPL Benefits Office. Include appropriate receipts with the claim form and mail to UniAccount for reimbursement. (See claim form for filing and mailing instructions.)

For DCSA claims, the IRS requires you to provide the name, address, and taxpayer identification number (or social security number) of the dependent care provider. You will need to provide this information on your claim form and on your annual federal tax return.

For DCSA claims, expenses must be incurred while you are a plan participant and during the calendar year. Expenses paid for or reimbursed by another employer or program are not eligible for reimbursement through the spending account(s).

All claims for health care and/or dependent care expenses incurred prior to the end of the calendar year must be postmarked by March 31 of the following year or they will not be reimbursed. You will receive a statement prior to the end of the year showing your reimbursements and your account balance.

If you have any questions about the status or filing of your claims, call UniAccount at 1-888-209-7976.

### TERMINATION OF EMPLOYMENT

If you leave the Institute for any reason (including retirement, Disability, or death), you or your Beneficiary may use your spending account(s) for expenses incurred prior to the end of the month in which you leave. All claims must be filed by March 31 following the end of the calendar year in which you left.

In order to submit HCSA claims for health care expenses incurred after the first of the month following your termination of employment, you must elect COBRA continuation of coverage for HCSA and continue to make contributions on an after-tax basis. You may continue your HCSA participation under COBRA only through the end of the calendar year in which your COBRA...
qualifying event occurs (see page 2.20 in the General Information section for further details on COBRA coverage under the HCSA). COBRA continuation is not available for the DCSA.
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THE BASE RETIREMENT PLAN

The California Institute of Technology Defined Contribution Retirement Plan (the “Plan”) is a Defined Contribution Plan. This plan is often referred to as the Base Retirement Plan. Under this plan benefits are provided through fixed-dollar annuities issued by the Teachers Insurance and Annuity Association (TIAA), variable annuities offered by TIAA’s companion organization, the College Retirement Equities Fund (CREF) and certain mutual funds offered under the Plan. TIAA is an insurance company founded in 1918 and incorporated under New York State Law. CREF is registered with the Securities and Exchange Commission as an open-end diversified investment company.

The Plan operates under Section 403(b) of the Internal Revenue Code and prior to January 1, 2010 used TIAA and CREF Retirement Annuity (RA) contracts and effective January 1, 2010 uses TIAA and CREF Retirement Choice (RC) contracts to provide benefits. The Administrator of the Plan is the Institute. The Plan year begins on January 1 and ends on December 31.

Eligibility

You are an Eligible Employee if you are in an employment category as stated below:

- **Faculty.** A person who holds an Institute appointment as a member of the faculty except those faculty members who are Research Fellows, Part-Time Lecturers, Visiting Associates, and Visitors.

- **Key Staff Employee.** A person who is regularly scheduled to work 20 or more hours per week in any one of the following two categories:
  1. A campus employee promoted to or hired in a classification of:
     - Member of the Professional Staff;
     - Librarian;
     - Associate Librarian;
     - Member of Beckman Institute.
     - Not applicable to JPL employees on and after March 17, 1997.

2. On or after the following effective dates
   - **JPL:** March 17, 1997*
   - **Campus:** First pay period in October 1999**

A Benefit-Based employee (but not a Post Doctoral Scholar) who is receiving Regular Salary (see definition on page 7.5) equal to at least the “Minimum Compensation Level”. The Minimum Compensation Level as indexed is $103,948. as of October 1, 2014.

* If you were an Eligible Employee at JPL, and were considered a Key Staff Employee on March 16, 1997 according to the Plan’s terms in effect at that time, you are a Key Staff Employee (even though in 1997 and later years your Regular Salary is less than the Minimum Compensation Level).

** If you were an Eligible Employee on campus on April 30, 2002 and
(a) were considered a Key Staff Employee in accordance with (1) on page 7.1, and
(b) Regular Salary is less than the Minimum Compensation Level on that date,
you are a Key Staff Employee even though in 2002 and later years your Regular Salary is less than the Minimum Compensation Level.

If any campus employee (other than as described in the preceding paragraph) receives Regular Salary that falls below the applicable Minimum Compensation Level for the year and does not meet the definition in (2) on page 7.1, such employee will participate in the Plan as a Staff Employee until such time as the employee again receives Regular Salary equal to the applicable Minimum Compensation Level.

• **Staff Employee.** A person who meets the definition on page 2.3, is not a Faculty or Key Staff Employee, and is not covered by any other Institute-funded retirement plan. In addition, effective July 1, 2005, a Staff Employee will include a Post Doctoral Scholar (including senior Post Doctoral Scholars) who has completed two (2) years of Eligibility Service except where noted otherwise.

An Eligible Employee does not include (i) any leased employee deemed to be an employee of the Institute as provided in Internal Revenue Code (Code) section 414(n) or (o), (ii) any individual who has not been considered to be, nor treated as, a common law employee of the Institute, including individuals classified by the Institute as independent contractors, and (iii) effective September 1, 1999, any employee whose employment is incidental to being a student.

**Participation**

**Commencement Of Participation**

Eligible Employees will begin participation in this Plan as follows:

• **Faculty.**

Except as provided below, participation in this Plan is mandatory for an Eligible Employee who is a Faculty member. Participation begins on the first working day of the month coincident with or next following the date the employee meets the eligibility conditions.

A Faculty member described below may participate on an optional basis at any time at which he or she is not considered a “highly compensated employee” under the Code and is either:

(1) A Faculty member who is neither a citizen of the United States nor a permanent resident alien; or

(2) Visiting Professorial Faculty.

An election to participate on an optional basis is irrevocable for the individual’s entire period of service with the Institute whether in this classification or under any other Eligible Employee classification under the Plan. Participation on an optional basis begins the first of the month coincident with or next following the date the individual returns a completed Plan enrollment application.
If a faculty member described in (1) or (2) on page 7.2 becomes a “highly compensated employee” and was not participating under the Plan on an optional basis, he or she will participate on a mandatory basis beginning on the first day of the Plan year for which the employee is determined to be a “highly compensated employee.” An employee is a highly compensated employee for 2014 if he or she earned more than $115,000 in 2013 and is among the top 20% paid. The $115,000 may be adjusted annually to reflect cost of living changes in $5,000 increments. The amount applicable for 2014 earnings is $115,000 which will be used to determine if an employee is highly compensated for 2015.

- **Key Staff Employees**

  **New Hires.** Participation of an Eligible Employee who is a Key Staff Employee is mandatory and will begin on the first working day of the month coincident with or next following the date of hire as a Key Staff Employee.

  **Promotions or Attainment of Minimum Compensation Level.** If a Staff Employee who is not a Postdoctoral Scholar is promoted to Key Staff Employee status or reaches the Minimum Compensation Level, his or her participation will begin as of the first of the month coincident with or next following the effective date of promotion or reaching the Minimum Compensation Level.

  However, if a Staff Employee under age 55 is promoted to a Key Staff classification or level, or reaches the Minimum Compensation Level and such employee is considered a “nonhighly compensated employee” under the Code, he or she may elect to remain in the Staff Employee eligible class of employees for purposes of the Plan. When initially promoted to key staff or reaching the MCL, the election to remain in the Staff Employee eligible class must be made within 15 business days of their notification of the change. Any election to remain in the Staff Employee eligible class remains in effect even if the employee has a salary increase taking him/her above the HCE threshold, until the first of the month coincident with or next following the employee’s 55th birthday, on which date the employee will participate in the Plan as a member of the Key Staff Employee eligible class provided he/she still satisfies the definition of Key Staff Employee.

- **Staff Employees.**

  Effective January 1, 2001, participation in this Plan is mandatory for an eligible Staff Employee (excluding Postdoctoral Scholars as described below) who has completed six months of Eligibility Service. Participation for someone in this class will begin the first of the month coincident with or next following the later of (i) the date the Staff Employee completes six months of Eligibility Service or (ii) the date he or she becomes a member of the Staff Employee eligible class.

  Effective July 1, 2005, participation in this plan is mandatory for an eligible Post Doctoral Scholar, who has completed two (2) years of Eligibility Service. Participation will begin on the first of the month coincident with or next following the later of (i) the date the Postdoctoral Scholar completes twenty-four months of Eligibility Service or (ii) the date he or she becomes a Postdoctoral Scholar.

  Your Eligibility Service is a period of service with the Institute during which you complete 1 hour of service. All time periods are combined, beginning with your date of employment and ending on your “severance from service date” (and beginning on any following date of reemployment and ending on your next “severance from service date”). Fractional periods of a year are expressed in terms of days. Thirty days are considered to be one month in the case of aggregation of fractional months.

  Your “severance from service date” is:
PARTICIPATION

(A) the date you retire, quit, die, or are discharged. However, if you are reemployed within 12 months of such date, the period of absence will be treated as service; or

(B) the first 12-month anniversary of the date you are first absent from service for any other reason (other than a paid leave or a disability leave), or the date within such 12-month period that you quit, are discharged, die, or retire. However, if you are reemployed within 12 months of the first day of absence, the period of absence will be treated as service. In determining Eligibility Service, paid leaves or disability leaves are treated as service. Eligibility Service will also include all periods after your initial date of employment during which you worked in a student or postdoctoral scholar position whether or not your wages were subject to FICA taxes.

The Institute will notify you when you have completed the requirements necessary to participate in the Plan. All determinations about eligibility and participation will be made by the Institute. The Institute will base its determinations on its records and the official Plan document on file with the Plan Administrator. Each Eligible Employee must complete their enrollment in the Plan.

Your participation in the Plan will continue until the earlier of the date you are no longer an Eligible Employee or the date the Plan is terminated.

Election Not To Participate

Within 30 days of first becoming eligible to participate in the Plan, you may make a written election not to participate. However, once made, your election cannot be revoked and applies to your entire service with the Institute.

Participation Upon Reemployment

If you are an Eligible Employee who has met the eligibility requirements for participation under the Plan, you will participate immediately upon reemployment as an Eligible Employee, unless you had previously irrevocably elected not to participate under the Plan. If you have begun income payments prior to reemployment you may be required to stop payments depending on the type of income you selected. Contact TIAA-CREF for information regarding your retirement account.

Participation During An Approved Leave Of Absence

During a paid leave of absence, the Institute’s contributions on your behalf and your contributions will continue, based on your rate of pay, the Minimum Compensation Level, and the Social Security Wage Base in effect at the time your leave begins. See the following paragraphs regarding leaves of absence for qualified military service or disability.

During an unpaid leave of absence granted for any reason other than qualified military service or disability both Institute and Participant Plan Contributions will stop.

Participation In The Event Of Military Leave

The Institute (Caltech/JPL) supports calls to military training and active duty and complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. Eligible employees may qualify for paid leave, unpaid leave, or a combination of paid and unpaid leave, continuation of benefits and reinstatement. Effective January 1, 2009, during a period of qualified military service, the Institute will continue making Institute contributions, based on your rate of pay in effect on the last day worked and taking into account the Minimum Compensation Level and the Social Security Taxable Wage Base on that date. Employees also have the opportunity to make mandatory and/or voluntary contributions during an unpaid military leave. For a complete description of the Institute’s policies for military leaves, please contact the Benefits Office for a copy of the policy.
Participation In The Event Of Disability

If you become Disabled (as defined by the Institute), the Institute will continue to make contributions on your behalf while you are disabled until the end of your sixth month of leave or when your paid leave status ends, whichever is later.

Contributions for Faculty and Key Staff Employees will be based on the Regular Salary you were receiving and the Social Security Taxable Wage Base in effect at the time you became disabled. Contributions for Staff Employees will be based on the rate of pay you were receiving at the time you became disabled.

Plan Contributions

Beginning January 1, 2010 when you begin participation in the Plan, contributions will be made to a Retirement Choice contract with TIAA-CREF. The contributions are based on a percentage of your pay and a contribution schedule. If you participate in the Plan for only a part of a year, your allocation will be based on the portion of salary applicable to the period in which you participate. Plan contributions by you are made on a pre-tax (salary reduction) basis.

For Faculty and Key Staff Employees:

Institute Contributions

Before age 55: The Institute will contribute 8.3% times your annual Regular Salary up to the Social Security taxable wage base, plus 14% of your annual Regular Salary above the Social Security taxable wage base, $117,000 for 2014.

After age 55: Beginning with the first of the month coincident with or next following your 55th birthday, the Institute will contribute 12.3% of your annual Regular Salary up to the Social Security taxable wage base, plus 18% of your salary above the Social Security taxable wage base, $117,000 for 2014.

Regular Salary

For Faculty, “Regular Salary” means the salary stated in the academic year contract. For Key Staff Employees, “Regular Salary” means salary (including a regular salary increase which is paid in a lump sum) exclusive of benefits, overtime, bonuses, commissions, extended work week compensation, per diems, shift differential, field rate bonuses, flight bonuses, offset service pay, and similar pay. Regular Salary includes any differential wage payments made during a period of qualified military service. Regular Salary excludes all compensation paid after severance of employment, except as permitted under Code Section 415.

Regular Salary includes, in the case of a Faculty member or Key Staff Eligible Employee, the lump sum payment, if any, paid under the Institute’s Early Retirement Option. In addition, for terminating or retiring Key Staff Employees, Regular Salary shall include any amounts paid under a separation and/or severance program (to the extent such amounts are paid on or before the employee's date of termination) and any unused vacation pay.

In no event will the Regular Salary taken into account under the Plan exceed the limits of Code Section 401(a)(17). (The limit for 2014 is $260,000. This amount is adjusted under the Code to reflect cost of living increases.)

For the purposes of determining whether or not Regular Salary exceeds the Minimum Compensation Level, a participant’s hourly rate of pay (a regular salary increase which is paid in a lump sum is excluded when determining a participant’s hourly rate) is compared to the equivalent Minimum Compensation Level hourly rate. The equivalent Minimum Compensation Level hourly rate is determined as follows:
• The annual Minimum Compensation Level is converted to a full-time weekly salary rate and truncated to whole dollars, and

• This weekly salary rate is converted to an hourly rate assuming a full-time workweek.

**Faculty and Key Staff Participant Contributions**

You pay 5.7% of your annual Regular Salary, which is in excess of the Social Security taxable wage base.

Participant Contributions will be divided evenly over the year and will not be limited to the period you are not paying Social Security taxes.

However, Participant Contributions will not be required for the following amounts:

• A Regular Salary increase which is paid in a lump sum instead of being paid throughout the year if before the increase, your Regular Salary was not in excess of the Social Security taxable wage base and you were not already making Participant Contributions; and

• Lump sum payments made under the Institute’s Early Retirement Option (effective January 1, 2005 the ERO benefit is discontinued for executive and senior management).

The Social Security taxable wage base means the contribution base on which the Old-age, Survivors, and Disability Insurance (OASDI) portion of your Social Security taxes are determined. For 2014, the Social Security taxable wage base is $117,000.

**Adjustment to contribution rates if Social Security tax rates increase:** The Social Security tax rate for old age benefits is considered to be 5.7%. This rate has been in effect for many years and may be adjusted. If this Social Security tax rate changes, the contribution rates described above will be adjusted as follows:

• Before age 55, the 8.3% Institute contribution rate on annual Regular Salary up to the Social Security taxable wage base will equal 14% minus the new Social Security tax rate.

• After age 55, the 12.3% Institute contribution rate on annual Regular Salary up to the Social Security taxable wage base will equal 18% minus the new Social Security tax rate.

• Employee contribution percentages will change to equal the new Social Security tax rate.

**For Staff Employees and Postdoctoral Scholars**

**Institute Contributions**

<table>
<thead>
<tr>
<th>Completed Years of Service</th>
<th>Plan Contribution Percentage*</th>
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</thead>
<tbody>
<tr>
<td>Six months (two years for Postdoctoral Scholars**) but less than ten years</td>
<td>5.0%</td>
</tr>
<tr>
<td>Ten or more, but under age 50</td>
<td>8.0%</td>
</tr>
<tr>
<td>Ten or more, and age 50 or older</td>
<td>12.0%***</td>
</tr>
</tbody>
</table>

* Plan Contribution Percentages are effective the first of the month after an Eligible Employee’s completion of full Years of Service as described above.

** Fellowship stipends distributed by Caltech are not considered “salary” eligible for Institute contributions.

*** An Eligible Employee must be at least age 50 and have 10 or more Years of Service with the Institute. The stated Plan Contribution Percentage is effective the first of the month following an Eligible Employee’s 50th birthday or completion of 10 Years of Service, whichever is later.

**Staff Retirement Plan Earnings**

Effective January 1, 2002, “Retirement Plan Earnings” means W-2 wages for the period plus pre-tax contributions made to an eligible plan of deferred compensation (such as pre-tax contributions for medical/dental benefits, TDA contributions, etc.). In the event a participant is receiving Short Term or Long Term Disability benefits, Institute contributions are based on the Participant’s rate of pay in effect at the time of Disability. During a period of qualified military service, Institute contributions are based on the
Participant’s rate of pay in effect on the last day worked. Retirement Plan Earnings excludes all compensation paid after severance of employment, except as permitted under Code Section 415.

Determining Years Of Service For Purposes Of Institute Contributions For Staff Employees and Postdoctoral Scholars

Eligibility Service is used to determine a Staff Employee’s initial eligibility to participate in the Plan and is defined on page 7.3.

A Staff Employee’s Years of Service are used to determine Institute contributions to the Plan. Years of Service are credited for the following periods of employment with the Institute in an Eligible Employee classification. (See page 7.1 for a definition of Eligible Employee.)

Years of Service include the following periods of service as an Eligible Employee:

- Up to six months of Eligibility Service completed before the Staff Employee became a Participant. However, if a Staff Employee becomes eligible for the Plan on or after July 1, 2005 and had previous service as a Postdoctoral Scholar, service as a Postdoctoral Scholar will be included up to a maximum of two years.

- Up to two years of Eligibility Service completed before a Postdoctoral Scholar became a Participant. However, for those Postdoctoral Scholars who become participants on July 1, 2005, Years of Service shall be defined by the Plan as of July 1, 2005 without regard to the two year limitation.

- The period beginning with the date the Staff Employee or Postdoctoral Scholar becomes a Participant in the Plan and ending on the Severance from Service Date. After July 1, 2005, Years of Service will also include all periods after the eligible employee’s initial date of employment during which he/she worked in a postdoctoral scholar position whether or not wages were subject to FICA taxes; and

- Any subsequent period beginning on a reemployment date and ending on a Severance from Service Date.

A Year of Service is credited for each 12-month period of service described above. Fractional periods of service are expressed in terms of days. Thirty days are considered to be one month in the case of aggregation of fractional months.

The “severance from service date” for this purpose is:

- the date the Staff Employee retires, quits, dies or is discharged; or

- the first 12-month anniversary of the date he or she is first absent from service for any other reason (other than a paid leave or a disability leave), or the date within such 12-month period that he or she quits, is discharged, dies or retires

In determining Years of Service, paid leaves or disability leaves lasting longer than 12 months are treated as service.

Limitations On Contributions

The total amount of contributions made on your behalf for any year will not exceed the limits imposed by Sections 402, 403, and 415 of the Internal Revenue Code. These limits may be adjusted from time to time. For more information on these limits, contact TIAA-CREF.

When Contributions Are Made

Contributions will be forwarded to the funding vehicles at least monthly.

Vesting Of Contributions

You are fully and immediately vested in the benefits arising from contributions made to your accounts under RC and RA annuity contracts. Such amounts are nonforfeitable.
Investment Options

Effective January 1, 2010, a wider range of investment options are available to help you achieve your retirement savings goals. You can simplify your decision-making process by choosing one of TIAA-CREF’s Lifecycle Funds – model portfolios targeted to your anticipated year of retirement which automatically rebalance to become more conservative as you move closer to that date. Or you can build your own portfolio with investment choices in the essential asset classes you need: equities (stocks), fixed income (bonds), guaranteed, real estate and money market.

It is intended that the Plan qualify as a participant directed account plan under ERISA Section 404(c). In selecting funds for the main investment options, Caltech’s objective is to offer competitive choices and top-quality funds to Caltech employees. Caltech will periodically review the main investment menu to ensure that the available funds continue to help employees reach their retirement goals. The Institute’s current selection of investment funds is not intended to limit future additions or deletions. You will be notified of any additions or deletions. See next page for the Investment Menu as of February 6, 2014. For the latest Investment Menu go to [www.tiaa-cref.org/caltech](http://www.tiaa-cref.org/caltech) click on Plan and Investments tab, then click on plan and investment choices.
## Investment Menu

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<th>ACCOUNT/FUND NAME</th>
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<td>Wells Fargo Advantage Emerging Growth I</td>
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<td>Vanguard Extended Market Idx Inst</td>
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<td>Dodge &amp; Cox Stock Fund</td>
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<td></td>
<td>Matthews Asia Growth Fund Instl</td>
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<tr>
<td></td>
<td>Vanguard Total Intl Stock Index</td>
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</tbody>
</table>
Allocating Contributions Among Available Investment Options

You may allocate contributions among the TIAA Traditional Annuity, TIAA Real Estate, the CREF Accounts or any available mutual funds in any whole-number percentage. You specify the percentage of contributions to be directed to each investment option when you begin participation and enroll online in the Retirement Choice contracts at www.tiaa-cref.org/caltech.

One-Stop Investing: Life Cycle Funds

If you’re uncertain about selecting specific investments for your own portfolio, you can direct your contributions to a TIAA-CREF Lifecycle Fund. Lifecycle funds are based on the idea that most retirement investors share a common characteristic: the longer they have to save before retirement, the more aggressively they can afford to invest in order to capitalize on the potential for growth. Conversely, as the actual retirement date gets closer, the investment strategy becomes more conservative to provide more stability and less potential for dramatic changes in the retirement account balance.

Each Lifecycle Fund has a different “target date” – the year that the investor expects to retire. The funds combine different types of assets with underlying funds that invest in various stocks, bonds, and money market instruments – starting off with an asset allocation generally considered appropriate for investors at a particular stage of retirement planning. The objective of lifecycle funds is to achieve the highest possible returns while minimizing potential risks. (Please keep in mind that there is no guarantee that this objective will be met.) Over time, the funds are readjusted by professional investment managers to maintain an appropriate balance of various assets as you move through your career and into retirement.

Build Your Own Portfolio

Alternatively, you can choose to create your own portfolio. Please refer to the chart on page 7.9 for a list of all the funds available to you under the Plan. The menu features a wide range of funds in different asset classes from a variety of companies – with funds representing varying degrees of investment risk. Risk is tied directly to rewards – the more risk you’re willing to take, the greater the potential for gains, as well as for losses.

Using Annuities in Your Retirement Planning

The Plan’s investment options include several annuity accounts that are available through contracts issued by TIAA or CREF. Unlike mutual funds, annuities offer a variety of ways to receive income in retirement, including lifetime income and cash withdrawals. To learn more about how you can take income in retirement, please visit www.tiaa-cref.org/caltech, click on “Plans and Investments”, choose the “Caltech Institute Base Plan” on the right side of the page.

How Your Contributions are Invested if You Do Not Provide Investment Direction

The Plan’s default investment option for a Participant who does not make an affirmative investment election is the lifecycle fund that corresponds to an assumed retirement date falling closest to the Participant’s 65th birthday.

Changing How Your Future Contributions are Invested

You may change your allocation of future contributions after participation begins by modifying your investment elections online, by calling TIAA-CREF’s Automated Telephone Service (ATS) or TIAA-CREF’s Telephone Counseling Center. Please refer to the Tools and Resources section for more detail on alternative contact methods.

Contributions To TIAA and CREF Retirement Choice Contracts

TIAA: Contributions to a TIAA Traditional Annuity are used to buy a contractual or guaranteed amount of future retirement benefits for you. Once purchased, the guaranteed benefit of principal plus interest cannot be decreased, but it can be increased by dividends. Once you begin
receiving annuity income, your accumulation will provide an income consisting of the contractual, guaranteed amount plus dividends that are declared each year and which are not guaranteed for the future. Dividends may increase or decrease, but changes in dividends are usually gradual.

**TIAA Real Estate:** The TIAA Real Estate fund seeks favorable long-term returns primarily through rental income and appreciation of real estate investments owned by the account. The account also invests in publicly traded securities and other investments that are easily converted to cash to make redemptions, purchase or improve properties or cover other expenses.

**CREF:** You have the flexibility to accumulate retirement benefits in any of the CREF variable annuity accounts approved for use under the Plan. Each account has its own investment objective and portfolio of securities. Contributions to a CREF account are used to buy Accumulation Units, or shares of participation in an underlying investment portfolio. The value of the Accumulation Units changes each business day. For more information on the CREF accounts, you should refer to the CREF prospectus.

For a recorded message of the current interest rate for contributions to TIAA Traditional or the latest Accumulation Unit Values for the CREF Accounts and the seven-day yield for the CREF Money Market Account, call 1-800-842-2776 or access the TIAA-CREF Web site on the Internet at [http://www.tiaa-cref.org](http://www.tiaa-cref.org). The recording is updated each business day.

Amounts contributed prior to 2010 remain in your Retirement Annuity (RA) contracts until you elect to transfer funds to any of the new investment funds.

**Objective Guidance, Planning and Advice**

TIAA-CREF, as the Plan’s single administrative services provider, offers a number of services to help you as you evaluate your investment options. For example, if you want help developing your own portfolio, TIAA-CREF can provide you with examples of model portfolios you can use as a guideline. All you need to do is determine what kind of investor you are – what your goals are, how long you have to invest, and how you feel about taking investment risk. You can answer the TIAA-CREF Asset Allocator questionnaire online to identify your risk tolerance profile and view a sample portfolio that matches your profile.

In addition, TIAA-CREF’s noncommissioned consultants are committed to helping you make the best decisions for your financial future. TIAA-CREF consultants are available to help you understand your investment choices and make your selections. You can also choose to receive personalized investment advice that provides objective fund recommendations for your retirement portfolio based on your goal and investment time horizon, and tolerance for risk. Please refer to the Tools and Resources section for information on how to sign up for an individual appointment.

**Transferring Accumulations In the Plan**

Accumulations may be transferred among the CREF Accounts, the TIAA Real Estate Account and the available mutual funds. Accumulations may be transferred to the TIAA Traditional Annuity. Complete transfers may be made at any time. Partial transfers may be made from any of the available investment options to the TIAA Traditional Annuity or among any of the available investment options at any time. Transfers from CREF Accounts, TIAA Real Estate Account and the available mutual funds must be at least $1,000 each time (except for systematic transfers which must be at least $100 each time), or your entire accumulation, whichever is less. Transfers made as a percentage must also meet the dollar minimums. Transfers from TIAA Real Estate Account are limited to once per calendar quarter. TIAA-CREF can place limits on transfers in the future. Transfers may be made until the date annuity income begins. There is no charge for transferring accumulations among the available investment options.
TIAA Traditional accumulations in RC contracts may be transferred to any of the CREF Accounts, TIAA Real Estate or any of the available mutual funds in substantially equal monthly amounts over a period of 84 months (7 years). Such transfers are subject to the terms of that contract. The minimum transfer from TIAA to a CREF account is $10,000 (or the entire accumulation if it totals less than $10,000).

Alternatively, if your total TIAA Traditional accumulation is $2,000 or less, you can transfer your entire TIAA accumulation in a single sum to any of the CREF Accounts.

Your RC contract stays open as long as you have an accumulation remaining in TIAA, in one of the CREF Accounts or any of the available mutual funds.

For contributions made prior to 2010 that continue to remain in the Retirement Annuity (RA) contract (until you elect to transfer funds to investment funds offered under your RC contract), slightly different transfer rules apply. Please refer to the chart on page 7.13, which compares the features of Retirement Annuity contracts (for contributions made prior to 2010) to those of Retirement Choice contracts (for contributions made after 2009).

You may complete fund transfers or change the investment of your ongoing contributions online, by phone, or in writing. Please see Tools And Resources for more detailed contact information. Transfers, as well as contribution allocation changes, will be effective as of the close of the New York Stock Exchange (usually 4:00 p.m. Eastern time) on the day the instructions are received by TIAA-CREF.

Information Regularly Furnished About Your Account

TIAA-CREF sends you a Quarterly Retirement Portfolio Review. This report shows the accumulation totals within each asset class, a summary of transactions made during the period, personalized rate of return which estimates your retirement portfolio’s performance based on certain stated assumptions, TIAA Traditional interest credited, net investment gain and loss, and the number and value of CREF, TIAA Real Estate and mutual fund accumulation units, plus a hypothetical projection of monthly retirement income based on certain factors. You also may receive Premium Adjustment Notices. These notices summarize any adjustments made to your annuities and are sent at the time the adjustments are processed.

And once a year, you will receive the TIAA-CREF Annual Report. The Annual Report summarizes the year’s activity, including details on TIAA, CREF and mutual fund investments, earnings, and investment performance.

Additional educational and retirement planning tools are available on the TIAA-CREF website.

Contract Ownership and Vesting

The Institute (as Plan sponsor) holds ownership of the TIAA-CREF Retirement Choice (RC) contracts for the exclusive benefit of Plan participants. Payments under the Plan are made directly from TIAA-CREF to Plan participants. Participants are 100% vested in their account under the Plan’s vesting provisions. This means that Plan participants retain the right to the vested account balances under the Plan – 100% immediate vesting in accordance with Caltech’s plan provisions.
## Contract Requirements Summary

| **Contract: Retirement Annuity**  
| (For contributions made through December 31, 2009) | **Contract: Retirement Choice**  
| (For contributions made beginning January 1, 2010) |
|---|---|
| **Guaranteed interest rate in TIAA Traditional accumulation state:** | **Guaranteed interest rate in TIAA Traditional accumulation state:** |
| 3% | Floats between 1% and 3% based on the five-year Constant Maturity Treasury Rate, less 125 basis points. The TIAA Traditional Annuity also offers the opportunity to receive additional amounts of interest plus the guaranteed rate. These additional amounts, when declared by the TIAA Board of Trustees, remain in effect for the “declaration year” that begins each March 1. |
| The TIAA Traditional Annuity also offers the opportunity to receive additional amounts of interest plus the guaranteed rate. These additional amounts, when declared by the TIAA Board of Trustees, remain in effect for the “declaration year” that begins each March 1. | |
| **Lump-sum transfers** | **Lump-sum transfers** |
| TIAA Traditional – Not available. Transfers may only be made in 10 annual installments through a Transfer Payout Annuity (TPA) to any variable annuity accounts or mutual funds offered within the plan. | TIAA Traditional – Not available. Transfers of all or a portion of accumulation may be made over 84 months (7 years) in monthly systematic payments. Systematic payments may be made to any variable annuity accounts or mutual funds offered within the plan. |
| CREF, TIAA Real Estate and Mutual Funds – Available | CREF, TIAA Real Estate and Mutual Funds – Available |
| **Lump-sum withdrawals on Termination** | **Lump-sum withdrawals on Termination** |
| TIAA Traditional – Lump-sum withdrawals are not available. Withdrawals of the participant’s TIAA Traditional accumulation can be made in 10 annual installments through a Transfer Payout Annuity (TPA) to any variable annuity accounts or mutual funds offered through TIAA-CREF within the plan or to approved alternate carriers within the plan. | TIAA Traditional – Lump-sum withdrawals only available within 120 days of termination of employment with a 2.5% surrender charge. If after 120 days, full or partial withdrawals may be made over 84 months (7 years) in monthly systematic payments. |
| CREF, TIAA Real Estate and Mutual Funds – Available | CREF, TIAA Real Estate and Mutual Funds – Available |
| **Other types of withdrawals include:** | **Other types of withdrawals include:** |
| • Lifetime income (with 10-, 15-, and 20-year guaranteed periods)  
• Systematic withdrawals through variable annuities and mutual funds  
• Fixed-period payments  
• Interest-only option from TIAA Traditional (IPRO)  
• Retirement transition benefit (RTB)  
• Minimum Distribution Option (MDO) | • Lifetime income (with 10, 15 and 20-year guaranteed periods)  
• Systematic withdrawals through variable annuities and mutual funds  
• Distribution options similar to IPRO, RTB and MDO are available, |
| **Annuity Settlement Rates for TIAA Traditional** | **Annuity Settlement Rates for TIAA Traditional** |
| Based on 2.5% guaranteed interest, and a fixed mortality table. | Based on 2% guaranteed interest and a mortality table that is updated each year. |
| **Contract Ownership and Vesting** | **Contract Ownership and Vesting** |
| Each participant “owns” their TIAA/CREF contracts. Participants are 100% vested in their accounts under the Plan’s vesting provisions. | The Institute (as plan sponsor) “owns” the TIAA/CREF contracts. Participants are 100% vested in their account under the Plan’s vesting provisions. |
| **Institutional Transfers of plan assets** | **Institutional Transfers of plan assets** |
| Not available for TIAA Traditional, TIAA Real Estate and CREF annuity accounts within the RA contract. | Available for all investment options except TIAA Traditional if the plan changes the plan’s investment offerings (for instance, due to a fund’s poor performance). TIAA Traditional will be transferred over an 84-month period. |
Death Benefits

Death Before Retirement Benefits Begin

If you die before beginning retirement benefits, the full current value of your accounts is payable as a death benefit. Your entire interest must normally be paid out within five years after your death. Calendar year 2009 will not be counted in the five year period, so if the five years would otherwise include 2009, the period is extended by one year. Under a special rule, death benefits may be payable over the life or life expectancy of a designated Beneficiary if the distribution of benefits begins not later than one year from the date of your death. If the designated Beneficiary is your spouse, the commencement of benefits may be postponed until you would have attained age 70 ½ had you continued to live.

Federal tax law puts limitations on when and how beneficiaries receive their death benefits. TIAA-CREF will notify your Beneficiary of the applicable requirements at the time he or she applies for benefits.

You should review your Beneficiary designation periodically to make sure that the person you want to receive the benefits is properly designated. You may change your Beneficiary by completing the “Designation of Beneficiary” form available from TIAA-CREF. You may also change your beneficiary designation on the internet by using TIAA-CREF’s secured web site at www.tiaa-cref.org. If you die without having named a Beneficiary, your spouse will automatically receive half of your accumulation. Your estate will receive the other half. If there is no spouse, your estate receives the entire accumulation.

Death Benefit Distribution Options

You may choose one or more of the options listed in your annuity contracts for payment of the death benefit, or you may leave the choice to your Beneficiary. The payment options include:

- Income for the lifetime of the Beneficiary, with a minimum guaranteed period of payments of either 10, 15 or 20 years, as selected.
- Income for a fixed period of at least two but not more than 30 years, as elected, but not longer than the life expectancy of the Beneficiary. (For RA contracts only)
- A single sum payment. A single sum must be paid if your Beneficiary is your estate, a corporation, association or other entity that is not a natural person.
- A minimum distribution option for beneficiaries required to begin retirement benefits under federal law. This option pays the required federal minimum distribution each year. A similar option for receiving minimum distributions is available for RC contracts.

Both Spouse and non-spouse Beneficiaries have certain direct rollover rights that may apply to single sum payments or payments over periods of less than 10 years.

Death After Distributions Begin

If you die after distributions begin, your remaining interest will be paid at least as rapidly as under the method of distribution used before your death.

In-Service Withdrawals

You may elect an in-service distribution if you are at least age 59 ½ and you are or become a “Non-Benefit-Based Employee” provided it is permitted under and subject to the provisions of the relevant funding vehicle and the distribution is not prohibited under the Internal Revenue Code.

Withdrawals from your accounts are not available before termination of employment with the Institute or while you are on a leave of absence or on disability leave.
of absence.. If you reached age 70-1/2 before 2000, you must begin receiving distributions by your Required Beginning Date. (See page 7.16.) When Annuity Income Payments Can Begin

Although income usually begins on the normal retirement date, you may begin to receive income at any time following termination of employment, which may be either earlier or later than the normal retirement date. You may not withdraw any funds from your account while you are still employed by the Institute, including periods while you are on leave of absence or on disability leave of absence. See above for an exception to in-service distributions if you are at least age 59 ½ and are no longer a Benefits-Based Employee.

The beginning date of your payments is subject to federal law that sets a date by which payments must begin (see “Required Benefit Beginning Date” on page 7.16).

Normal Retirement Under The Plan

The normal retirement date under the Plan for tenured Faculty members is the June 30 coincident with or next following their 65th birthday. The normal retirement date under the Plan for all other Eligible Employees is the first day of the month coincident with or next following their 65th birthday.

Termination Of Employment Before Retirement

If you terminate employment before normal retirement, your RA and RC contracts remain in force, including all benefits purchased by the Institute’s contributions. You do not forfeit any of the benefits that have already been set aside for you. If you relocate to one of the many other institutions with a TIAA-CREF funded retirement plan, you may be able to participate in that institution’s plan immediately. Even if you do not participate in another institution’s retirement plan, or if you stop contributions to your TIAA and CREF annuities for another reason, your accumulations in TIAA will continue to be credited with the same interest and dividends as they would have been had you continued contributions. Accumulations in the available CREF and mutual fund accounts will continue to participate in the market experience of those accounts.

When you terminate employment, you will continue to have the flexibility to make investment transfers at any time before beginning income, subject to restrictions on the TIAA Traditional Account, or to start receiving annuity income from the broad range of income options offered by TIAA-CREF (see “Distribution Options” on page 7.16).

Beginning TIAA And CREF Retirement Annuity Income At Different Times And Under Different Options

Once you decide to receive your benefits as income, you have the flexibility to begin payment of all or a portion of your benefits from your TIAA annuity on one date and your CREF annuity on another date provided you have at least $10,000 of accumulation in your annuity or account on the date payment begins. Under current administrative practice, you can also elect to receive income from your TIAA and/or CREF annuities under more than one distribution option, provided your accumulations under each option selected are at least $10,000.
Required Benefit Beginning Date

Except for your accumulations as of December 31, 1986 (not including investment earnings after 1986) which are not required to begin payments before the date you reach age 75, retirement benefits must begin:

(A) if you reach age 70 ½ before the calendar year 2000, no later than April 1 of the calendar year following the year in which you reach age 70 ½; or

(B) if you reach age 70 ½ after December 31, 1999, no later than April 1 of the calendar year following the later of the calendar year in which you reach age 70 ½ or the calendar year in which you retire.

If you reached age 70 ½ during 2013, you have the option of deferring receipt of your benefits until April 1, 2014.

The payment of benefits according to the above rules is extremely important. Federal tax law imposes a 50% excise tax on the difference between the amount of benefits required by law to be distributed and the amount actually distributed if it is less than the required minimum amount.

TIAA-CREF will automatically contact you several months before the date you scheduled your benefits to begin on your application. You may decide, however, to begin receiving income sooner, in which case you should notify TIAA-CREF about two months in advance of that date. Usually, the later you begin to receive payments, the larger they will be: in TIAA, more dollars each month for life; in CREF, more Annuity Units each month for life.

Distribution Options

You may choose from among several types of income options when you retire or terminate employment. If you are married at the time you elect to begin retirement income, your right to choose an income option will be subject to your spouse’s right (under federal pension law) to survivor benefits (see “Spouse’s Rights Under the ERISA Plans” on page 7.27), unless this right is waived by you and your spouse. The following income options are available.

Retirement Annuity Income Options

One-Life (Single Life) Annuity — is designed to pay you an income for as long as you live. This option provides a larger monthly income for you than other annuity options, with all payments stopping at your death. This option is also available with a 10, 15 or 20 year guaranteed payment period (but not exceeding your life expectancy at the time you begin annuity income). If you die during the guaranteed period, payments in the same amount that you would have received continue to your Beneficiary for the rest of the guaranteed period.

Survivor Annuity — pays you a lifetime income, and if your spouse (or other Second Annuitant) lives longer than you, he or she continues to receive an income for life. The amount continuing to the survivor depends on which of the following three options you choose:

- Two-thirds Benefit to Survivor. At the death of either you or your Second Annuitant, the payments are reduced to two-thirds the amount that would have been paid if both had lived, and are continued to the survivor for life.

- Full Benefit to Survivor. The full income continues as long as either you or your Second Annuitant is living.

- Half Benefit to Annuity Partner. The full income continues as long as you live, and if your Second Annuitant survives you, he or she receives for life one-half the income you would have received if you had lived. If your Second Annuitant dies first, the full income continues to you for life.

These options are also available with a 10, 15 or 20 year guaranteed period, but not longer than the joint life expectancies of you and your spouse (or other Second Annuitant). The period may be limited by federal tax law.
Systematic Withdrawals

You may take systematic withdrawals (monthly, quarterly, or annually) from your CREF accounts, the TIAA Real Estate Account and mutual funds.

Lump Sum Withdrawals

TIAA Traditional — Lump sum withdrawals from your Retirement Choice (RC) contracts (for contributions made after 2009) are available only within 120 days of termination of employment. There is a 2.5 percent surrender charge for this option. After 120 days of termination, full or partial withdrawals may be made over 84 months (7 years) in monthly systematic payments.

All Other Funds — You can elect a lump sum withdrawal of 100% of your accumulations in CREF and the available mutual funds without restrictions after you have terminated employment.

Payments Over A Fixed Period

TIAA Traditional — TIAA accumulations may be withdrawn through the Transfer Payout Annuity (TPA) (see “Transferring Accumulations in the Plan” on page 7.11), and will be paid to you in substantially equal annual payments over a period of 7 years (9 years for RA contracts) when you terminate employment. Payments made under the TPA contract are subject to the terms of that contract.

All Other Funds — You may elect to receive 100% of your total accumulations from your CREF Accounts, TIAA Real Estate account and mutual funds over a fixed period of between two and 30 years (for RA contracts only). At the end of the selected period, all benefits will end. If you die during the period, payments will continue in the same amount to your Beneficiary until the end of the selected period. Current tax law requires that the period chosen not exceed your life expectancy or the joint life expectancy of you and your Beneficiary.

Other Distribution Options

The following options are also available but may have slightly different terms under the RC and RA contracts. Please contact TIAA-CREF for more details on the specifics of each of these options under each contract type (RC and RA) when you are eligible to commence payments.

Minimum Distribution Option — This option is for Participants age 70 ½ or older. Under the MDO, you will receive the required federal minimum distribution while preserving as much of your accumulation as possible.

Retirement Transition Benefit Option (Combining Partial Cash Withdrawal and Annuity) — Under the Retirement Transition Benefit Option (RTB) you can receive one lump sum payment up to 10% of your TIAA and CREF accumulations at the time you start to receive your income as an annuity. The one lump sum payment can not exceed 10% of each account’s accumulation then being converted to annuity payments.

Interest Payment Retirement Option (IPRO) — TIAA Participants with a TIAA Traditional accumulation of at least $10,000 under their RA contracts, may elect the TIAA Interest Payment Retirement Option (IPRO) which allows you to receive income while preserving your accumulation. IPRO is available if you are at least age 55 and it is at least one year prior to the required minimum distribution date. A similar distribution option is available for TIAA Traditional accumulations under RC contracts.

Under this option, you can receive monthly payments equal to the interest that would otherwise be credited to your TIAA Traditional annuity. Your accumulation is not reduced while you are receiving interest payments.

If you die while receiving interest payments under this option, your Beneficiary will receive the amount of your starting accumulation, plus interest earned but not yet paid. If you die after you have begun to receive your accumulation as an annuity, your Beneficiary will receive the benefits provided under the annuity income option you have selected.
Small Sum Repurchase — If you have terminated employment, you can request to “repurchase” small sums of accumulations in your RA and RC contracts. Upon repurchase, your entire accumulation will be payable by TIAA-CREF to you in a lump sum. This will be in full satisfaction of your rights and your spouse’s rights to retirement or survivor benefits. To request a repurchase, you must satisfy all of the following conditions at the time you request the repurchase:

- The total accumulation in all your TIAA RA/RC contracts (including contributions to RA/RC contracts under plans of other employers) is $2,000 or less.
- You do not have a TIAA Transfer Payout Annuity (TPA) in effect.

Withdrawals may be subject to a surrender charge.

Rollover of Distributions

If you are entitled to receive a distribution from your contract which is an eligible “rollover distribution” (subject to any lump sum withdrawal limits), you may roll over all or a portion of it, either directly or within 60 days after receipt, into another eligible retirement plan, a traditional IRA, or a Roth IRA. Your payment cannot be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account (formerly known as an education IRA). An “eligible retirement plan” includes a plan qualified under Section 401(a) of the Internal Revenue Code (i.e., a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan or money purchase plan), a section 403(b) plan, and an eligible section 457(b) plan maintained by a governmental employer. An eligible rollover distribution, in general, is any cash distribution other than an annuity payment, a minimum distribution payment or a payment which is part of a fixed period payment over ten or more years. The distribution will be subject to a 20% federal withholding tax unless it is rolled over directly into another retirement plan or into a traditional IRA — this process is called a “direct” rollover. If you roll over your distribution to a Roth IRA, you will be subject to federal income tax on the full amount of your distribution but you may be eligible for tax benefits when you take a distribution from the Roth IRA if certain conditions are satisfied.

If you have the distribution paid to you, then the plan must withhold 20% for federal income tax even if you intend to roll over the money into another retirement plan or into a traditional IRA within 60 days. To avoid withholding, instruct the fund sponsor to directly roll over the money for you.

Retirement Plan Loans

You may borrow against your TIAA Real Estate and CREF accumulations in your Retirement Annuity (RA) and Retirement Choice (RC) contracts. You will have to transfer funds into a TIAA Retirement Loan (RL) contract to obtain a loan.

Effective October 14, 2011, you are limited to a maximum of 4 outstanding loans at any given time (whether from your RC or your RA accounts). Effective January 1, 2014, only actively employed participants may obtain loans. However, if you terminate employment while you have an outstanding loan, you may continue to repay the loan in accordance with its terms.

The loan provision gives you the flexibility to use your retirement plan savings (your accounts due to your mandatory contributions and Institute contributions) as collateral for a loan of the same amount — while continuing to preserve the advantages of tax deferral, investment growth opportunity and security.

Generally the minimum loan amount is $1,000 and the maximum loan amount is $50,000. The maximum amount you can borrow may be less, however, depending on two factors: 1) the amount of your accumulation, and 2) whether you have had any other loans from any of Caltech’s plans within the last year.

If you have not had a plan loan in the previous year, your maximum loan cannot exceed the lesser of one-half of your vested account balance or $50,000. In addition, your maximum loan amount is further limited to the lesser of:
1) 45% of your combined TIAA and CREF accumulation attributable to participation under this plan; or

2) 90% of your CREF and TIAA Real Estate accumulation attributable to participation under this plan.

The amount you are eligible to borrow is coordinated with any loans you may have from your TDA accounts. If you have had another loan from any Caltech plan (including the NonERISA TDA) within the last year, the maximum you can borrow will be reduced by that amount. In addition, if you default on a loan, your right to a future loan may be restricted. Further, the maximum loan amount will be reduced by the amount in default (plus interest) until the defaulted amount can be deducted from your accumulation.

The amount you borrow does not reduce your plan account. Instead, your plan account serves as collateral for the loan and continues to earn the normal crediting rate for the TIAA Traditional account. You are borrowing from TIAA and interest paid on the loan is retained by TIAA.

Interest on loans from this plan will be computed based on:

– Initially, the higher of

  1) the Moody’s Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or

  2) the interest credited before your annuity starting date, as stated in the applicable rate schedule, plus 1 percent.

– Thereafter the rate will change annually, but only if the Moody’s Corporate Bond Yield Average for the calendar month ending two months before the anniversary of your loan differs from your current rate by at least a half percent. If the latest average differs by less than a half percent, your interest rate will remain the same for the next year.

Generally, you have one to five years to repay your loan. However, if you use the loan solely to purchase your primary residence, you can take up to ten years to repay. In addition, if you are married, your spouse must consent in writing to your request for a plan loan.

During a period of qualified military service, your loan payments may be suspended.

Contact TIAA-CREF to apply for a loan or if you have questions about the loan program. Contact information is provided in the Tools and Resources section.
THE ERISA TDA PLAN

This section describes opportunities offered by the Institute for voluntary 403(b) retirement savings called Tax Deferred Accounts (TDAs). The ERISA TDA plan was adopted effective January 1, 2010, for voluntary 403(b) contributions made on and after that date. Participation in the ERISA TDA plan is voluntary.

All Faculty, Postdoctoral Scholars, senior Postdoctoral Scholars, student employees and staff employees who are on the Caltech or JPL payroll may participate in the ERISA TDA plan. Visiting professors who are considered common law employees of another organization are not eligible to participate.

A TDA is a 403(b) tax-deferred retirement savings program available to employees of education and research institutions and certain tax-exempt organizations. It allows you to:

- Set aside money for retirement on a pre-tax basis.
- Reduce your taxable income, thus lowering your current income taxes.
- Defer taxes on TDA investment income until you begin receiving payments.

The investment vehicles offered under the ERISA TDA plan are offered solely through TIAA-CREF and are the same funds available under the Base Retirement Plan. It is intended that the Plan qualify as a participant directed account plan under ERISA Section 404(c). In selecting funds for the main investment options, Caltech’s objective is to offer competitive choices and top-quality funds to Caltech employees. Caltech will periodically review the main investment menu to ensure that the available funds continue to help employees reach their retirement goals. The Institute’s current selection of investment funds is not intended to limit future additions or deletions. You will be notified of any additions or deletions.

In addition, a self-directed brokerage account is also available.

The Administrator of the Plan is the Institute. The Plan year begins on January 1 and ends on December 31.

This summary highlights the details of the ERISA TDA. More detailed information is available from the Campus or JPL Benefits Office.

Contract Ownership and Vesting

The Institute (as Plan sponsor) holds ownership of the TIAA-CREF Retirement Choice Plus (RCP) contracts for the exclusive benefit of Plan participants. Payments under the Plan are made directly from TIAA-CREF to Participants. Participants are 100% vested in their account under the Plan’s vesting provisions. This means that Plan participants retain the right to the vested account balances under the Plan – 100% immediate vesting in accordance with Caltech’s plan provisions.

Your Contributions

You may contribute as much as allowed by federal tax law (Sections 402(g), 403(b), and 415(c) of the Internal Revenue Code). The maximum contribution allowed depends on a number of different factors, such as your salary*, length of service, and amount of prior contributions. You can find out your maximum contribution from the Campus or JPL Benefits Office.

Contributions are deducted from your paycheck on a pre-tax basis and are forwarded to TIAA-CREF at least monthly. Upon retirement, you may be eligible to defer compensation associated with the payment of sick leave credit. You can contact the Campus or JPL Benefits Office for more information. Your contributions are invested in Retirement Choice Plus (RCP) contracts with TIAA-CREF. You choose how to invest your contributions among the available investment options. You may enroll plus complete a salary deferral agreement online at www.tiaa-cref.org/caltech.

* Fellowship stipends distributed by Caltech are not considered “salary” eligible for pre-tax contributions.
Changing Or Stopping Your Contributions

A Salary Deferral Agreement is required to start, change, or stop your ERISA TDA plan contribution. To change or stop your Salary Deferral Agreement go to www.tiaa-cref.org/caltech and select the “Salary Deferral Agreement” link.

Transfers from the NonERISA TDA Plan to the ERISA TDA Plan

Your contributions made prior to 2010 will continue to be invested with the investment company you selected under the terms of the NonERISA TDA plan in effect on December 31, 2009. If you wish, you have the option of making a plan-to-plan transfer of funds currently in the NonERISA TDA plan to the ERISA TDA plan at any time. Once the transfer is processed by TIAA-CREF, check your Quarterly Statement to make sure your transfer is complete and accurate. Once a transfer is processed by TIAA-CREF you will not be able to transfer funds back to the NonERISA TDA plan.

Return from Military Leave

If you have returned to work from a military leave as defined in the Institute’s military leave policy, you may be eligible to “catch up” on contributions you were not able to make during your leave. Contact the Benefits Office immediately upon return to work for options available to you.

Rollover Contributions

Your account in the ERISA TDA is considered an account in “an eligible retirement plan”. Therefore, you can roll over any distribution of pre-tax contributions and investment gains or losses you may be entitled to receive from your prior employer’s retirement plan into your ERISA TDA. You may not roll over distributions from after-tax contribution accounts or Roth contribution accounts into your ERISA TDA account. Please contact TIAA-CREF to obtain information on any restrictions on rollover contributions and the procedures that must be followed to make a rollover contribution.

Investment Options

The ERISA TDA plan offers a wide range of investment options to help you achieve your retirement savings goals.

The investment options are the same options available under the Base Retirement Plan. Please refer to the Investment Menu page 7.9. In addition, a self-directed brokerage account is also available.

Build Your Own Portfolio

The Investment Menu features a wide range of funds in different asset classes from a variety of companies – with funds representing varying degrees of investment risk. Risk is tied directly to rewards – the more risk you’re willing to take, the greater the potential for gains, as well as for losses.

It is up to you to choose which investment option is right for you, based on the amount of risk and potential rate of return. Before you choose an investment, you should investigate the performance of the investment options offered and determine if they meet your individual needs. Description of the individual funds may be obtained by contacting TIAA-CREF (see Tools and Resources on page 7.31).

You can simplify your decision-making process by choosing one of TIAA-CREF’s Lifecycle Funds – model portfolios targeted to your anticipated year of retirement which automatically rebalance to become more conservative as you move closer to that date. Or you can build your own portfolio with investment choices in the essential asset classes you need: equities (stocks), fixed income (bonds), guaranteed, real estate and money market.

In addition, once you are enrolled in the ERISA TDA Plan, a self-directed brokerage window is available if you seek a wider menu of investments than available from the core Investment Menu.

The self-directed brokerage window offers a wide array of the nation’s best-known fund families, including Fidelity. There can be additional costs associated with the
brokerage account. You can transfer balances from your mutual fund and annuity accounts to your brokerage account and back again with certain restrictions. You can also arrange to have automatic contributions made to your brokerage account. However, if you elect to open a brokerage account, keep in mind that Caltech has not selected, nor is it responsible for monitoring, any of the investments available under the brokerage window. You are fully and solely responsible for your brokerage window investment decisions, including performing the due diligence necessary to determine suitability of the investment securities that you may select. Caltech also is not responsible for an act or failure of the brokerage firm or brokerage representatives providing services under the brokerage window.

Changing Your Investment Choices

You may change your investment allocation as often as daily by contacting TIAA-CREF directly or through TIAA-CREF’s website at www.tiaa-cref.org. You may change future contributions and leave your existing balances intact or you may choose to change your accumulated balances among investment funds, as allowed.

Transfers from CREF Accounts, TIAA Real Estate Account and the available mutual funds must be at least $1,000 each time (except for systematic transfers which must be at least $100 each time), or your entire accumulation, whichever is less. Transfers made as a percentage must also meet the dollar minimums. Transfers from TIAA Real Estate Account are limited to once per calendar quarter. TIAA-CREF can place limits on transfers in the future.

Also, various educational workshops and printed materials are offered by TIAA-CREF to assist you with managing your investments and preparing for your retirement.

Retirement Choice Plus Annuities (RCP)

All contributions under the ERISA TDA Plan will be invested in a Retirement Choice Plus contract. This contract has similar provisions to the Retirement Choice contracts now being used in the Base Retirement Plan. A comparison of the main contract features that differ from the SRA contracts used in the NonERISA TDA Plan is shown below:
Contract Requirements Summary

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<tr>
<td>Plan not subject to ERISA</td>
<td>Plan subject to ERISA</td>
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<tr>
<td>Guaranteed interest rate in TIAA Traditional accumulation stage: 3%</td>
<td>Guaranteed interest rate in TIAA Traditional accumulation state: Floats between 1% and 3% based on the five-year Constant Maturity Treasury Rate, less 125 basis points.</td>
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<tr>
<td>The TIAA Traditional Annuity also offers the opportunity to receive additional amounts of interest plus the guaranteed rate. These additional amounts, when declared by the TIAA Board of Trustees, remain in effect for the “declaration year” that begins each March 1.</td>
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<td>Available if the plan changes the plan’s investment offerings (for instance, due to a fund’s poor performance).</td>
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</table>
Withdrawals
The ERISA TDA is intended to help you save for your retirement. In general, you may begin receiving your benefits following termination of employment. You may withdraw your funds anytime after age 59½ regardless of employment status without tax penalty. All withdrawals are subject to federal and state income tax. If you choose a lump sum withdrawal and do not directly rollover the funds to another eligible retirement plan or Individual Retirement Account (IRA), your withdrawal will be subject to a 20% federal tax withholding.

Hardship Withdrawals
Under certain circumstances, you may be permitted to withdraw your contributions in the case of a financial hardship, as defined by the IRS. These withdrawals are limited to the amount you have contributed and do not include any earnings you have accumulated. Contact TIAA-CREF for information about hardship withdrawals.

Lump sum withdrawals during active employment before age 59½ are permitted only if you are called to active military duty for more than 30 days or if you experience a bona fide hardship as defined by the IRS, and may be subject to a 10% federal penalty tax.

If you take a hardship withdrawal from any of your TDA accounts, any existing employee voluntary pre-tax deferrals to all Caltech-sponsored plans will stop immediately following your hardship withdrawal for a period of six months. After the six month suspension is over you must complete a new online Salary Deferral Agreement.

Withdrawals During Active Military Duty
If you are called to active military duty for more than 30 days, you are eligible to withdraw part or all of your TDA accounts, even though you may be considered still actively employed. In that event, your voluntary pre-tax deferrals to the ERISA TDA plan will be suspended for six months. If you are ordered to active duty for at least 180 days, you may be eligible to receive a qualified reservist distribution, which does not require a suspension of deferrals.

Penalties For Early Withdrawals
If you terminate employment with the Institute, you may elect to receive a lump sum distribution before you reach age 59½. However, it may be subject to a 10% federal penalty tax. In general, you may defer receiving your benefits until the April 1 following the calendar year in which you reach age 70½. If you reached age 70½ during 2013, you have the option of deferring receipt of your benefits until April 1, 2014.

Direct Rollovers
Following termination of employment you can choose a direct rollover of all or any portion of your distribution that is an “eligible rollover distribution”. You may rollover your funds anytime after age 59½ regardless of employment status. In a direct rollover, the eligible rollover distribution is paid directly from your 403(b) account to a traditional IRA, a Roth IRA, or another eligible retirement plan that accepts rollovers. Your payment can not be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account (formerly known as an education IRA). An “eligible retirement plan” includes a plan qualified under Section 401(a) of the Internal Revenue Code (i.e., a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan or money purchase plan), a section 403(b) plan and an eligible section 457(b) plan maintained by a governmental employer.

If you choose a direct rollover to an eligible retirement plan or a traditional IRA, you are not taxed on the distribution until you actually take it out of the receiving eligible retirement plan or traditional IRA account. If you have the distribution paid to you, then the plan must withhold 20% for federal income tax even if you decide to roll over the money into another retirement plan or into a traditional IRA within 60 days. If you choose a direct rollover to a Roth IRA, you will be taxed on the full amount of your distribution in the year of distribution but you may
be eligible for tax benefits when you take a distribution from the Roth IRA if certain conditions are satisfied.

Effective for distributions after December 31, 1999, a financial hardship withdrawal cannot be rolled over to another eligible retirement plan (i.e., 401(k), 403(b), etc.) or an IRA.

**TDA Plan Loans**

The loan provision gives you the flexibility to use your TDA account savings in the GSRA (prior to January 1, 2010) and RCP (beginning January 1, 2010) as collateral for a loan – while continuing to preserve the advantages of tax deferral, investment growth opportunity and security. For loans based on RCP accumulations, you will have to transfer funds into a TIAA Retirement Loan (RL) contract to obtain a loan.

Effective January 1, 2014, only actively employed participants may obtain loans from the ERISA TDA Plan. However, if you terminate employment while you have an outstanding loan, you may continue to repay the loan in accordance with its terms.

Generally the minimum loan amount is $1,000 and the maximum loan amount is $50,000. The maximum amount you can borrow may be less, however, depending on two factors: 1) the amount of your accumulation, and 2) whether you have had any other loans from any of Caltech’s plans within the last year.

If you have not had a plan loan in the previous year, your maximum loan cannot exceed the lesser of one-half of your vested account balance or $50,000. Your maximum loan amount is further limited to

1) 45% of your combined TIAA and CREF accumulation attributable to participation under this plan; or

2) 90% or your CREF and TIAA Real Estate accumulation attributable to participation under this plan for RL loans or

3) 90% of your TIAA Annuity accumulation attributable to participation under this plan for a GSRA loan.

If you have had another loan from any Caltech plan (including the NonERISA TDA) within the last year, the maximum you can borrow will be reduced by that amount. In addition, if you default on a loan, your right to a future loan may be restricted. Further, the maximum loan amount will be reduced by the amount in default (plus interest) until the defaulted amount can be deducted from your accumulation.

The amount you borrow does not reduce your plan account. Instead, your plan account serves as collateral for the loan and continues to earn the normal crediting rate for the TIAA Traditional account. You are borrowing from TIAA and interest paid on the loan is retained by TIAA.

Interest on loans from this plan will be computed based on:

- Initially, the higher of
  1) the Moody’s Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or
  2) the interest credited before your annuity starting date, as stated in the applicable rate schedule, plus 1 percent.

- Thereafter the rate will change annually, but only if the Moody’s Corporate Bond Yield Average for the calendar month ending two months before the anniversary of your loan differs from your current rate by at least a half percent. If the latest average differs by less, your interest rate will remain the same for the next year.

Generally, you have one to five years to repay your loan. However, if you use the loan solely to purchase your primary residence, you can take up to ten years to repay. In addition, for loans from the ERISA TDA plan, your spouse must consent in writing to your request for a plan loan if you are married.
During a period of qualified military service, your loan payments may be suspended. Contact TIAA-CREF to apply for a loan or if you have questions about the loan program. Contact information is provided in the Tools and Resources section.

Payment Of Benefits
You may choose from among several types of income options when you retire or terminate employment. If you are married at the time you elect to begin retirement income, your right to choose an income option from the ERISA TDA plan will be subject to your spouse’s right (under federal pension law) to survivor benefits (see “Spouse’s Rights Under the ERISA Plans” on page 7.27), unless this right is waived by you and your spouse. The following payment options are available (contact TIAA-CREF for more detailed descriptions of the contract terms for each option):

- **Lump Sum** — you will be paid the entire balance of your account in one lump sum payment.

- **Annuity Income** — you may choose from a variety of annuity income options, which pay benefits either over the remainder of your life, with optional guaranteed periods. You may also choose options that will continue all or a percentage of your benefits to your spouse or other Beneficiary in the event of your death.
SPOUSE’S RIGHTS
UNDER THE ERISA PLANS

Under the Base Retirement Plan and the ERISA TDA Plan, benefits must be paid to married Participants in the Plan only as described below, unless a written waiver of the benefits by the Participant and a written consent to the waiver by the spouse is filed with TIAA-CREF. This provision applies to both retirement benefits and pre-retirement death benefits.

If benefits began before your death, your surviving spouse at your death will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, the full current value of your annuity accumulation becomes payable (pre-retirement death benefit). Federal law requires that at least 50% of such benefit be paid to your spouse (with the remaining 50% paid to your designated Beneficiary) unless your spouse has waived, and consented in writing to an alternate Beneficiary for, such benefit. Pre-retirement death benefits are payable in a single sum or under one of the income options offered by TIAA-CREF.

Married Participants and their spouses may waive the spouse’s right to a joint and survivor annuity or his or her pre-retirement death benefit only if a written waiver of the benefit signed by the Participant and the spouse (and notarized) is filed with TIAA-CREF. The necessary forms will be provided to the Participant by TIAA-CREF.

For post-retirement survivor benefits (joint and survivor annuity), the waiver may be made only during the 180-day period before benefits begin. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.

The period during which you and your spouse may elect to waive the pre-retirement survivor death benefit begins on the first day of the Plan year in which you reach age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before reaching age 35 — that is, before you have had the option to make a waiver — 50% of the current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by TIAA-CREF; the remaining 50% is payable to your designated Beneficiary. If you terminate employment before age 35, the period for waiving the spousal pre-retirement death benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

If a judgment, decree or order made following a state domestic relations law establishes the rights of another person (the “alternate payee”) to your benefits under this Plan, and if such an order (called a “qualified domestic relations order”) is for providing child support, alimony or other marital property payments, then payments will be made according to that order provided the order does not conflict with the provisions of the Plan or the terms of a previous qualified domestic relations order. If a court issues a qualified domestic relations order, the order overrides the usual requirements that your spouse be considered your primary Beneficiary for a portion of the accumulation. Copies of the Plan’s procedures relating to qualified domestic relations orders are available on written request to the Plan Administrator.
CLAIMS PROCEDURES

The following rules describe the claim procedures under the Base Retirement Plan and the ERISA TDA Plan:

- **Filing a claim for benefits** — A claim or request for Plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to the Director of Benefits, Human Resources.

- **Processing the claim** — The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to make its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

- **Denial of claim** — If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent Plan provisions on which the denial is based, a description of any additional material or information necessary for claim approval, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not given to you within the 90/180-day period, the claim is considered denied and you must be permitted to proceed to the review stage.

- **Review procedure** — You or your authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to see all Plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.

  **Decision on review** — The Plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the Plan procedures provide for such a hearing), you must be furnished with written notice of the extension. Such notice must be provided no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. If appeal is denied, in whole or in part, you have a right to file suit in a state or federal court.

ADDITIONAL PLAN INFORMATION

Since the Base Retirement Plan and the ERISA TDA Plan are defined contribution plans, they are not insured by the Pension Benefit Guaranty Corporation (“PBGC”). The PBGC is the government agency that guarantees certain types of benefits under covered plans.

Base Retirement Plan  ERISA Plan Number: 002

The benefits under the Base Retirement Plan are provided by retirement choice annuity contracts and retirement annuity contracts issued by TIAA and CREF (TIAA plan number 403497).

Teachers Insurance and Annuity Association
College Retirement Equities Fund
730 Third Avenue, New York, NY 10017
1-800-842-2733
ERISA TDA  ERISA Plan Number: 005

The benefits under the ERISA TDA Plan are provided by retirement choice plus annuity contracts issued by TIAA and CREF (TIAA plan number 403498).

Teachers Insurance and Annuity Association
College Retirement Equities Fund
730 Third Avenue, New York, NY 10017
1-800-842-2733
THE 457(B) DEFERRED COMPENSATION PLAN

This section describes opportunities offered by the Institute for voluntary deferred compensation savings called the 457(b) Deferred Compensation Plan. The 457(b) Plan is a tax-deferred compensation plan that is available to employees who meet the salary threshold for eligibility. It works similar to the Voluntary Retirement Savings (TDA) Plan. You make pretax contributions to the 457(b) Plan, reducing your current taxable income, so you pay less in taxes now. Your earnings also remain tax free until you begin making withdrawals. You can use this plan in addition to participating in the Caltech Base Retirement Plan and Voluntary Retirement Savings (TDA) Plan. Because the 457(b) Deferred Compensation Plan is a non-qualified plan, the account and investments held are assets of the California Institute of Technology and are subject to the claims of general creditors.

Eligibility

What determines eligibility for the 457(b) plan?
Your annual salary rate as of November 1 of each year must meet the salary threshold for eligibility. The November 1, 2013 salary threshold of $208,100 determines your eligibility to participate in the plan for the plan year beginning January 1, 2014.

How is eligibility determined in the future?
Each year the salary rate threshold ($208,100 for 2014, for example) is increased to ensure the plan remains limited to a select group of management or highly compensated employees. The Plan Administrator determines the new salary rate threshold each November for determining who is eligible for the plan the following January 1.

What if the salary falls below the threshold for eligibility?

As long as your annual salary rate does not fall below 90% of the salary rate threshold, you may continue to participate in the plan and make contributions. If your annual rate of salary falls below 90% of the indexed salary rate threshold for any reason, you will not be able to make contributions to the plan effective the following January 1. You may become eligible for the plan in a future year if your regular salary equals or exceeds the indexed compensation salary rate threshold in effect on a subsequent November 1.

How much can I contribute?
In 2014, you can contribute up to $17,500, the maximum annual contribution amount.

How does participation in the 457(b) Plan affect the Voluntary Retirement Savings (TDA) Plan?
You can choose to participate in the TDA Plan, the 457(b) Plan (if you are eligible), or both. Generally speaking, you may want to contribute to the 457(b) Plan if you are making the maximum allowable contributions to the TDA Plan. If you choose to contribute to both plans, in 2014 the maximum allowable contribution amount is generally up to $17,500 to each plan, or $35,000 total for both plans. Contact TIAA-CREF or the Caltech/JPL benefits office for questions regarding your specific personal contribution limits.

What Investment options are available under the 457(b) Plan?
The 457(b) Plan provides the same investment options as the Caltech Base Retirement Plan. See the Investment Menu on page 7.9 for options as of February 6, 2014. For the latest Investment Menu go to www.tiaa-cref.org/caltech click on Plan and Investments tab, then click on plan and investment choices.

What are the differences between the TDA 403(b) and 457(b) plans?
The primary distinction between the two plans is that the assets of a non-qualified 457(b) plan are considered part of the employer’s general assets.
and are subject to the claims of its creditors. The plan participants are not protected by ERISA fiduciary requirements. Other differences between the two plans are summarized below.

- Non-qualified 457(b) deferred compensation plan account balances are subject to the claims of the employer’s general creditors.
- Loans and hardship withdrawals are not available in the 457(b) Deferred Compensation Plan;
- 457(b) account balances cannot be rolled over into other plan types and IRAs.
- Catch-up contributions are not available in the 457(b) plan.

**Death Benefits**

**Death of the participant before benefits begin: what distribution options are available to beneficiary?**
Distribution to the beneficiary will be paid as designated by the participant as a lump sum, a series of equal payments for a fixed time, or equal payments over the beneficiary’s lifetime. If the participant has not specified a method of payment, distribution to the beneficiary will be made in a lump sum 121 days after the participant’s date of death. Payments to a surviving spouse must begin no later than the end of the year the participant would have attained age 70½. Non-spouse beneficiaries have the same distribution options as spousal beneficiaries except that their benefits must begin no later than the end of the calendar year following the year in which the participant died.

**Distributions upon Termination or Retirement**

**Distribution Options from the plan**
You are eligible to receive a lump sum distribution when you terminate employment. You have the option of completing a written election, within 120 days after your employment ends, to defer the start of your benefits to a date you choose. You must promptly notify TIAA-CREF of your termination to receive the election form. If your written election to defer payment is not received within 120 days after your employment ends, your benefit will be paid in a lump sum amount and will be subject to applicable income taxes.

**How long can I defer the start of my benefits from the plan?**
Federal law requires that distribution of your account begin no later than the April 1 following the calendar year in which you reach age 70½.

**Rollovers**
Federal law prohibits rolling over contributions from an IRA or other plan into your 457(b) account. However, you can roll 457(b) amounts only into another tax-exempt organization’s 457(b) plan.
TERMS YOU SHOULD KNOW

Accumulation Units
Shares of participation in an underlying investment portfolio. Your contributions to a CREF variable annuity account are used to buy Accumulation Units in the underlying portfolio of securities held in that account. (See page 7.11)

Annual Regular Salary
Your Regular Salary paid for the Plan Year. Regular Salary is described on page 7.5.

Base Retirement Plan
An alternative name for the California Institute of Technology Defined Contribution Retirement Plan often used internally.

Eligible Employee
Eligible Employee is defined in the section titled “Eligibility” beginning on page 7.1.

Eligibility Service
A period used in determining the initial eligibility of a Staff Employee to participate in the plan (See page 7.3.)

Faculty
See the Eligibility Section on page 7.1, under the heading “Faculty.”

Key Staff Employee
See the Eligibility Section on page 7.1 under the heading “Key Staff Employee.”

Minimum Compensation Level
As described on page 7.1, the Minimum Compensation Level is $102,440 as of October 1, 2013. This amount will be adjusted each October 1 to reflect future cost of living increases.

Participant Contributions
Those contributions which certain Faculty and Key Staff Participants are required to make as described on page 7.6.

Plan Administrator
The California Institute of Technology.

Postdoctoral Scholars
See the Eligibility Section on page 7.2 under the heading “Staff Employee”

Retirement Annuities
A form of payment generally providing periodic payments at fixed intervals during retirement. Different payment options are available for your retirement annuity. (See page 7.16.)

Retirement Plan Earnings for Staff Employees
If you are a staff employee, your earnings as reported on your W-2 Box 1 plus pre-tax contributions to an eligible plan of deferred compensation (such as medical/dental plans, 403(b), 457(b) etc.) are used to determine Institute Contributions. See page 7.6.

Salary Deferral Agreement
The enrollment form you must complete online to authorize your contributions to a Tax Deferred Account (see page 7.20). A new agreement is required each time you start, increase, decrease, or stop your contributions.

Second Annuitant
The person designated under a survivor annuity form of payment to receive benefits after your death. (See page 7.16.)

Staff Employee
See the Eligibility Section on page 7.2 under the heading “Staff Employee.”

Year of Service
A 12-month period of service used to determine the amount of Institute contributions for staff employees. (See page 7.7.)
TOOLS AND RESOURCES

TIAA-CREF

TELEPHONE COUNSELING CENTER
Call 800 842-2776
Monday to Friday, 5 a.m. to 7 p.m., Saturday 6 a.m. to 3 p.m. (PT)
• Enter SSN or contract number to be directed to your Caltech team
• Enroll in Voluntary TDA Plan and/or sign up to receive asset allocation advice

IN-PERSON ASSISTANCE
Sign up for an individual appointment. Consultants can meet with you in our local Pasadena Office (35 North Lake Ave., Suite 800, Pasadena, CA 91101)
Go to www.tiaa-cref.org/events or call 800 732-8353
Monday to Friday, 5 a.m. to 5 p.m. (PT)

AUTOMATED TELEPHONE SYSTEM (ATS)
Call 800 842-2253
Available 24 hours a day, 7 days a week
You may call the automated telephone system to create a Personal Identification Number (PIN), you will be asked to provide your date of birth, social security number and contract number.

ONLINE ASSISTANCE
• Go to www.tiaa-cref.org/caltech
• To gain access to your accounts create a Personal Identification Number (PIN). You will need to provide your date of birth, social security number and contract number
• Research information on new investment options
• Click on links to salary deferral tool (for Voluntary TDA Plan)
• Click on link to “Account Access” to submit asset allocation changes

TTY DIRECT LINE
Call 800 842-2755
A designated line for hearing- or speech impaired participants using text telephones. Consultants are available
Monday to Friday, 5 a.m. to 7 p.m., Saturday, 6 a.m. to 3 p.m. (PT)

TTIAA-CREF Brokerage Service
www.tiaa-cref.org/brokerage or call 800 927-3059

FIDELITY

AUTOMATED TELEPHONE SYSTEM (ATS)
Call 800-343-0860
Available 24 hours a day, 7 days a week

IN-PERSON ASSISTANCE
Fidelity Investor Center
123 South Lake Avenue
Pasadena, CA 91101
Phone: 800-638-0620
Hours: 8:30 a.m. – 5:00 pm, Monday - Friday

ONLINE ASSISTANCE
www.fidelity.com
NonERISA TDA PLAN

This section describes opportunities offered by the Institute for voluntary 403(b) retirement savings called Tax Deferred Accounts (TDAs). Prior to January 1, 2010, the TDA plan allowed you to select from investment vehicles offered by Fidelity and the Teachers Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF). This TDA plan continues to be maintained, but does not accept any new contributions after December 31, 2009. It is not subject to ERISA and is referred to as the “NonERISA TDA plan” throughout this handbook.

The program is considered a “Tax Deferred Annuity” or TDA plan. A TDA is a 403(b) tax-deferred retirement savings program available to employees of education and research institutions and certain tax-exempt organizations. It allows you to:

- Set aside money for retirement on a pre-tax basis.
- Reduce your taxable income, thus lowering your current income taxes.
- Defer taxes on TDA investment income until you begin receiving payments.

Rollover Contributions

Your account in the NonERISA TDA plan is considered an account in “an eligible retirement plan”. Therefore, you can roll over any distribution of pre-tax contributions and investment gains or losses you may be entitled to receive from your prior employer’s retirement plan into your NonERISA TDA plan contract. You may not roll over distributions from after-tax contribution accounts or Roth contribution accounts into your NonERISA TDA plan account. Please contact TIAA-CREF or Fidelity as appropriate to obtain information on any restrictions on rollover contributions and the procedures that must be followed to make a rollover contribution.

Investment Options

The NonERISA TDA plan offers a variety of investment options. The investment options available for funds that you have in the NonERISA TDA plan, for contributions made prior to 2010, have not changed. No new contributions will be accepted in this plan after 2009, but you may transfer assets within this plan at any time among the following investment options. Some transfer limitations may apply. Please contact the investment company for details.

Fidelity Investments

Fidelity offers over 100 mutual fund options with different levels of risk and return. Descriptions of the individual funds are available by calling Fidelity, see Tools and Resources on page 7.31 for contact information.

Your mutual fund options are divided into the following categories:

Money Market Funds
Income (or Bond) Funds
Growth and Income Funds
Growth Funds

Asset Allocation Funds which allocate investments among stocks, bonds, and short-term instruments seeking high total return with reduced risk over the long term. Share price, yield, and return will vary.

Freedom Funds that vary asset allocation among stocks, bonds and short-term investments with target maturity or retirement dates. After the fund’s target maturity date, the fund’s investment objective will be to seek high current income and, as a secondary objective, capital appreciation.

You may make transfers among the available Fidelity funds at any time.

Contact Fidelity for details regarding transfers from Fidelity funds or refer to the Fidelity web site at http://www.fidelity.com/non-profits for more specific information.
TIAA-CREF Supplemental Retirement Annuity (SRA)

Descriptions of the TIAA-CREF accounts are available via the TIAA-CREF web site noted below. TIAA-CREF currently offers ten investment options with varied levels of risk and return. The investment options are as follows:

- TIAA Traditional Annuity
- CREF Bond Market Account
- CREF Equity Index
- CREF Global Equities Account
- CREF Growth Account
- CREF Inflation-Linked Bond Account
- CREF Money Market Account
- TIAA Real Estate
- CREF Social Choice Account
- CREF Stock Account

You may make transfers among TIAA-CREF funds at any time.

You may refer to the TIAA-CREF web site at http://www.tiaa-cref.org for more specific information. Please see a CREF Prospectus for additional information regarding the CREF Accounts.

Transfers from the NonERISA TDA Plan to the ERISA TDA Plan

If you wish, you have the option of making a plan-to-plan transfer of funds currently in the NonERISA TDA plan to the ERISA TDA plan at any time. However, if you do so, you will not be able to transfer funds back to the NonERISA TDA plan.

Changing Your Investment Choices

You may choose to change your accumulated balances among investment funds, as allowed.

Transfers from CREF Accounts, TIAA Real Estate Account and the available mutual funds must be at least $1,000 each time (except for systematic transfers which must be at least $100 each time), or your entire accumulation, whichever is less. Transfers made as a percentage must also meet the dollar minimums. Transfers from TIAA Real Estate Account are limited to once per calendar quarter. TIAA-CREF can place limits on transfers in the future.

Also, various educational workshops and printed materials are offered by TIAA-CREF to assist you with managing your investments and preparing for your retirement.

Prudential MEDLEY Program

The Prudential Medley Program was closed for new enrollments and contributions as of January 1, 2001. If you have a Prudential TDA, you may refer to the Prudential web site at http://www.prudential.com for status on your account.

Mutual Benefit Life

Mutual Benefit Life was closed for new enrollments as of June 1991. However, if you have a Mutual Benefit Life TDA, you may call Sun America (formerly Mutual Benefit Life) at 1-877-999-9205 for information on the status of your account, or the Campus or JPL Benefits Office.

If you have a Prudential or a Mutual Benefit Life TDA, you have the option of exchanging your old contract for a TIAA-CREF contract in the NonERISA TDA Plan at any time. However, if you do so, you will not be able to transfer funds back to the old contract.

Withdrawals

The NonERISA TDA plan is intended to help you save for your retirement. In general, you may begin receiving your benefits following termination of employment. You may withdraw your funds anytime after age 59½ regardless of employment status without tax penalty. All withdrawals are subject to federal and state income tax. If you choose a lump sum withdrawal and do not directly rollover the funds to another eligible retirement plan or Individual Retirement Account
(IRA), your withdrawal will be subject to a 20% federal tax withholding.

**Direct Transfers**

Effective January 1, 2010 accumulations in the NonERISA TDA plan may be transferred from Fidelity to TIAA RCP account at any time (direct transfers). See individual contracts for any restrictions that may apply.

**Hardship Withdrawals**

Under certain circumstances, you may be permitted to withdraw your contributions in the case of a financial hardship, as defined by the IRS. These withdrawals are limited to the amount you have contributed and do not include any earnings you have accumulated. Contact the individual carrier for information about hardship withdrawals.

Lump sum withdrawals during active employment before age 59½ are permitted only if you are called to active military duty for more than 30 days or if you experience a bona fide hardship as defined by the IRS, and may be subject to a 10% federal penalty tax.

If you take a hardship withdrawal from any of your TDA accounts, any existing employee voluntary pre-tax deferrals to all Caltech-sponsored plans will stop immediately following your hardship withdrawal for a period of six months. After the six month suspension is over you must complete a new online Salary Deferral Agreement.

**Withdrawals During Active Military Duty**

If you are called to active military duty for more than 30 days, you are eligible to withdraw part or all of your TDA accounts, even though you may be considered still actively employed. In that event, your voluntary pre-tax deferrals to the ERISA TDA plan will be suspended for six months. If you are ordered to active duty for at least 180 days, you may be eligible to receive a qualified reservist distribution, which does not require a suspension of deferrals.

**Penalties For Early Withdrawals**

If you terminate employment with the Institute, you may elect to receive a lump sum distribution before you reach age 59½. However, it may be subject to a 10% federal penalty tax. In general, you may defer receiving your benefits until the April 1 following the calendar year in which you reach age 70½.

**Direct Rollovers**

Following termination of employment you can choose a direct rollover of all or any portion of your distribution that is an “eligible rollover distribution”. You may rollover your funds anytime after age 59½ regardless of employment status. In a direct rollover, the eligible rollover distribution is paid directly from your 403(b) account to a traditional IRA, a Roth IRA, or another eligible retirement plan that accepts rollovers. Your payment can not be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account (formerly known as an education IRA). An “eligible retirement plan” includes a plan qualified under Section 401(a) of the Internal Revenue Code (i.e., a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan or money purchase plan), a section 403(b) plan and an eligible section 457(b) plan maintained by a governmental employer.

If you choose a direct rollover to an eligible retirement plan or a traditional IRA, you are not taxed on the distribution until you actually take it out of the receiving eligible retirement plan or traditional IRA account. If you have the distribution paid to you, then the plan must withhold 20% for federal income tax even if you decide to roll over the money into another retirement plan or into a traditional IRA within 60 days. If you choose a direct rollover to a Roth IRA, you will be taxed on the full amount of your distribution in the year of distribution but you may be eligible for tax benefits when you take a distribution from the Roth IRA if certain conditions are satisfied.
Effective for distributions after December 31, 1999, a financial hardship withdrawal cannot be rolled over to another eligible retirement plan (i.e., 401(k), 403(b), etc.) or an IRA.

**TDA Plan Loans**

The loan provision gives you the flexibility to use your TDA account savings in the GSRA and RCP as collateral for a loan of the same amount – while continuing to preserve the advantages of tax deferral, investment growth opportunity and security. For loans based on RCP accumulations, you will have to transfer funds into a TIAA Retirement Loan (RL) contract to obtain a loan.

Generally the minimum loan amount is $1,000 and the maximum loan amount is $50,000. The maximum amount you can borrow may be less, however, depending on two factors: 1) the amount of your accumulation, and 2) whether you have had any other loans from any of Caltech’s plans within the last year.

If you have not had a plan loan in the previous year, your maximum loan cannot exceed the lesser of one-half of your vested account balance or $50,000. Your maximum loan amount is further limited to

1) 45% of your combined TIAA and CREF accumulation attributable to participation under this plan; or

2) 90% or your CREF and TIAA Real Estate accumulation attributable to participation under this plan for RL loans or

3) 90% of your TIAA Annuity accumulation attributable to participation under this plan for a GSRA loan.

If you have had another loan from any Caltech plan within the last year, the maximum you can borrow will be reduced by that amount. In addition, if you default on a loan, your right to a future loan may be restricted. Further, the maximum loan amount will be reduced by the amount in default (plus interest) until the defaulted amount can be deducted from your accumulation.

The amount you borrow does not reduce your plan account. Instead, your plan account serves as collateral for the loan and continues to earn the normal crediting rate for the TIAA Traditional account. You are borrowing from TIAA and interest paid on the loan is retained by TIAA.

Interest on loans from this plan will be computed on the following basis:

- The interest rate you pay initially will be the higher of 1) the Moody’s Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or 2) the interest credited before your annuity starting date, as stated in the applicable rate schedule, plus 1 percent. Thereafter the rate will change annually, but only if the Moody’s Corporate Bond Yield Average for the calendar month ending two months before the anniversary of your loan differs from your current rate by at least a half percent. If the latest average differs by less, your interest rate will remain the same for the next year.

Generally, you have one to five years to repay your loan. However, if you use the loan solely to purchase your primary residence, you can take up to ten years to repay. In addition, for loans from the ERISA TDA plan, your spouse must consent in writing to your request for a plan loan if you are married.

During a period of qualified military service, your loan payments may be suspended.

There are no loan provisions available with Fidelity. Contact TIAA-CREF if you have questions about the loan program.

**Payment Of Benefits**

You may choose from among several types of income options when you retire or terminate employment. The Campus or JPL Benefits Office and the individual TDA investment companies have more detailed information about your payment options. The rules of each individual
TDA may vary slightly, but in general they each offer the following payment options:

- **Lump Sum** — you will be paid the entire balance of your account in one lump sum payment.

- **Installment Payments** — you may receive payments over a specified number of years, not to exceed your life expectancy. In the event of your death, payments are continued to your Beneficiary for the remainder of the specified period.

- **Annuity Income** — you may choose from a variety of annuity income options, which pay benefits either over the remainder of your life, with optional guaranteed periods. You may also choose options that will continue all or a percentage of your benefits to your spouse or other Beneficiary in the event of your death.
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INTRODUCTION

This Handbook (along with the carriers’ Evidence of Coverages (EOC) where applicable) constitutes the SPD for the Caltech benefit program.* This section provides important information about the administration of the Caltech benefit program as follows:

- If you lose medical plan coverage
- Claim denial and appeal process
- Your rights under the Employee Retirement Income Security Act (ERISA)
- Plan continuation
- Plan information

If you have any questions about this information, please contact the Campus or JPL Benefits Office.

*See Section 7 for additional information on the Retirement Plan.

CLAIM DETERMINATION AND APPEAL PROCEDURES OVERVIEW

The Caltech benefit program is covered under Title I of ERISA. In accordance with section 503 of Title I of ERISA, the Institute has designated one or more Claims Administrators to serve as named fiduciaries (which may include the Institute itself), each with complete authority to review all denied claims for benefits. In exercising its responsibilities, the named fiduciary has authority to determine whether participants and Dependents are eligible for benefits, and to construe disputed terms. The Institute, by action of its Board of Trustees, may also delegate any of its power and duties with respect to any plan or plan amendments, to one or more officers or other employees of the Institute. Any such delegation shall be stated in writing.

The Claims Administrators shall be responsible for administering claims for benefits under the plans on all fully insured coverages. The Claims Administrators shall also provide a full and fair review of denied claims. The Claims Administrators’ decision on appeal of disputed claims shall be the final review for the plans. The Claims Administrators shall have sole and complete discretionary authority to determine eligibility for persons to receive benefits under the plans, to construe the terms of the plans, to make factual determinations and to determine the validity of charges. The Claims Administrators will exercise good faith, apply standards of uniform application, and refrain from acting arbitrarily or capriciously.

IF YOU LOSE MEDICAL PLAN COVERAGE UNDER THIS PLAN

If you lose health coverage under the Caltech medical plan, you will receive a certificate of prior medical coverage directly from the carrier. You and/or your Dependents will receive a certificate of creditable coverage when your coverage terminates, again when COBRA coverage terminates (if you elect COBRA), and upon request (if the request is made within 24 months of either loss of coverage).

See Appendix III, page 9.3 for a sample of the coverage certification.
CLAIM DETERMINATION AND APPEAL PROCEDURES FOR MEDICAL AND DENTAL PLANS

The following information applies to Kaiser and Anthem Blue Cross medical plans only.

You must use and exhaust the plan's administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

Time Frame for Claim Determination

For urgent care claims and pre-service claims (claims that require approval of the benefit before receiving medical care), the Claim Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- As soon as possible but not later than 72 hours after receipt of a claim initiated for urgent care (an adverse benefit determination can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification).

- Within a reasonable time but not later than 15 days after receipt of a pre-service claim.

For post-service claims (claims that are submitted for payment after receiving medical care), the Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Claim Administrator’s receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claim Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the Plan’s time frame for making a benefit determination is stopped from the date the Claim Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fail to follow the plan’s procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be
followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

1. Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and

2. Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

**Urgent Care Claims**

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s life, health or ability to regain maximum function, or

- In the opinion of a physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient’s medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

**Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

**Note:** Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

**Attention Kaiser Members:** (Kaiser is not a claims based entity. Therefore they do not require either pre-service or in-network urgent care claims. Additional Information on non-plan Emergency care of out-of-network Urgent care can be obtained directly from Kaiser.)

**If You Receive an Adverse Benefit Determination**

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
4. A description of the plan’s appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;

5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

Attention Kaiser Members: Kaiser members seeking a referral or provision of reimbursement for services to which they believe they were inappropriately denied by Kaiser Permanente, may submit a verbal or written grievance to a Member Services representative. Receipt of the grievance will be acknowledged in writing within five calendar days. An Acknowledgment letter will include the name of the Member Service representative who will respond to the member, on behalf of the Medical Center Review Committee, and will offer the member the opportunity to appear before (or teleconference into) the committee to present their case if they wish to do so. The committee’s decision will be made within 20 days of receipt of grievance.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
   i) Was relied upon in making the benefit determination;
   ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
   iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; or
   iv) Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination;

3. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information
was submitted or considered in the initial benefit determination;

4. A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate;

5. A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgement (including whether a particular treatment, drug or other item is experimental);

6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

7. In the case of a claim for urgent care, an expedited review process in which:

   i) you may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination, and

   ii) all necessary information, including the plan’s benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- As soon as possible, but not later than 72 hours after receipt of your request for review of an urgent care claim.

- 30 days after receipt of your request for review of a pre-service claim.

- 60 days after receipt of your request for review of a post-service claim.

The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. 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 your claim;

4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request; and

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your
local U.S. Department of Labor Office and your State insurance regulatory agency.

Attention Kaiser Members: If after receiving the response and the member disagrees with the decision, they may submit an appeal for reconsideration. The appeal should be in writing and explain why they believe the decision was in error. The appeal must be sent to the Member Relations Department, at the address specified within the initial response, within 60 days after receiving the decision from Kaiser Permanente. Kaiser will acknowledge the appeal within five calendar days, and will include the name of the Member Relations specialist who will respond to the member on behalf of the Appeals Committee. The process will continue as described above. Please refer to the Kaiser Permanente Evidence of Coverage for further information regarding the Claims Appeals process.

The following information applies to the Delta Dental PPO plan only.

If you have any questions about the services received from a Delta Dental Dentist, Delta Dental recommends that you first discuss the matter with your Dentist. If you continue to have concerns, you may call or write Delta Dental. Delta Dental will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of eligibility should first be handled directly between you and the Campus or JPL Benefits Office. If you have a question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call Delta Dental toll-free at 800-765-6003, contact Delta Dental on their website at: deltadentalins.com or write Delta Dental at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review with Delta Dental within 180 days after receipt of the denial or modification. Delta Dental will treat the request for review as a grievance. If in writing, the correspondence must include the group name and number, the Primary Enrollee’s name and ID number, the inquirer’s telephone number and any additional information that would support the claim for benefits. The correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Delta Dental’s review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of Delta Dental’s regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta Dental’s review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and we will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, Delta Dental shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Delta Dental will provide a written acknowledgement within five days of receipt of the request for review. Delta Dental will render a decision and respond to you within 60 days of receipt of the request for review. Delta Dental will respond, within 72 hours to grievances involving severe pain and imminent and serious threat to a patient’s health (urgent care grievance).

You may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about your rights under the Employee Retirement Income Security Act (ERISA).

The following information applies to dental plans other than the Delta Dental plan. You must use and exhaust this plan's administrative claims and appeals procedures before bringing a suit in either state or Federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

**Time Frame for Claim Determination**

For **urgent care claims**, the Claim Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- As soon as possible but not later than 72 hours after receipt of a claim initiated for urgent care (an adverse benefit determination can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification).

For **post-service claims** (claims that are submitted for payment after receiving medical care), the Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **urgent care claims**, if you fail to provide the Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Claim Administrator’s receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **post-service claims**, a 15-day extension may be allowed to make a determination, provided that the Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claim Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **post-service claims** due to your failure to submit necessary information, the Plan’s time frame for making a benefit determination is stopped from the date the Claim Administrator sends you an extension notification until the date you respond to the request for additional information.

**Urgent Care Claims**

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s life, health or ability to regain maximum function, or
In the opinion of a physician with knowledge of the patient’s condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient’s medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

**Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an **urgent care claim** as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a **non-urgent circumstance**, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

**Note:** Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

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**If You Receive an Adverse Benefit Determination**

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
4. A description of the Plan’s appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.
Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits;

2. Request, free of charge, reasonable access to, and copies, of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
   i) Was relied upon in making the benefit determination;
   ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
   iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
   iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

3. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;

4. A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate;

5. A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental);

6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

7. In the case of a claim for urgent care, an expedited review process in which:
   i) you may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination, and
   ii) all necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- 72 hours after receipt of your request for review of an urgent care claim.
- 60 days after receipt of your request for review of a post-service claim.
The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;
2. References to the specific Plan provisions on which the benefit determination is based;
3. 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 your claim;
4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request; and
6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

For non-grandfathered medical and dental plan benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules would not apply to standalone dental or vision claims or health care flexible spending account claims.

**CLAIM DETERMINATION AND APPEAL PROCEDURES FOR HCSA CLAIMS**

You must use and exhaust this plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

**Time Frame for Claim Determination**

For post-service claims (claims that are submitted for payment after receiving medical care), the Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim.

An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For post-service claims, a 15-day extension may be allowed to make a determination, provided that the Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claim Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for post-service claims due to your failure to submit necessary information, the plan’s time frame for making a benefit determination is stopped from the date the Claim Administrator sends you an extension.
notification until the date you respond to the request for additional information.

**If You Receive an Adverse Benefit Determination**

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;
2. Reference to the specific plan provisions on which the benefit determination is based;
3. A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
4. A description of the plan’s appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;

If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**Procedures for Appealing an Adverse Benefit Determination**

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits;
2. Request, free of charge, reasonable access to, and copies, of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
   i) Was relied upon in making the benefit determination;
   ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
   iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; or
   iv) Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
3. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;
4. A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate;
5. A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental);

6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

Ordinarily, a decision regarding your appeal will be reached within:

- 60 days after receipt of your request for review of a post-service claim.

The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. 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 your claim;

4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request; and

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**CLAIM DETERMINATION AND APPEAL PROCEDURES FOR VISION**

You must use and exhaust this plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

**Time Frame for Claim Determinations**

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claim Administrator will notify you of the adverse determination within a reasonable period of time, but no later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Claim Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the
plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.

**If You Receive an Adverse Benefit Determination**

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;

4. A description of the plan’s appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

**Procedures for Appealing an Adverse Benefit Determination**

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits;

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:

   i) Was relied upon in making the benefit determination;

   ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;

   iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

3. A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Claim Administrator will notify you of the plan’s benefit determination on review within a reasonable period of time, but no later than 30 days after receipt of your request for review by the plan. This 30 day period may be extended for up to an additional 30 days, if the Claim Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 30 day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the required date you respond to the request for additional information.
Plan Information

The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. 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 your claim; and

4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Claim Determination and Appeal Procedures

For Group Long Term Disability

You must use and exhaust this plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination. No lawsuit may be started to obtain benefits until 60 days after proof is given. No lawsuit may be started more than 3 years after the time proof must be given.

Time Frame for Claim Determinations

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claim Administrator will notify you of the adverse determination within a reasonable period of time, but no later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the Claim Administrator both determines the extension is necessary due to matters beyond the control of the plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claim Administrator again determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the Claim Administrator must notify you, before the first 30-day extension period expires, of the reason(s) requiring the extension of time and the date by which the plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- the standards on which entitlement to a benefit is based,
- the unresolved issues that prevent a decision on the claim, and
- the additional information needed to resolve those issues.

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.
If You Receive an Adverse Benefit Determination

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;

4. A description of the plan's appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal;

5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination will be provided free of charge to you upon request; and

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Procedures for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits. Your appeal must include at least the following information:
   i) Name of Employee
   ii) Name of Plan
   iii) Reference to the initial decision
   iv) An explanation of why you are appealing the initial decision

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
   i) Was relied upon in making the benefit determination;
   ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
   iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
   iv) Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

3. A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in
the initial benefit determination;

4. A review that does not defer to the initial adverse benefit determination and that is conducted by a named fiduciary of the plan that is neither the individual who made the adverse determination nor that person's subordinate;

5. If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination nor the subordinate of any such individual; and

6. The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.

The Claim Administrator must notify you of the plan’s benefit determination on review within a reasonable period of time, but no later than 45 days after receipt of your request for review by the plan, unless the Claim Administrator determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the Claim Administrator expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.

The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. 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 your claim; and

4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

5. Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or notice that a copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination will be provided free of charge upon request; and

6. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

7. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to
find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.

CLAIMS PROCEDURES FOR THE BASE RETIREMENT PLAN AND ERISA TDA PLAN

The following rules describe the claim procedures under the Base Retirement Plan and the ERISA TDA Plan:

- **Filing a claim for benefits** — A claim or request for Plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to the Sr. Director of Total Rewards, Human Resources.

- **Processing the claim** — The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to make its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

- **Denial of claim** — If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent Plan provisions on which the denial is based, a description of any additional material or information necessary for claim approval, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not given to you within the 90/180-day period, the claim is considered denied and you must be permitted to proceed to the review stage.

- **Review procedure** — You or your authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to see all Plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.

**Decision on review** — The Plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the Plan procedures provide for such a hearing), you must be furnished with written notice of the extension. Such notice must be provided no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based. For a plan with a committee or board of trustees designated as the appropriate named fiduciary, a decision does not have to be made within the 60-day limit if the committee or board meets at least four times a year (about every 90 days). Instead, it must be made at the first meeting after the request is filed, except that when a request is made less than 30 days before a meeting, the decision can wait until the date of the second meeting following the Plan’s receipt of request for review. If a hearing must be held, the committee can wait to decide until the first meeting after the hearing. However, it must
notify you and explain the delay, which can be no later than the third meeting of the committee or board following the Plan’s receipt of the request for review. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. If appeal is denied, in whole or in part, you have a right to file suit in a state or federal court.

**CLAIM DETERMINATION AND APPEAL PROCEDURES FOR ALL PLANS OTHER THAN MEDICAL, DENTAL, VISION, HCSA AND GROUP LONG TERM DISABILITY**

You must use and exhaust this plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

**Time Frame for Claim Determinations**

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claim Administrator will notify you of the adverse determination within a reasonable period of time, but no later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Claim Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.

**If You Receive an Adverse Benefit Determination**

The Claim Administrator will provide you with a notice of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;
2. Reference to the specific plan provisions on which the benefit determination is based;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;
4. A description of the plan’s appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

**Procedures for Appealing an Adverse Benefit Determination**

You, or your authorized representative, have 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits;
2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. For this purpose,
A document, record, or other information is treated as “relevant” to your claim if it:

i) Was relied upon in making the benefit determination;

ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;

iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

3. A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Claim Administrator will notify you of the plan’s benefit determination on review within a reasonable period of time, but no later than 60 days after receipt of your request for review by the plan. This 60-day period may be extended for up to an additional 60 days, if the Claim Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.

The Claim Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

1. The specific reason(s) for the adverse benefit determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. 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 your claim; and

4. A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

GRIEVANCE PROCESS

Health Care Service Plans and Non-Profit Plans

If you have a dispute with your prepaid medical or dental HMO plan, which has not been satisfactorily resolved by the plan or an emergency grievance, these are the steps you should follow:

1. Call your medical or dental plan using their published toll free number and follow their grievance procedure. See page 2.2 for phone numbers.

2. If you encounter difficulties with that process, call the Benefits Office at Caltech or JPL for assistance.

3. If you need further help, you may call the California Department of Managed Care using their toll free number 1-800-400-0815.
Plan Information

**Insured Health Plans**

If you have a dispute with your medical plan, these are the steps you should follow:

1. Call or write to your health plan and follow their grievance procedure. See page 2.2. In the case of Anthem Blue Cross, there is a special Complaint Form that you may use.

2. If you encounter difficulties with that process, call the Campus or JPL Benefits Office for assistance.

3. If disputes cannot be settled through the appeals process, they may be settled by arbitration following the rules of the American Arbitration Association.

You can begin this process by giving written notice to each party.
YOUR RIGHTS UNDER ERISA

As a participant in the Caltech benefits plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, you may:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of all plan documents, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.
- In the case of an ERISA-covered retirement plan, obtain a statement telling you whether you have a right to receive a benefit at Normal Retirement Age under the plan and if so, what your benefit would be at such date if you were to stop working. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse, or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for you, ERISA imposes duties on the people responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries", have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA.
**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce these rights.

**For example:**
If you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive them, unless the reason you do not receive them is beyond the administrator’s control.

If you have a claim for benefits denied or ignored in whole or in part, you may file suit in a state or Federal court, but only after you have exhausted the plan’s claims and appeals procedures, as described in section 8 of this Handbook.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court.

If plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court decides who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your benefit plans, contact the Campus or JPL Benefits Office. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC, 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of The Employee Benefits Security Administration.

**SPOUSE’S RIGHTS UNDER THE ERISA PLANS**

Under the Base Retirement Plan and the ERISA TDA Plan, benefits must be paid to married Participants in the Plan only as described below, unless a written waiver of the benefits by the Participant and a written consent to the waiver by the spouse is filed with TIAA and CREF. This provision applies to both retirement benefits and pre-retirement death benefits.

If benefits began before your death, your surviving spouse at your death will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, the full current value of your annuity accumulation becomes payable (pre-retirement death benefit). Federal law requires that at least 50% of such benefit be paid to your spouse (with the remaining 50% paid to your designated Beneficiary) unless your spouse has waived, and consented in writing to an alternate Beneficiary for, such benefit. Pre-retirement death benefits
are payable in a single sum or under one of the income options offered by TIAA and CREF.

Married Participants and their spouses may waive the spouse’s right to a joint and survivor annuity or his or her pre-retirement death benefit only if a written waiver of the benefit signed by the Participant and the spouse (and notarized) is filed with TIAA and CREF. The necessary forms will be provided to the Participant by TIAA and CREF.

For post-retirement survivor benefits (joint and survivor annuity), the waiver may be made only during the 180-day period before benefits begin. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.

The period during which you and your spouse may elect to waive the pre-retirement survivor death benefit begins on the first day of the Plan year in which you reach age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before reaching age 35 — that is, before you have had the option to make a waiver — 50% of the current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by TIAA and CREF; the remaining 50% is payable to your designated Beneficiary. If you terminate employment before age 35, the period for waiving the spousal pre-retirement death benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

If a judgment, decree or order made following a state domestic relations law establishes the rights of another person (the “alternate payee”) to your benefits under this Plan, and if such an order (called a “qualified domestic relations order”) is for providing child support, alimony or other marital property payments, then payments will be made according to that order provided the order does not conflict with the provisions of the Plan or the terms of a previous qualified domestic relations order. If a court issues a qualified domestic relations order, the order overrides the usual requirements that your spouse be considered your primary Beneficiary for a portion of the accumulation. Copies of the Plan’s procedures relating to qualified domestic relations orders are available on written request to the Plan Administrator.

YOUR RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). You may still need precertification from the plan to avoid a reduction of the dollar amount covered by the plan.
MASTECTOMY COVERAGE

The medical plan provides benefits related to breast reconstruction in compliance with the requirements of the Women's Health and Cancer Rights Act (WHCRA) of 1998. The medical plan will include covered expenses, expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery and reconstruction on the other breast to achieve symmetry, the cost of prostheses and the costs of treatment of physical complications at any stage of the mastectomy including lymphedemas. Normal plan deductibles and coinsurance will apply. Please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu (under the Health tab).

PLAN CONTINUATION

The Institute expects and intends to continue its benefits program but reserves the right to amend, modify, suspend or terminate it, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the Vice-President for Business and Finance or Human Resources, as applicable.

The Institute does not guarantee the continuation of any benefits during any periods of active employment, inactive employment or retirement, nor does it guarantee any specific level of benefits. Benefits under this plan are at the Institute’s discretion and do not create a contract of employment.

LIMITATION NECESSARY TO SATISFY VARIOUS NONDISCRIMINATION TESTS UNDER THE INTERNAL REVENUE CODE

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 employee’s pre-tax salary reduction contributions, and modify benefit selection, availability and/or the method of allocating 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.
### PLAN INFORMATION

#### Plan Names/Numbers

The employer identification number assigned to the plan sponsor by the IRS is **95-1643307**. The official names of the plans and their plan numbers are shown below. Plans that do not have numbers are not subject to ERISA.

#### Plan Year

The plan year for all plans is January 1 through December 31.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Number</th>
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<tbody>
<tr>
<td>Defined Contribution Retirement Plan (Base Retirement Plan)</td>
<td>002</td>
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<tr>
<td>California Institute of Technology Pension Plan</td>
<td>004</td>
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<tr>
<td>ERISA Tax Deferred Account Plan (ERISA TDA Plan)</td>
<td>005</td>
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<tr>
<td>Consolidated Welfare Plan of California Institute of Technology which includes the following:</td>
<td>601</td>
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<tr>
<td>• Group Life Insurance and Accidental Death &amp; Personal Loss Plan</td>
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<td>• Group Long Term Disability Plan</td>
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<td>• Travel Accident Plan</td>
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<td>• Extra Hazardous Duty Insurance Plan</td>
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<td>• Kaiser Permanente Health Plans</td>
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<td>• Anthem Blue Cross HMO Plan</td>
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<td>• Anthem Blue Cross PPO Plan</td>
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<td>• Anthem Blue Cross Health Savings Plan</td>
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<td>• Anthem Blue Cross/Blue Card PPO</td>
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<td>• Delta Dental PPO Plan</td>
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<td>• VSP PPO Plan</td>
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<td>• Employee Assistance Program (EAP)</td>
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<td>• California Institute of Technology Safeguard Dental Plan</td>
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<tr>
<td>• California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HCSA not DCSA)</td>
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<tr>
<td>Educational Assistance Program*</td>
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<td>International SOS Medical Access/International Referral Service</td>
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<td>Prudential Tax Deferred Annuity Plan*</td>
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<tr>
<td>TIAA-CREF Non ERISA TDA Plan*</td>
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</tr>
<tr>
<td>Fidelity Investment Non ERISA TDA Plan*</td>
<td></td>
</tr>
</tbody>
</table>

* Plans that do not have numbers are not subject to ERISA.
Plan Sponsor

The plan sponsor for all plans is the California Institute of Technology. You may contact the plan sponsor at the following addresses:

Mailing Address:

California Institute of Technology
1200 E. California Boulevard
Mail Code 161-84
Pasadena, CA 91125

Physical Address:

California Institute of Technology
399 S. Holliston
Mail Code 161-84
Pasadena, CA 91125

Plan Funding and Type of Administration

The medical, dental, group life, LTD, PAI Travel Accident Insurance Plan and Extra-Hazardous Insurance Plan benefits are insured as listed below under the “Claims Administrator” section. Benefits are guaranteed under contracts of insurance (see policy numbers on page 2.2).

The health and dependent day care spending accounts (HCSA and DCSA) are self-insured and paid out of general assets. Claims are administered by a third party administrator. The name and address of the Claims Administrator for these benefits is listed below under the “Claims Administrator” section. The Claims Administrator for the spending accounts is responsible for determining whether you are entitled to benefits and authorizing payment. Benefits under the reimbursement accounts are not guaranteed by the Claims Administrator under a contract or policy of insurance.

Source of Contributions

Employees who participate in the plan are required to make contributions for certain coverage. The California Institute of Technology in its sole and absolute discretion, shall determine the amount of any required employee contributions under the plan and may increase or decrease the amount of the required contribution at any time. The California Institute of Technology may require different contribution levels for different classes of employee and will notify employees annually as to what the employee contribution rates will be.

The California Institute of Technology shall contribute the difference between the amount employees contribute and the premiums for the group insurance coverage. Any experience credits or refunds under a group insurance contract shall be applied first to reimburse The California Institute of Technology for its contributions, unless otherwise provided in that group insurance contract or required by applicable law. Voluntary coverages are entirely paid by employees.

Plan Administrator

The plan administrator for all plans is the Institute. Caltech has named the Sr. Director of Total Rewards, Human Resources to be responsible for enrolling participants and for performing other duties required for the operation of the plans.

You may contact the plan administrator at the following addresses:

Mailing Address:

California Institute of Technology
1200 E. California Boulevard
Mail Code 161-84
Pasadena, CA 91125

Physical Address:

California Institute of Technology
399 S. Holliston
Mail Code 161-84
Pasadena, CA 91125

Refer to the box on page 2.1 for a description of governing documents under the plan.
Claims Administrator
The benefits are guaranteed under a contract and/or policy of insurance issued by the issuer. The issuers provide various administrative services including claims administration.

The Claims Administrator for each plan is as follows:

Anthem Blue Cross PPO (Medical)
21555 Oxnard Street
Woodland Hills, CA 91367

Anthem Blue Cross Health Savings Plan (Medical)
21555 Oxnard Street
Woodland Hills, CA 91367

Anthem Blue Cross HMO (Medical)
21555 Oxnard Street
Woodland Hills, CA 91367

Kaiser Foundation Health Plan, Inc. (Medical)
393 East Walnut Street
Pasadena, CA 91188-8110

Employee Assistant Program (EAP)
Campus SFCC-626-395-8360 or via e-mail: SFCC@caltech.edu
JPL EAP-818-354-3680 or via e-mail: EAP@jpl.nasa.gov

Delta Dental of California (Dental)
P. O. Box 997330
Sacramento, CA 95899-7330

Group Health Cooperative (Claims)
P.O. Box 34585
Seattle, WA 98124
1-888-901-4636

MetLife (DHMO) Safeguard. (Dental)
Claims Department
P.O. Box 30930
Laguna Hills, CA 92654

Anthem Blue Cross UniAccount (Reimbursement Accounts)
21555 Oxnard Street
Woodland Hills, CA 91367

Vision Service Plan (VSP)
P.O. Box 997105
Sacramento, CA 95899-7105
800-877-7195

Aetna Life Insurance Service Center
(Life Insurance and AD&PL)

International SOS (Medical Access/International Referral Service)
800-523-6586
International SOS Accepts Collect Calls from Members Overseas

Teachers Insurance and Annuity Association
College Retirement Equities Fund
730 Third Avenue, New York, NY 10017
1-800-842-2733

Agent of Legal Process
Any legal correspondence regarding the plans should be sent to:

General Counsel
California Institute of Technology
1200 E. California Blvd., 108-31
Pasadena, CA 91125

Contract of Employment Disclaimer
This SPD provides detailed information about the benefit plans and how they work. This SPD does not constitute an implied or expressed contract or guarantee of employment.
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## APPENDIX I*

**Benefit Program – Affiliate Organizations**

<table>
<thead>
<tr>
<th>If you are employed by</th>
<th>Available plans:</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Association for Research and Astronomy (CARA)</td>
<td>• Travel Accident Insurance Plan</td>
</tr>
<tr>
<td>Caltech Children’s Center (CCC)</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Dental Plans</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Personal Accident Insurance Plan</td>
</tr>
<tr>
<td>Child Educational Center - JPL (CEC)</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Dental Plans</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Personal Accident Insurance Plan</td>
</tr>
<tr>
<td>Caltech Federal Employees Credit Union</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Dental Plans</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Group Life Insurance Plans</td>
</tr>
<tr>
<td></td>
<td>• Group Long Term Disability Plan</td>
</tr>
<tr>
<td></td>
<td>• Personal Accident Insurance Plan</td>
</tr>
<tr>
<td>Caltech Y</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Dental Plans</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Group Life Insurance Plans</td>
</tr>
<tr>
<td></td>
<td>• Group Long Term Disability Plan</td>
</tr>
<tr>
<td></td>
<td>• Personal Accident Insurance Plan</td>
</tr>
<tr>
<td>CELT Development Corporation</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Dental Plans</td>
</tr>
<tr>
<td></td>
<td>• Vision Plan</td>
</tr>
<tr>
<td></td>
<td>• Group Life Insurance Plans</td>
</tr>
<tr>
<td></td>
<td>• Group Long Term Disability Plan</td>
</tr>
<tr>
<td></td>
<td>• Personal Accident Insurance Plan</td>
</tr>
<tr>
<td>Huntington Library</td>
<td>• Medical Plans</td>
</tr>
<tr>
<td></td>
<td>• Medical Plans</td>
</tr>
</tbody>
</table>

Check with your employer regarding cost-sharing and plan enrollment. Please refer to your organizations benefits summary plan documents for plan and coverage information. *As referenced on page 2.4.

1/1/2014
APPENDIX II*

Medical Plan:  
Pre-April 1, 1991 Retiree Transition Eligibility Rules

When you retire, you will qualify for the pre-April 1, 1991 medical plan retiree cost-sharing rules providing you were “Actively At Work” and had a minimum of ten years of continuous service immediately prior to April 1, 1991, and you met at least one of the following criteria as of April 1, 1991:

- You had attained age 55.
- Your age plus your years of service was greater than or equal to 72.
- Your years of service plus three times your age was greater than or equal to 175.

If you have any questions about these transition rules, please contact the Campus or JPL Benefits Office.

*As referenced on page 2.18.
APPENDIX III*

California Institute of Technology
Important Notice of Your Right
to Documentation of Health Coverage

Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a “certificate of creditable coverage” that will show evidence of your prior health coverage.

You, your Spouse, your Registered Domestic Partner, your Same-Sex Domestic Partner and/or Dependent child(ren) who lose group health coverage must receive certification of your coverage under the program. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You, your Spouse, your Registered Domestic Partner, your Same-Sex Domestic Partner and/or Dependent child(ren) will receive a coverage certificate when your coverage terminates, again when COBRA coverage terminates (if applicable and if you elected COBRA), and again upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer’s plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements).

If you are purchasing individual coverage, you may need to present the coverage certificate to your insurer at that time as well. A certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your state insurance department for further information.

Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, complete the attached form and return it to:

California Institute of Technology
1200 E. California Boulevard, 161-84
Pasadena, CA 91125
626-395-6443

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your Dependents (including your Spouse, Registered Domestic Partner and Same-Sex Domestic Partner) who are enrolled under your health coverage.

*As referenced on page 8.1.
REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _________________________________  SSN: __________________

Address: __________________________________________

Telephone Number: _________________________________  Date: __________________

Name and relationship of any Dependents for whom certificates are requested (and their address if different from above): ________________________________
NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

APPENDIX IV

Notice of Creditable Prescription Drug Coverage

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read this notice carefully. It has information about prescription drug coverage with Caltech and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving Caltech coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by a Caltech prescription drug plan, you’ll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2012. This is called creditable coverage. Coverage under a Caltech plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your Caltech coverage. In this case, the Caltech plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Caltech coverage, Medicare will be your only payer. You can re-enroll in the Caltech plan at annual enrollment or if you have a special enrollment event.

You should know that if you waive or leave coverage with Caltech and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if the Caltech coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook (See ISSUE LOG – Ok to have both soft and hard due to access) do we need to have a supply of these? Is soft copy ok?). Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here’s how to get more information about Medicare prescription drug plans:

Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, please contact:

<table>
<thead>
<tr>
<th>Campus</th>
<th>JPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>JPL Benefits Office</td>
</tr>
<tr>
<td>Monday – Friday</td>
<td>Monday – Friday</td>
</tr>
<tr>
<td>7:30 a.m. – 5:00 p.m.</td>
<td>7:30 a.m. – 4:30 p.m.</td>
</tr>
<tr>
<td>399 South Holliston</td>
<td>T1720-B</td>
</tr>
<tr>
<td>(626) 395-6443</td>
<td>(818) 354-3760</td>
</tr>
<tr>
<td><a href="mailto:hrbenefits@caltech.edu">hrbenefits@caltech.edu</a></td>
<td><a href="mailto:benefits@jpl.nasa.gov">benefits@jpl.nasa.gov</a></td>
</tr>
</tbody>
</table>
APPENDIX V
California Institute of Technology
Information Regarding Plan Grandfathered Status

Please reference the below table that outlines the grandfathered status of the medical plan you are enrolled in:

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Grandfathered/Non Grandfathered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross HMO</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Anthem Blue Cross PPO</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Anthem Blue Cross Health Savings Plan</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Anthem Blue Cross HMO (Huntington Library Only)</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Anthem Blue Cross PPO (Huntington Library Only)</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Group Health Cooperative</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Non Grandfathered</td>
</tr>
<tr>
<td>Kaiser Permanente Mid Atlantic</td>
<td>Grandfathered</td>
</tr>
</tbody>
</table>

As applicable in the table above, 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, for example, 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, for example, 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 web site 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.
Appendix VI: Employee Privacy Notice

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 of the Institute’s Employee Assistance Program (EAP). 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.
EMPLOYEE PRIVACY NOTICE

- **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:

<table>
<thead>
<tr>
<th>Workers’ compensation</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary to prevent serious threat to health or safety</td>
<td>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</td>
</tr>
<tr>
<td>Public health activities</td>
<td>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</td>
</tr>
<tr>
<td>Victims of abuse, neglect, or domestic violence</td>
<td>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)</td>
</tr>
<tr>
<td>Judicial and administrative proceedings</td>
<td>Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)</td>
</tr>
<tr>
<td>Law enforcement purposes</td>
<td>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</td>
</tr>
<tr>
<td>Decedents</td>
<td>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</td>
</tr>
<tr>
<td>Organ, eye, or tissue donation</td>
<td>Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death</td>
</tr>
<tr>
<td>Research purposes</td>
<td>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</td>
</tr>
<tr>
<td>Health oversight activities</td>
<td>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</td>
</tr>
</tbody>
</table>
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 confidential 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.