

**CSU, CHICO RESEARCH FOUNDATION
WELFARE FLEXIBLE BENEFITS PLAN**

*Summary Plan Description
Effective January 1, 2009*

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CSU, CHICO RESEARCH FOUNDATION

WELFARE FLEXIBLE BENEFITS PLAN

INTRODUCTION

We have amended the flexible benefits plan that we previously established for you and other eligible employees. The amended plan is called the CSU, Chico Research Foundation Welfare Flexible Benefits Plan, but is referred to as the "Plan" in this document. Under the Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of the Plan and the benefits you will receive. You should direct any questions you have to the Administrator (see Section VIII for information regarding the Plan Administrator and contact information).

There is a Plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the Plan document, the Plan document will control. The Plan document includes the policies and contracts of insurance negotiated by CSU, Chico Research Foundation to provide group benefits to you. If there is an ambiguity in the Plan document because some portion of the Plan document conflicts with an insurance contract or policy, the Plan will be interpreted to give effect to the insurance contract or policy.

The rights under this Plan may not be assigned or alienated. This Plan does not provide any guarantee of tax consequences or employment. No benefits are payable for expenses that are not genuine obligations of the covered persons and receipt of any Plan benefits is conditioned on an agreement to subrogate and reimburse the Plan with respect to any amounts recovered from third parties without regard to whether the covered person has been fully compensated for injuries and without offset for attorney's fees. The Plan may recover for amounts paid in error through any legal means, including offset of future benefits. Anyone who intentionally withholds information or provides false information to the Plan forfeits his or her rights to benefits. We may amend or terminate this Plan at anytime.

I ELIGIBILITY

1. When Can I Become a Participant in the Plan?

Before you begin receiving Plan benefits, there are three rules which you must satisfy. First, you must meet the “eligibility requirements.” Second, you must actually join the Plan on the “entry date” that we have established for all employees. The “entry date” is the first day of the month after you meet “eligibility requirements.” Third, you will also be required to complete certain application forms before you can enroll in the Plan. Once you satisfy all three rules, you will become a member or a “Participant” in the Plan, which means that you will be able to receive Plan benefits.

2. What Are the Eligibility Requirements for the Plan?

For purposes of the Plan an “Eligible Employee” means any employee of the CSU, Chico Research Foundation receiving compensation in the form of wages who is a “benefited” status employee, as defined in the Foundation Employee Handbook, who is 18 years old or older and scheduled to work a minimum of 1,040 hours during the Plan Year and who works for a grant or project that provides funding for participation. If you are a member of a union working in covered employment with CSU, Chico Research Foundation, you will not be an “Eligible Employee.” If your spouse or dependents may enroll in a benefit, the evidence of coverage or benefit book for that benefit will describe the conditions under which they may enroll. Coverage for a child may be required under a Qualified Medical Child Support Order. You may request a free copy of the Plan’s procedures for processing Qualified Medical Child Support Orders from the Plan Administrator.

3. When Is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the month next following the date that you met the eligibility requirements.

4. What Must I Do to Enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits that are being offered under the Plan. If the total cost of the benefits that you elect is greater than the amount that we will contribute on your behalf, you must authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II OPERATION

1. How Does The Salary Reduction Work?

Each year, you will be able to elect to have some of your upcoming pay contributed to the Plan to pay for Plan benefits. The election will apply for the “Plan

Year,” which is generally the 12 month period that begins on January 1 and ends on December 31.

Each Plan Year you may elect to participate in the Health Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan (see Section IV for a description of those benefits). Each Plan Year you will also be able to change your previous insurance elections and you may choose to pay your portion of the costs through salary reduction if necessary.

The portion of your pay that is paid to the Plan for medical insurance, dental insurance, vision insurance, dependent care reimbursement and health expense reimbursement is generally not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. You will also receive long-term disability insurance and group-term life insurance at no cost to you on a pre-tax basis. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction for that expense on your return.

If you pay for supplemental or dependent life insurance, these payments will be after-tax. If you provide insurance coverage to a person who is an eligible dependent under an insurance policy, but not under the Internal Revenue Code, the payments made for that person’s coverage will be taxable to you. The Internal Revenue Code provisions are complex and you should consult a tax advisor if you have questions about a person’s status under the Internal Revenue Code, but generally, your domestic partner’s children and a child who you do not live with will not be your dependent under the Internal Revenue Code. Generally, an adult relative or a domestic partner will not be your dependent unless you provide over half of their support for the year. There are special rules for disabled individuals and for children of divorced parents. You should contact the Administrator or your tax advisor if you have questions about a person’s status as a dependent under the Internal Revenue Code.

III CONTRIBUTIONS

1. How Much of My Pay May be Used to Pay for Benefits?

Each year, we will make contributions on your behalf for you to pay for benefits. You will automatically receive group-term life insurance and long-term disability insurance at no cost to you. Other contributions are specific to a certain benefit option and are intended to defray some of the cost of health coverage. If you do not elect these options, you will not receive that contribution. Finally, we make contributions that provide a subsidy that is flexible in that you can use that subsidy to pay for any Plan benefit or you may receive the contribution in cash. In this way, this contribution is a “flexible subsidy.” The amount of the “flexible subsidy” is based on a uniform formula, but the formula may change from year to year. The employer contribution for the year will be communicated to you during the open enrollment period. You may elect to have

us contribute on your behalf enough of your compensation to pay the remaining costs for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the Health Expense Reimbursement Plan and Dependent Care Reimbursement Plan benefits that you want, if any. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. Any amount that is not used to pay expenses incurred during the Plan Year will be forfeited.

You will also decide whether to change your insurance benefits. If you decide to change your insurance or if the cost of your insurance changes, your required contribution may also change, which means that your salary reduction will be automatically adjusted to pay for benefits.

3. When Must I Decide Which Benefits I Want to Receive?

You are required by Federal law to decide which benefits you want and how much should go toward each benefit before the Plan Year begins. You must make these decisions during the Plan's "election period."

4. When Is the "Election Period" for the Plan?

Your election period starts on the date you first meet the "eligibility requirements" and ends 30 days after your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period.

5. May I Change My Elections During the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status" that permit an election change consistent with the event if the event affects eligibility for benefits:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status of you, your spouse or dependent;
- One of your dependents satisfied or ceases to satisfy the requirements for coverage due to a change in your dependent's age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent.

In addition, if you are participating in the Dependent Care Reimbursement Plan, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is consistent with a "change in status." In addition, your medical insurance gives you rights to change medical coverage for you, your spouse, or your dependents because of a HIPAA special enrollment event. You may also have a right to change your medical coverage, dental coverage, vision coverage, and Health Expense Reimbursement Plan elections because of a court order, judgment or decree, FMLA leaves of absence, and Medicare or Medicaid eligibility. If you change health care coverage due to rights you have under these laws, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the costs of a benefit option increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary reduction election. If the costs increase significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage. If no similar coverage is available, you may revoke your election entirely.

If the coverage under a benefit option is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis other similar coverage. In addition, if we add a new coverage option or significantly improve an existing option, you may elect the new option and make corresponding election changes to other options providing similar coverage, or if you are not a Participant, you may elect to join the Plan. You also may be able to change your elections on account of an increase or decrease in coverage under another employer's plan (for example, your spouse's employer's plan).

These rules apply to the insured benefits only to the extent the changes are allowed pursuant to that insurance contract or policy. These rules on change due to cost

or coverage do not apply to the Health Expense Reimbursement Plan, and you may not change your election to the Health Expense Reimbursement Plan if you make a change due to cost or coverage for insurance.

The rules on changes due to significant curtailment, new coverage options and increases or decreases in another employer's plan also apply to your Dependent Care Reimbursement Plan. If the cost of dependent care significantly increases you may increase or revoke your Dependent Care Reimbursement Plan election, but you may not change your election under the Dependent Care Reimbursement Plan if the cost change is imposed by a dependent care provider who is your relative.

6. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you choose not to participate in the Plan, you may receive the "flexible subsidy" contribution that we would have made to pay benefits under this Plan as taxable wages.

IV BENEFITS

1. What Benefits Are Available?

Each year, you will automatically receive group-term life insurance and long-term disability insurance. These benefits are provided at no cost to you. You will also have the option of receiving medical, dental, vision, supplemental life insurance, dependent life insurance, health expense reimbursements and dependent care expense reimbursements. Each year, we decide how much of these benefits we will pay for. For some benefits, we will subsidize a certain portion of the cost of that particular benefit. If you do not elect that benefit, you will not be able to use that subsidy. Additionally, we may provide subsidies that you can use to fund any benefit that you choose or even receive in cash. Generally we have provided this type of "flexible subsidy" using a formula, which provides you with 5% of your projected annualized base pay plus \$1,620. The formula that we use and our decision to provide this type of subsidy is discretionary and may change from year to year. The subsidies that we will provide will be communicated to you at the beginning of the year so that you have the information that you need to make your benefit decisions.

Cash Payment Option:

If you chose not to receive any benefits, you will receive a portion of the contribution that we would have provided on your behalf as taxable wages. The portion that you may receive as taxable wages is limited to the "flexible subsidy" that we have designated as available for cash payment. This amount will be paid in equal payments over the year. You may also elect benefits that cost less than the amount that we would contribute on your behalf, in which case the difference will be paid as taxable wages to the extent that it is less than the "flexible subsidy." If you change your election during

the year, the amount that you receive in cash will also change so that our total contribution for the “flexible subsidy” remains stable and your benefits are paid.

Health Expense Reimbursement Plan:

The Health Expense Reimbursement Plan was previously called the Medical Expense Reimbursement Plan, but has been renamed because it not only enables you to pay for expenses which are not covered by your medical insurance, it also allows you to pay for other unreimbursed health care expenses such as vision expense, dental expenses and both prescription and nonprescription drugs. The Health Expense Reimbursement Plan account allows you to be reimbursed for out-of-pocket health expenses incurred during the Plan Year by you, your spouse, and your tax dependents while you are a Plan Participant. The expenses which qualify are those permitted by Section 213 and they are generally the same health expenses that may be deducted EXCEPT that you may not be reimbursed for the cost of other health care coverage maintained outside of the Plan, insurance premiums or for long-term care expenses. Additionally, you may receive reimbursements for over the counter nonprescription drugs.

The most that you can contribute to your Health Expense Reimbursement Plan each Plan Year is \$5,000. If you are employed for only part of the year this amount will be prorated. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider within 90 days after the end of the Plan Year within which the expense was incurred. If your participation terminates, the bill must be submitted within 90 days after the termination of coverage. For expenses that may be partially paid through health insurance, you must first submit the claim to your insurance carrier and include an EOB with your Health Expense Reimbursement Plan claim to show the unpaid amount. For over the counter nonprescription drugs, you must submit an original cash register receipt showing the vendor information along with the date, amount, and type of drug purchased. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursements will be paid at least once a month. All amounts paid as a Health Expense Reimbursement Plan benefit are paid out of the general assets of CSU, Chico Research Foundation. Any amounts that are not paid to reimburse claims incurred during the Plan Year will be forfeited on the 91st day following the end of the Plan Year.

Dependent Care Reimbursement Plan:

The Dependent Care Reimbursement Plan enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse is disabled or goes to school full-time. Unmarried employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 “Credit for Child and Dependent Care Expenses.” Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, if care is provided by the facility for more than six individuals and the facility complies with applicable state and local laws.
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An “Individual” who provides care inside or outside your home. The “Individual” may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under the Plan.

Contributions are made to your account each month equal to the annual amount divided by your months of participation. You may not at any time during the Plan Year receive a reimbursement for an expense that exceeds the amount contributed. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Reimbursement Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself is treated as having a monthly earned income of \$250 for one dependent or \$500 for two or more dependents). To receive a reimbursement, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. All amounts paid as a Dependent Care Reimbursement Plan benefits are paid out of the general assets of CSU, Chico Research Foundation. Any amounts that are not paid to reimburse claims incurred during the Plan Year will be forfeited on the 91st day following the end of the Plan Year.

Federal tax laws permit a tax credit for certain dependent care expenses that you may be paying for if you are not a Participant in this benefit. You will not be eligible for this tax credit for expenses reimbursed through the Dependent Care Reimbursement Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Reimbursement Plan under the Plan. Ask your tax adviser which is better for you.

Premium Expense Account and Group Insurance Benefits:

A Premium Expense Account allows you to use salary reduction to pay for your portion of certain premium expenses to purchase group insurance benefits. These group insurance benefits include:

- Medical insurance;
- Dental insurance;

- Vision insurance;
- Supplemental life insurance;
- Dependent life insurance.

In addition to these benefits, you will also receive group-term life insurance and long-term disability insurance at no cost to you. The terms of the group insurance contracts and policies negotiated by CSU, Chico Research Foundation for the benefit of you and your fellow employees are a part of the Plan document and are described in benefit booklets and evidences of coverage. These benefit booklets and evidences of coverage describe the benefits offered through the insurance contracts and policies and the limitations on those benefits. These benefit booklets and evidences of coverage are incorporated into and are a part of this Summary Plan Description. You should keep a current copy of your benefit booklets and evidences of coverage with this document.

We may terminate or modify Plan benefits at any time. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or if we terminate the Plan.

Except for long-term disability and group-term life insurance, which you receive automatically, any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you. Amounts provided through a policy of insurance are paid for by the insurance company and we are not responsible for paying any insured benefits that are not paid for by the insurance company.

Individual Premium Cafeteria Plan Account:

In addition to offering group insurance coverage and benefits, the “Cafeteria Plan” allows individuals to pay for certain individual insurance premiums. These individual policies are NOT a part of the Plan. None of the Plan’s terms or rights apply to these policies and these are NOT group policies. These individual policies are not endorsed by or maintained by CSU, Chico Research Foundation and CSU, Chico Research Foundation provides this payment mechanism only as a convenience to its employees. CSU, Chico Research Foundation may, from time to time, allow insurance carriers to provide employees with insurance information and employees may seek their own insurance policies. CSU, Chico Research Foundation may discontinue this service at any time and has the right to refuse to process payments for a particular policy if CSU, Chico Research Foundation determines that doing so creates too great of an administrative burden. The decision to purchase an individual policy is voluntary and the sole responsibility for negotiating the policy belongs to the individual and is NOT an election under this Plan. The sole relationship between this Plan and the individual policy is the salary reduction that this Plan facilitates.

V
BENEFIT PAYMENTS

1. When Will I Receive Payments From My Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses covered by your Health Expense Reimbursement Plan or your Dependent Care Reimbursement Plan account that you have incurred. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. The Administrator will provide you with forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements that are made from the Plan are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. You will only be reimbursed from the Dependent Care Reimbursement Plan account to the extent that there are sufficient funds in the Account to cover your request. Contributions paid to provide Premium Expense Account benefits will be applied to premiums due under your insurance coverages. The provisions of the insurance contracts will control what benefits will be paid and when.

2. What Happens If I Don't Spend All Plan Contributions?

Any contributions not used to pay Plan benefits at the end of the Plan Year after all qualifying expenses are paid will be forfeited. Forfeited amounts will be used to pay Plan expenses. You must make your requests for reimbursement no later than three months after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to contribute carefully and conservatively.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, your group health benefit may continue as if you were actively employed. When you take an FMLA leave, you may revoke or change your existing elections for health insurance and the Health Expense Reimbursement Plan. If your coverage in these benefits terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Expense Reimbursement Plan, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for three months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference—from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for three months, your amount will be reduced to \$900. The expenses you incur during the time you are not a Participant in the Health Expense Reimbursement Plan are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for your portion of the coverage, you may pay for your portion of your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to “catch up” your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights include extended health care coverage. You will receive this coverage on the same basis that you did as an active employee for the first 31 days of your leave. After the first 31 days of leave, your coverage may continue if you pay premiums equal to 102% of the total cost of coverage. USERRA also provides special reinstatement rights and other protections. If you may be affected by this law, ask your Administrator for further details. Your USERRA continuation coverage runs concurrently with any COBRA continuation coverage that may be available.

5. What Happens If I Terminate Employment?

If you leave employment during the Plan Year, your right to benefits will be determined in the following manner:

- You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Reimbursement Plan account at the time of termination of employment. However, no further contributions will be made on your behalf after you terminate.
- Your participation in the Health Expense Reimbursement Plan will cease, and no further contributions will be contributed on your behalf. You will be able to submit claims for health care expenses incurred prior to your date of termination after your termination of employment.

Under Federal law, if you, your spouse, and/or your covered dependents lose coverage under our medical insurance, vision insurance, dental insurance, or the Health Expense Reimbursement Plan, then you, your spouse, and/or your covered dependents may be entitled to continuation of the health care coverage. The Administrator will provide you with a “COBRA Notice” that informs you of these rights under this Plan. This “COBRA Notice” is part of this SPD and you should keep a copy of it with this SPD. As described in 3 and 4 above, special rules apply to FMLA and USERRA leave. An FMLA leave of absence is not a COBRA qualifying event, but a USERRA leave of absence is. If applicable, USERRA continuation coverage periods and COBRA continuation periods run concurrently. The COBRA Continuation period for the Health Expense Reimbursement Plan will end at the end of the Plan Year.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because of your receipt of tax-free benefits under our Plan that reduce the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, “highly compensated employees” are Participants who are highly paid. The dollar amount that is considered “highly paid” changes from year to year. The amount is \$110,000 in 2009.

If you are a highly compensated employee or you make less than the “highly paid” amount, but are in the highest paid 25% of employees, your contributions and benefits under the Plan may be limited or recharacterized as taxable compensation so that the Plan does not lose tax qualified status because it, as a whole, unfairly favors those who are highly paid, their spouses or their dependents. Plan experience will dictate whether contribution or benefit limitations will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your Health Expense Reimbursement Plan and Dependent Care Reimbursement Plan balances. It is important to read these statements carefully so that you understand the balances remaining. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information

CSU, Chico Research Foundation Welfare Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on July 1, 2005. Your Plan was originally effective on July 1, 1997.

The Plan Year begins on January 1 and ends on December 31, but for periods prior to July 1, 2005, the Plan Year begins on July 1 and ends on the last day of June. There is also a short Plan Year of 6 months beginning on July 1, 2005 and ending on December 31, 2005. Your Plan's records are maintained for the Plan Year.

CSU, Chico Research Foundation may amend or terminate the Plan at any time at its sole discretion.

Plan benefits are funded through CSU, Chico Research Foundation's general assets. No amounts are held in trust or otherwise segregated from the general assets of CSU, Chico Research Foundation.

2. Employer Information

Your Plan Sponsor's name, address, and identification number are:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Employer ID No. 68-0386518

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

Telephone: (530) 898-6811

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Richard Jackson
Foundation Administrative Director
CSU, Chico Research Foundation
Building 25, CSUC

Chico, CA 95929-0246

5. Type of Administration

The type of Administration is employer administration.

6. Claims Submission

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

**IX
ADDITIONAL PLAN INFORMATION**

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of CSU, Chico Research Foundation may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. Although ERISA does not apply to the “Cafeteria Plan” portion of the Plan, it may apply to some Plan benefits. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, 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.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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 benefit or exercising your rights under ERISA.

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 documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If it should happen that 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 you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person 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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You may submit claims for benefits to the Administrator. To claim benefits you must use the Plan's claims procedure, which is described in Attachment #1. The claims procedure for insured benefits includes the claims procedure described in the applicable evidence of coverage or benefits booklet. You must exhaust the Plan's reasonable claims procedure prior to bringing any court action to obtain Plan benefits.

3. Health Plan Protections

Attachment #2 describes special rights that you have under the Plan's group health coverage.

Attachment 1 CLAIMS PROCEDURES

You should submit claims during the Plan Year, but in no event later than three months after the end of a Plan Year. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be reviewed in accordance with procedures contained in the policies, which are incorporated by reference into this claims procedure. All other general claims or requests should be directed to the Administrator of our Plan. Unless the Plan provision is contained or controlled by an insurance contract, the Administrator has the sole discretion to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding. Submit claims for Health Expense Reimbursements and Dependent Care Reimbursements to:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

Telephone: (530) 898-6811

1. What happens if an application for benefits is denied?

If your application for a benefit payment is denied, you will receive a written notice within the timeframe outlined in the following table applicable to the type of claim for which the benefit payment was denied. The denial notice will include:

-Specific reason(s) for the denial;

-Specific references to Plan provisions on which the denial is based;

-A description of any additional material or information necessary for you to complete your application and an explanation of why the material or information is necessary;

-A statement that you will be provided, upon request, reasonable access to and free-of-charge, copies of all documents, records and other information relevant to your claim;

-An explanation of the steps you must take should you disagree with the denial and wish to have your benefit application reviewed again.

2. How can I request a review of a denied claim?

Under the self-insured welfare benefit plans (which includes the Health Expense Reimbursement Plan and the Dependent Care Reimbursement Plan), if you do not agree with the claims decision made by the claims administrator you may request that your application be reviewed by the Administrator. Submit the application for review to:

CSU, Chico Research Foundation

Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

If the claim is for insured benefits, you must follow the claims procedure described in the applicable evidence of coverage or benefits booklet.

You must file your written request for review of any health benefit or disability claims within 180 days after you receive the written notification of benefit denial. All other written requests for review must be filed within 60 days after you receive the written notification of benefit denial. Your request must include a summary of all the reasons why you believe the benefits should be paid, including any documents, records or other information relevant to or that support your claim and any issues or comments that you think are pertinent to your claims.

3. How does the appeal process work?

Your application will be reviewed fairly and fully, and a decision will be made on your claim within the timeframe outlined in the table below following receipt of your review request. If additional time is needed to render a decision, you will be notified about the reasons why the extension is needed and the date by which you may expect a decision.

In the case of a claim under a group health or disability plan, the party considering the appeal will not give deference to the initial claim denial and will not be the individual who made the initial adverse benefit determination nor that individual's subordinate. Additionally, if a group health plan or disability plan determination is based on medical judgment, the fiduciary deciding the appeal will consult with an appropriate health care professional (who was not consulted during the initial adverse benefit determination and is not subordinate to a professional consulted during the initial adverse benefit determination).

If the original denial is upheld, you will receive a written notice stating:

- 1) Specific reason(s) for the denial;
- 2) Specific references to Plan provisions on which the denial is based;
- 3) A statement that you will be provided, upon request, reasonable access to and free-of-charge, copies of all documents, records and other information relevant to your claim;
- 4) A statement regarding rights that you may have to bring an action under Section 502(a) under ERISA.

In the case of a claim under a group health or disability plan, your written notice will also include:

- 1) A copy of any internal rule, guideline, protocol or other similar criterion relied upon to determine the claim or a statement that the rule, guideline, protocol, or other criterion was used and that, upon request, a copy will be provided free-of-charge;
- 2) If the denial of the claim is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination or a statement that you can receive the explanation free-of-charge upon request.

A document, record, or other information shall be considered relevant to a claim if it:

- 1) was relied upon in making the claim determination;
- 2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- 3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- 4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The chart below describes the time limits for deciding claims and appeals for different types of claims. A pre-service claim is a claim for benefits for which the Plan conditions receipt of the benefit (in whole or in part) on approval of the benefit, before you receive medical care. An urgent care claim is a pre-service claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or—in the opinion of a physician with knowledge of your medical condition—would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A concurrent care claim is a claim related to an ongoing course of treatment that was previously approved by the Plan for a specific period of time or number of treatments. A post-service claim is a claim for benefits that are not pre-service or urgent claims, for care the patient has already received.

Type of claim	Timing for claim decision	Timing and notification of appeal decision
<p>A claim to participate in a benefit option or to change an election to participate during the plan year.</p>	<p>Within a reasonable period of time, but not later than 90 days after receipt of the claim by the Administrator.</p> <p>If special circumstances require an extension of time for processing the claim, this extension will not exceed an additional 90 days.</p>	<p>A reasonable period of time, but not later than 60 days after receipt of the request for review by the Administrator. If necessary, the period may be extended for an additional 60 days and a decision shall be made as soon as possible.</p>
<p>Any claim to receive benefits under:</p> <ul style="list-style-type: none"> • Group Term Life • Accidental Death and Dismemberment • Supplemental Life • Dependent Life 	<p>Within a reasonable period of time, but not later than 90 days after receipt of the claim by the claims administrator.</p> <p>If special circumstances require an extension of time for processing the claim this extension will not exceed an additional 90 days.</p>	<p>A reasonable period of time, but not later than 60 days after receipt of the request for review by the claims administrator, insurer, or Administrator. If necessary, the period may be extended for an additional 60 days and the decision shall be made as soon as possible.</p>
<p>Any post-service claim to receive benefits under:</p> <ul style="list-style-type: none"> • Medical insurance • Dental • Vision • Health Expense Reimbursement Plan 	<p>Within a reasonable period of time, but not later than 30 days after receipt of the claim by the claims administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the claims administrator.</p>	<p>A reasonable period of time, but not later than 60 days after receipt of the request for review by the claims administrator.</p>

Type of claim	Timing for claim decision	Timing and notification of appeal decision
<p>Any claim to receive benefits under:</p> <ul style="list-style-type: none"> • Long-term disability 	<p>Within a reasonable period of time, but not later than 45 days after receipt of the claim by the claims administrator, unless an extension of up to an additional 30 days is necessary due to matters beyond the control of the claims administrator.</p>	<p>A reasonable period of time, but not later than 45 days after receipt of the request for review by the claims administrator. If necessary due to special circumstances, the period may be extended for an additional 45 days and the decision must be made as soon as possible.</p>
<p>Any pre-service claim (not involving urgent care) to receive benefits under:</p> <ul style="list-style-type: none"> • Medical insurance • Dental 	<p>Within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of the claim by the claims administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the claims administrator.</p>	<p>A reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review by the claims administrator.</p>

Type of claim	Timing for claim decision	Timing and notification of appeal decision
<p>Any concurrent care claim to receive benefits under:</p> <ul style="list-style-type: none"> • Medical insurance • Dental 	<p>If the treatment involves urgent care and you request an extension of the course of treatment, the claims administrator must notify you of its determination as soon as possible, taking into account the medical exigencies, but generally no later than 24 hours after receipt of the claim. Your request must be made within 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claim is not made to the plan within 24 hours before the expiration of the course of treatment or number of treatments, notice of the claim decision will be provided as soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the claim by the claims administrator.</p>	<p>If it is an urgent claim for ongoing care, as soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the request for review by the claims administrator.</p> <p>If it is a non-urgent claim for ongoing care, the timing of the notice of decision on review will either be handled under the pre-service or post-service claim time frames addressed below (depending on type of claim).</p>
<p>Any urgent care claim to receive benefits under:</p> <ul style="list-style-type: none"> • Medical insurance • Dental 	<p>As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the claim by the claims administrator.</p>	<p>As soon as possible, taking into account the medical demands, but not later than 72 hours after receipt of the request for review by the claims administrator.</p>

4. Can the time for processing a claim be extended?

If special circumstances require an extension of time for processing the claim or deciding an appeal and an extension is allowed for that type of claim, you will receive a written notice before the end of the initial period. The notice will explain why an extension of time is necessary and when the Administrator expects to render a decision. If an extension is needed for a non-urgent medical insurance, non-urgent dental or vision

claim because you failed to submit necessary information, the notice will specify what information is necessary, and you'll have at least 45 days to provide it. You will be notified of the claims administrator's decision within 15 days after its receipt of the additional information or within 15 days after the 45-day deadline to provide the additional information passes, whichever is sooner.

5. What happens if I fail to follow proper claim procedures?

If you have a claim for medical, dental or vision benefits and fail to follow proper claim procedures, special rules apply. If the claim is urgent and you fail to follow the proper claims procedures, you will be notified of the failure as soon as possible, but no later than 24 hours after the claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 24-hour time frame only applies if your request is made to the proper person and the request names the claimant; his or her medical condition; and the specific treatment, service, or product being requested. For claims involving a claim that is not urgent, you will be notified of the failure to follow the proper claims procedures as soon as possible, but no later than five days after the claim was received. The notice will describe the proper procedures for filing a claim. The five-day time frame only applies if your request is made to the proper person and the request names the claimant; his or her medical condition; and the specific treatment, service, or product being requested.

If, with a claim for urgent (or concurrent) medical, vision or dental benefits, you fail to provide sufficient information to determine whether, or to what extent, benefits are payable from the Plan, you will be notified no later than 24 hours after the claims administrator receives your claim about the specific information you need to submit. You will have at least 48 hours to provide this information. You'll be notified of the claim decision as soon as possible, but not later than 48 hours after the claims administrator receives the specific information or within 48 hours after the deadline to provide this information passes.

If you file a disability claim that is not complete, the claims administrator will notify you within 45 days after receiving the claim of the information that is necessary to complete the claim. You will have 45 days to provide the additional information. The claims administrator will notify you of its decision within 30 days after receiving the additional information or within 30 days after the 45-day deadline to provide the additional information passes, whichever is sooner.

Attachment 2 SPECIAL NOTICES FOR GROUP HEALTH COVERAGE

1. Special Enrollment Notice:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in medical insurance provided under this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. ~~However, you~~ must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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Additionally, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 if you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility or if you or your dependent becomes eligible for a Medicaid or CHIP subsidy.

To request special enrollment or obtain more information, contact the Administrator at:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

Telephone: (530) 898-6811

2. Newborns' and Mothers' Health Protection Act Notice:

Group health plans and health insurance issuers 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 vaginal delivery, or less than 96 hours following a cesarean section. 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3. Women's Health and Cancer Rights Act Enrollment Notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Your evidence of coverage and benefits booklets describe these deductibles and coinsurance. If you would like more information on WHCRA benefits, contact your Administrator at:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

Telephone: (530) 898-6811

4. Notice of HIPAA Preexisting Condition Exclusions:

If you are enrolled in the Blue Cross PPO high option or the Blue Cross PPO low option, your medical insurance imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to the Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period prior. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the Plan or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months from the earlier of our first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but

you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to:

CSU, Chico Research Foundation
Building 25, CSUC
Chico, CA 95929-0246
Attention: Karen Finley

Telephone: (530) 898-6811

5. Continuation Rights

You may have a right to continue group health benefits pursuant to the Family and Medical Leave Act, the Uniformed Services Employment and Reemployment Rights Act of 1994, or COBRA continuation coverage requirements. Section VI of the Summary Plan Description describes these rights. If you have questions about continuation coverage, you may contact your Administrator.