

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 8.20), and the Tax Savings and Spending Account Plan. The TIAA-CREF Defined Contribution Retirement Plan (plan 002) 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, 2009 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.

Unless otherwise noted, information included in this Summary Plan Description (SPD) is applicable to all Faculty and Staff.

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.

This Benefits Handbook, together with the EOC issued by the insurance carrier or HMO constitutes your SPD under ERISA. You should refer to the Handbook first before referring to any other documents on your Caltech benefits. The Handbook covers eligibility features of each plan and other Caltech-specific policies and procedures. In addition, the Handbook along with the applicable EOC, provide you with a detailed summary of your benefits coverage. Any terms in the Handbook with respect to eligibility and Caltech-specific policies and procedures shall supersede any items in conflict with the applicable 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. With respect to the Retirement Plans, Tax Savings Plan and Spending Account Plan, in the event of a conflict between the legal plan documents and the Handbook, the legal plan documents shall govern.

The most recent versions of the applicable Evidence of Coverage Certificates (EOCs) and the Handbook are available online via the Internet at

http://cit.hr.Caltech.edu/benefits/Benefits_Handbook.htm

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.

PLAN	CUSTOMER SERVICE NUMBERS	CONTRACT NUMBERS	
		Campus	JPL
Medical Plans Anthem Blue Cross Power Advantage HMO Anthem Blue Cross PPO Anthem Blue Card PPO Vision Service Plan (VSP) Kaiser Permanente	1-866-820-0765 1-866-820-0765 1-866-820-0765 1-800-877-7195 1-800-464-4000 1-800-788-0616 (Spanish)	175104H020 175104M001 175104M003 101829-01	175104H024 175104M007 175104M009 101829-02
Dental Plans Delta Dental SafeGuard	1-800-765-6003 1-800-880-1800	3608-1 3195	3608-1002 726
Tax Savings Plan	Call the Campus or JPL Benefits Office		
Dependent Care and Health Care Spending Accounts UniAccount	1-888-209-7976		
Group LTD MetLife	Specific Claim Information: 1-800-300-4296 For general inquiries call the Campus or JPL Benefits Office		94835
Group Life (Basic and Supplemental) Aetna	1-800-523-5065 or Call the Campus or JPL Benefits Office		GP 701502
Personal Accident Insurance Plan (Non-ERISA)	Call the Campus or JPL Benefits Office		83071188
Travel Accident Insurance Plan Extra-Hazardous Duty Plan	Call the Campus or JPL Benefits Office		ETB-201240 ETB 201241
International SOS Medical Access/Referral Service	Specific Claim Information: 1-800-523-6586 (within U.S.) For general inquiries call the Campus or JPL Benefits Office		11BCMA000180
Retirement Plans TIAA-CREF Defined Contribution Retirement Plan Prudential Pension Plan	1-800-842-2252 1-800-421-1056	101205 GA949038	GA949310
Tax Deferred Accounts (Non-ERISA) Fidelity TIAA-CREF Defined Contribution Retirement Plan	1-800-343-0860 1-800-842-2252	85675 101206	85680

When you call 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 and dental plans available to Benefit-Based Employees and their Dependents. However, premium cost sharing by the Institute for the medical and dental 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 7.1 for eligibility to participate in voluntary retirement savings under the Tax Deferred Accounts (TDAs).

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
- Unmarried children (natural, step, adopted and children for whom you are a court-appointed guardian) up to their 19th birthday, or 25th birthday if a full-time student, who qualify as your tax dependents under the Internal Revenue Code and subject to applicable state and federal requirements.
- Unmarried children (natural, step, adopted and children for whom you are a court-

appointed guardian) who are incapable of employment because of physical or mental disability and who qualify as your tax dependents under the Internal Revenue Code. Coverage will continue beyond their 19th birthday if they have been covered under the Plan and became dependent upon you for support due to their physical or mental disability prior to attainment of age 19.

- Any unmarried 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 pages 6.5 and/or 6.8 for a description of eligible Dependents.

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. Proof of Dependent eligibility will be required by the Institute. All family members must be covered under the same **medical and dental coverages**.

When Two or More Family Members Work For Caltech

Unless otherwise noted, when both Spouses, 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 2.18 for retiree medical plan eligibility.)

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 or dental 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 or Adoption. 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 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.

When Participation *First* Begins

PLAN	COVERAGE BEGINS
<p>Category I</p> <p>Medical Plans Dental Plans Tax Savings Plan Group Life (Basic and Supplemental) Group LTD Personal Accident Insurance Plan Spending Account(s)</p>	<p>For Faculty, including Research Faculty, Visiting Faculty and Postdoctoral Scholars: coverage begins immediately.</p> <p>For all other 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.</p>
<p>Category II</p> <p>Travel Accident Insurance Plan</p> <p>International SOS Medical Access/Referral Service</p> <p>Extra-Hazardous Duty Plan</p> <p>Retirement Plans</p> <p>Tax Deferred Accounts (Non-ERISA)</p>	<p>Coverage is effective on the first day of Employment.*</p> <p>Coverage is effective immediately.</p> <p>Coverage is effective immediately.</p> <p>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.</p> <p>Postdoctoral Scholars: Postdoctoral Scholars participate on the first day of the month following two years of eligible Benefit-Based Employee service.</p> <p>Key Staff**: 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.</p> <p>Staff**: On the first day of the month following six months of eligible service.</p> <p>On the first day of any month. Enrollment forms must be received prior to payroll cutoff date.</p>

* 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 or dental 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. 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.

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 2.11 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 or dental plan because of other insurance or group plan coverage, you may be able to enroll yourself and your Dependents in the Caltech medical or dental 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 or dental 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 or dental 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; iii) a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on *all* benefits;¹ and iv) 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 or dental 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 or Adoption with the exception of Supplemental Group Life coverage (which begins 14 days after birth). 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

¹ With respect to loss of coverage due to an individual reaching a lifetime limit, application must be made within 31 days of the date a claim or portion of a claim is denied. Coverage will be effective on the first day of month following the date the application is filed.

ENROLLMENT AND MAKING CHANGES

- 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:

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

IF YOU HAVE THIS EVENT	YOU MAY MAKE THE FOLLOWING CHANGE TO YOUR MEDICAL ELECTION WITHIN 60 DAYS OF THE EVENT
You lose Medicaid or Children’s Health Insurance Program (CHIP) coverage due to a change in eligibility	Enroll yourself and/or your Dependent(s)
You later become eligible for a state’s premium assistance program under Medicaid or CHIP	Enroll yourself and/or your Dependent(s)

ENROLLMENT AND MAKING CHANGES

General Information

Changes in Your Benefits “At Other Times”

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

PLAN(S)	CHANGES
Medical, Dental, Anthem Blue Cross PPO Anthem Blue Cross Power Advantage HMO Kaiser Permanente Delta Dental Safeguard Dental	You may add or delete yourself and/or your Dependents within 31 days of a Change in Status or other IRS-recognized event.*
Tax Savings Plan and Spending Account(s)	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.
Group LTD (Basic and Supplemental)	Basic: Coverage is 100% employer paid and automatically provided to you. Supplemental: 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.
Group Life (Basic and Supplemental)	Basic: Coverage is 100% employer paid and automatically provided to you. Supplemental: 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.
Group Life (Supplemental Spouse, Domestic Partner and Dependent Coverage)	Enrollment after 31 days for Spouse’s or Domestic Partner’s coverage or after 45 days of birth for your Dependent child** and any future increases in coverage may require Evidence of Insurability. See page 5.4.
Personal Accident Insurance (Non-ERISA)	You may add or drop coverage at any time. Coverage changes become effective on the first of the month following receipt of your application.
Travel Accident Insurance Plan Extra-Hazardous Duty Plan	Enrollment is automatic once you are eligible.
TIAA-CREF Defined Contribution Retirement Plan	Faculty/Key Staff: You must enroll immediately. Staff: You must enroll within six months of Eligible Service. (You become eligible after six months of Eligible Service.) Postdoctoral Scholars: You must enroll prior to completing two years of Eligible Service. (You become eligible after two years of Eligible Service.)
Tax-Deferred Accounts (Non-ERISA)	You may supplement the Institute Retirement Plan with your own voluntary tax-deferred contribution up to the maximum allowable. You may enroll, change, or stop contributions at any time.

* 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 after 14 days of birth.

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 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.

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 changes. 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. Contact the Campus or JPL Benefits Office for more information.

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

Unpaid Family and Medical ("FMLA") Leave

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.² FMLA leave is measured on a rolling 12-month basis. During an approved FMLA leave of absence, Institute contributions for medical, dental, basic life and basic LTD coverage continue as if you were an active employee for the 12 weeks² of FMLA leave. If you decide to continue your medical, dental, supplemental life, supplemental LTD and/or Health Care Spending Account (HCSA) coverage, 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 weeks² 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.*

If you take FMLA leave, but your coverage under the plan is terminated, your coverage will be reinstated upon 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 leave, during the Annual Enrollment period, you may switch plans as if you were Actively At Work.

Unpaid Disability Leave (Non-FMLA)

Institute contributions for your medical, dental, basic life and basic LTD coverage continue as if you were an active employee for the first six

² FMLA is also available for up to 26 weeks in order to care for relatives with a serious injury or illness incurred during active duty in the Armed Forces.

months of leave. The six-month period is measured from the first day of leave, including FMLA leave, paid or unpaid. During that time, if you decide to continue your medical and dental 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) or Health Care Spending Account (HCSA) 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. You may continue dental coverage generally for a maximum of 12 months, from the first day of leave, subject to the terms of the insurance contract.

PAI may continue until the end of the month in which you retire or terminate employment.

Your HCSA may continue on an after-tax basis, 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. 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.

While on an unpaid disability leave (non-FMLA), you may not enroll in or switch medical or dental 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. Contact the Campus or JPL Benefits Office for further details.

Additional rules for Long Term Disability (LTD) benefits

If you are approved for Long Term Disability (LTD) insurance benefits after the first six months of your leave, your share of medical and group employee supplemental life insurance premiums and if key staff, your contributions to your retirement plan will be paid by the LTD insurance carrier (refer to Section 4 for further information on LTD).

Once approved for LTD, your Spouse and/or Child supplemental life insurance will end. You may convert your Spouse and/or Child supplemental life insurance to an individual policy (Refer to page 2.30 for details on conversion.)

Refer to Section 4 for further details on LTD.

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) during the duration of your unpaid disability leave. You will be billed monthly for your cost.

Personal Leave (Unpaid Non-Disability, Non-FMLA 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 upon your return 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 and dental 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 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 and dental 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 and dental 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, 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 5.12 for PAI exclusions and page 4.7 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).

Unpaid Non-military, Non-FMLA 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 6.2 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 pages 2.13- 2.15 for details.*

Pre-tax contributions to a voluntary tax-deferred annuity (TDA) 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 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 for more information upon your return to work.

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. 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. 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, 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 following the month you are rehired. Your pre-tax medical, dental 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.
- **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 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 Layoff policy.

All other rehire situations require that you meet the waiting periods of the individual plans. 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 2.20 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.

* See Appendix I, page 9.2, for special transition rules.

- **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.

Rate information — To find out the rate information that applies to you, contact the Campus or JPL Benefits Office for rate information. 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 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. Reimbursement is limited to a scheduled monthly amount or the actual premium paid, whichever is less. Premiums paid for by another entity or employer are not eligible for reimbursement. Contact the Campus Benefits Office at 626-395-6443 or the JPL Benefits Office at 818-354-3760 for information about this option.

Extension of Medical, Dental and Health Care Spending Account Coverage — At times like retirement, extended benefits under COBRA may be available. See pages 2.21-2.29 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. 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 2.29 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.

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 and dental 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

RETIRE/WHEN COVERAGE ENDS

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 deselection 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 and dental 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 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 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 2.13 through 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.

Your eligibility for LTD coverage will end on the last day of work, if earlier than the dates described above. 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 or dental 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 or dental 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 or dental 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 or dental 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 beneficiar(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 and/or dental 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, marriage license or letter from a university or institution indicating a change in student status.

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 listed below 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; or
- 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, DomesticPartner 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 and/or dental 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, marriage license or letter from a university or institution indicating a change in student status.

You must mail 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 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 listed below 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 decline 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.

Group Life Insurance

If your 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. 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. 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.

Personal Accident Insurance

You and your insured family members may apply to convert your PAI 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.

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