

INTRODUCTION

This Handbook 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.*

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). If you become covered under another plan after losing your Caltech coverage, check your new plan to see if coverage is excluded for pre-existing conditions and if you need to provide a certificate or other documentation of your previous Caltech coverage. A 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 any prior health coverage such as your coverage under the

Caltech plan. California plans may have different rules for pre-existing conditions based on the type of coverage.

See Appendix III, page 9.3 for a sample of the coverage certification.

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 a 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.

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.

The following information applies to Dental plans only.

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 **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.

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 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.
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.

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 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 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.

CLAIM DETERMINATION AND APPEAL PROCEDURES FOR ALL PLANS OTHER THAN MEDICAL, DENTAL, 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 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 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 plan (HMO or DMO) or Delta Dental, 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.

Insured Health Plans (Anthem Blue Cross PPO)

If you have a dispute with your medical or dental 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 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.

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 under 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 for treatment of physical complications at any stage of the mastectomy including lymphedemas. Normal plan deductibles and coinsurance will apply. Please refer to the Comparison of Health Plan benefits for coverage details.

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 Information

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.

Plan Name	Plan Number
California Institute of Technology TIAA-CREF Retirement Plan	002
California Institute of Technology Pension Plan	004
Consolidated Welfare Plan of California Institute of Technology which includes the following: <ul style="list-style-type: none"> • Group Life Plan • Group Long Term Disability Plan • Travel Accident Plan • Extra Hazardous Duty Insurance Plan • Kaiser Permanente Health Plans • Anthem Blue Cross HMO Plan • Anthem Blue Cross PPO Plan • Anthem Blue Cross/Blue Card PPO • Group Dental Plan (a.k.a. "Delta Dental Plan") • California Institute of Technology Safeguard Dental Plan • California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HCSA not DCSA) 	601
Educational Assistance Program*	
International SOS Medical Access/Referral Service	
Group Personal Accident Insurance Plan*	
Prudential Tax Deferred Annuity Plan*	
TIAA-CREF Tax Deferred Annuity Plan*	
Fidelity Investments Tax Deferred Annuity Plan*	

* 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 Director of Benefits, 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
Phone number: 626-395-6381**

PLAN INFORMATION

Plan Information

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 HMO (Medical)
21555 Oxnard Street
Woodland Hills, CA 91367

Kaiser Foundation Health Plan, Inc. (Medical)
393 East Walnut Street
Pasadena, CA 91188-8110

Delta Dental Plan of California (Dental)
P. O. Box 9973300
Sacramento, CA 95899-7330

Safeguard Health Plans, Inc. (Dental)
Claims Department
P.O. Box 30930
Laguna Hills, CA 92654

Anthem Blue Cross UniAccount
(Reimbursement Accounts)
21555 Oxnard Street
Woodland Hills, CA 91367

Aetna Life Insurance Service Center
(Life Insurance)
575 Pigeon Hill Road
P.O. Box 737
Windsor, CT 06095-0737

The Hartford Group Benefits
(Personal Accident Insurance)
P.O. Box 946790
Maitland, FL 32794-6790

MetLife Insurance Company (Disability)
P.O. Box 14590
Lexington, KY 40511-4590

International SOS (Medical Access/Referral Service)
215-942-8226
800-523-6586

VSP (Vision)
P.O. Box 997105
Sacramento, CA 95899-7105

Agent of Legal Process

Any legal correspondence regarding the plans should be sent to:

**General Counsel
California Institute of Technology
4800 Oak Grove Drive, 180-305
Pasadena, CA 91109
626-354-4321**

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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