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2022 Benefits Summary Plan Description

For Campus and JPL Retirees

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CALTECH RETIREE HEALTH AND LIFE BENEFITS PROGRAM

This Summary Plan Description (SPD) includes information about:

- Your eligibility for Caltech retiree benefits
- Medical plan options for those who are Medicare eligible, as well as for those who are not Medicare eligible
- Dental and vision plan options
- Life insurance

If you can't find the information you're looking for, refer to the *Contact Information* section of this Summary Plan Description (SPD for important phone numbers and websites, or, you can contact the Campus Campus Benefits Office (Caltech Retirees) or AskHR (JPL Retirees) with any questions you may have.

This Summary Plan Description (SPD) provides a description of the eligibility provisions and benefits offered by the various plans included in the Caltech Retiree Health and Life Benefits Program (also called the "Retiree Benefits Program"). The plan sponsor for all plans is the California Institute of Technology (also called the "Institute" or "Caltech") throughout this document. The administrator of the plans is the Caltech Retiree Service Center which is operated by Mercer (also called Mercer) throughout this document. Refer to the Caltech Retiree Annual Open Enrollment Guide and Future Retiree Guide for additional information.

This SPD is supplemented by other plan documents including plan booklets (also called Evidence of Coverage Booklets, or EOCs) and other plan information is available at **www.caltechretireebenefits.com** with details on the benefits offered by each plan. Together with this document, they constitute the SPD as required by the Employee Retirement Income Security Act of 1974 (ERISA).

ABOUT THIS SUMMARY PLAN DESCRIPTION (SPD)

The Caltech Retiree Health and Life Benefits Program is designed to provide quality, comprehensive benefits that support the needs of our current and future retirees. This Summary Plan Description (SPD) describes the benefits available to you and is intended to help you use each benefit more effectively.

In addition, you should refer to the Caltech Retiree Annual Open Enrollment Guide and Future Retiree Guide for additional information and specific details of the plan provisions.

This Summary Plan Description (SPD) highlights the important features of Caltech's retiree benefit plans. Plan documents and insurance contracts contain supplementary provisions. If there is a discrepancy between the information in this SPD and in plan documents/insurance contracts, the plan documents, including the Evidence of Coverage (EOC) booklets, will govern, with respect to the benefits provided under the Plan.

How to Use This Document

This document is divided into sections based on the benefits available to Caltech and JPL retirees. In addition to detailed benefit sections, there are several sections included in this SPD to help you understand your benefit options.

These sections include:

- The *Benefits at a Glance* section, which gives you a brief overview of your Caltech benefits and eligibility
- The *Rules, Regulations and Administrative Information* section, which includes greater details about ERISA, legal information, claims filing, and plan administrators
- The *Who to Contact* section, which provides addresses and phone numbers you can use to contact the Campus Benefits Office (Caltech Retirees) or AskHR (JPL Retirees). You may also contact The Caltech Retiree Service Center, operated by Mercer (the plan enrollment administrator), or your plan insurance carrier(s)
- The *Glossary* section, which defines important terms

The Employee Retirement Income Security Act of 1974 (ERISA) requires employers to provide employees with a Summary Plan Description (SPD) of certain benefit plans. This document provides you with information about the Caltech Retiree Health and Life Benefits Program. However, this SPD provides only a summary of these benefits and doesn't cover all of the details.

Additional plan details are provided in the following documents:

- Wrap Around Plan Document for the Caltech Retiree Health and Life Benefits Program for Campus Retirees;
- Wrap Around Plan Document for the Caltech Retiree Health and Life Benefits Program for JPL Retirees;
- Evidence of Coverage (EOC) booklets. Throughout this SPD, we will use the term "EOC booklet" or "plan documents" to refer to any of the following insurance company plan documents:

  - ─ "Booklet-Certificates", and
  - ─ Evidence of Coverage (EOC) booklets.
- Any additional contractual documents issued by the insurance company or Health Reimbursement Account (HRA) administrator.

If you would like to review the official plan documents, you can request a copy by contacting the Campus Benefits Office (Caltech retirees) or AskHR (JPL retirees).

Defined Terms
Important terms and phrases used in this summary can be found in the glossary. Be sure you understand the meaning of the terms—see the *Glossary*.

ABOUT THE BENEFIT PLANS

The Institute expects and intends to continue the Caltech Retiree Health and Life Benefits Program but reserves the right to amend, modify, suspend, or terminate the program, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension, or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP for Business & Finance or Human Resources, as applicable. Any change or discontinuation of benefits may apply to individuals who are currently retired at that time.

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. Any payment of benefits depends on your eligibility to receive them. See the *Participating in the Caltech Retiree Health and Life Benefits Program* section of this SPD for eligibility information.

UPDATED INFORMATION

Because the benefits described in this SPD may change, Caltech will provide you with updated information when changes occur, as required by law.

IF YOU HAVE QUESTIONS

If you have any questions about this summary or any provision of your benefit plans, you can refer to the benefits website at **www.caltechretireebenefits.com**, or contact the Campus Benefits Office (Caltech retirees) or AskHR (JPL retirees). You can also direct any enrollment or benefit-specific questions to the Caltech Retiree Service Center, operated by Mercer.

Call the Caltech Retiree Service Center for questions regarding plan eligibility, defined dollar credit amounts, address changes, qualified life events, death notifications, enrollments, billing calculations, and adding or removing eligible dependents from coverage.

Caltech Retiree Service Center
Phone: 855-251-0910
Hours: Monday - Friday, 5:30 a.m. to 6 p.m. (PT)

Benefits Office — Campus
Phone: 626-395-6443
Email: **hrbenefits@caltech.edu**

AskHR — JPL
Phone: 818-354-4447
Email: **HumanResources@jpl.nasa.gov**

PARTICIPATING IN THE CALTECH RETIREE HEALTH AND LIFE BENEFITS PROGRAM

Don't Remember Your Years of Service?
You will be informed of your number of Benefit-Based years of service when it is time to enroll for retiree benefits. For questions about your number of Benefit-Based years of service, you can contact the Campus Benefits Office (Caltech Retirees) or AskHR (JPL Retirees) or you can call The Caltech Retiree Service Center, operated by Mercer. See *Who to Contact*.

ELIGIBILITY

Retired Faculty and Staff

Retirees and their eligible dependents are eligible to enroll in the Caltech Retiree Health and Life Benefits Program, if an employee retires from the Institute and:

- Is at least 55 years old, AND
- Has at least 10 continuous years of service as a Benefit-Based employee immediately prior to retirement or death

OR

- Is at least 55 years old, AND
- Has more than 20 years of service as a Benefit-Based employee, AND
- Has a minimum of 12 months Benefit-Based service immediately prior to retirement.

Benefit-Based Employees

To qualify for benefits at Caltech, you must be a "Benefit-Based" employee. Service in the following positions qualifies you to be a Benefit-Based employee:

- Faculty
- Other Faculty and Non-Faculty Appointments (including Postdoctoral Scholars with External Funded Appointments)
- Postdoctoral Scholars and Senior Postdoctoral Scholars, as appointed by Caltech
- Staff Employees including Key Staff Employees and Temporary Staff Employees regularly scheduled to work 20 or more hours 'per week

"You" and "your" used throughout this document refer to retirees who are eligible for Caltech retiree benefits. For definitions of these and other important terms and phrases used in this document, see the *Glossary*.

Definitions of Faculty, Postdoctoral Scholars and Senior Postdoctoral Scholars, Staff Employees, Key Staff Employees and Temporary Staff Employees are included in the *Glossary*.

Non-Benefit Based Employees

The following are considered Non-Benefit-Based Employees:

- Staff Employees hired on a temporary basis for less than 90 days;
- Occasional employees; and
- Part-time employees regularly scheduled to work less than 20 hours per week.

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

Medicare Eligibility
If you are Medicare eligible and meet the eligibility requirements above, then you are eligible to enroll in one of Caltech's Medicare retiree medical plan options. If you are not Medicare eligible but meet the eligibility requirements listed above, then you may enroll in one of Caltech's non-Medicare retiree medical plan options. However, if you are Medicare eligible and have not enrolled in Medicare Part B coverage, you cannot be enrolled in a lower cost Medicare medical plan until you are enrolled in Medicare Part B.

Grandfathered Retiree Eligibility
If you retired with Caltech retiree medical coverage before April 1, 1991, you are considered to be a "grandfathered retiree."

You are also considered to be a grandfathered retiree if:

- You were actively at work on April 1, 1991, AND
- You had at least 10 years of continuous Institute service as a Benefit-Based employee, AND
- You met at least one of the following criteria as of April 1, 1991:
    1. You were age 55
    2. Your age plus years of service was greater than or equal to 72
    3. Your years of service plus three times your age was greater than or equal to 175.

Dependents
An eligible retiree's dependents are eligible to enroll in a Caltech retiree health care plan, although they are not eligible for life insurance. Eligible dependents are defined as follows:

Your "Dependents" who may be eligible for coverage under your retiree health care coverage include:

- Your legally married Spouse/Registered Domestic Partner or Surviving Spouse
- Your or your Spouse/Registered Domestic Partner's eligible Dependent children until the last day of the month in which they have reached age 26; and
- Your or your Spouse/Registered Domestic Partner's unmarried children of any age who are fully disabled. To be fully disabled, your dependent child must be mentally or physically disabled and incapable of self-support (subject to the insurance company's authorization/approval).

Dependent coverage eligibility is also subject to applicable state and Federal requirements. For additional information on how the plan defines eligible spouses, surviving spouses, registered domestic partners, or dependent child(ren), see the *Glossary*.

Spouse/Registered Domestic Partner Eligibility
An eligible retiree's legally married spouse, surviving spouse, or Registered Domestic Partner eligible to participate in the Caltech Retiree Health and Life Benefits Program provided that proof of the relationship is submitted to Caltech within 31 days of the date the dependent is added or enrolled in the Caltech Retiree Health and Life Benefits Program.

Effective January 1, 2015, only the current spouse, surviving spouse, or registered domestic partner at the time of retirement will be covered under the Caltech Retiree Health and Life Benefits Program. If a retiree, or surviving spouse, in this category re-marries or enters into a registered domestic partnership following retirement, the new spouse or registered domestic partner may be covered as a Dependent on the Caltech Retiree Health and Life Benefits program, but Caltech will not provide any contribution (Defined Dollar Credits) for the new spouse or registered domestic

partner. A marriage certificate or proof of a Registered Domestic Partnership must be provided before a new spouse is enrolled in coverage.

Dependent Child(ren) Eligibility

Child(ren), as defined below and in the *Glossary*, are eligible to be enrolled as your dependent(s) in the Caltech Retiree Health and Life Benefits Program (regardless of eligibility for other group coverage subject to applicable State and Federal requirements), as long as proof of the relationship is provided to Caltech within 31 days of the date the dependent is added or re-added to the Caltech Retiree Health and Life Benefits Program.

Dependent Child(ren) can be enrolled in the Caltech Retiree Health and Life Benefits Program; however, Caltech will not provide any subsidy (Defined Dollar Credits) for dependent child(ren).

Important
You must give accurate information about your family status and your dependents. Proof of dependent eligibility will be required by the Institute for any dependents added or re-added to our plan(s).

Unless otherwise noted, your eligible child(ren) includes an eligible retiree's:

- Child(ren) up to age 26 (coverage ends the last day of the month in which your child(ren) reaches their 26th birthday), *
- Child(ren) age 26 and over who are incapable of employment because of a physical or mental disability. (Eligibility is subject to review and approval by the insurance carrier), *
- Any child(ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMSCO).

*This includes natural child, stepchildren, adopted children, or children of a Registered Domestic Partner, and children for whom you are a court appointed guardian. Caltech adopted the above definitions for eligible dependents effective June 1, 2010.

Qualified Medical Child Support Orders (QMCSO)
Caltech's plans will extend coverage to your non-custodial child(ren), as required by any QMCSO and as defined in ERISA.

A QMCSO is any judgment, decree, or order issued by a court or through an administrative process established by state law, under which an employee, retiree, or spouse/registered domestic partner must provide medical coverage for a dependent child(ren). This might apply, for example, following a divorce.

Each plan has detailed procedures for determining if an order qualifies as a QMCSO. Participants and beneficiaries can obtain a copy, free of charge, from the Plan Administrator.

Important

You must always give accurate information about your family status and your Dependent(s) with respect to eligibility for benefits under the Caltech Retiree Health and Life Benefits Program. Misrepresentation of information about your family status and/or your Dependent(s) could result in termination of coverage under the Caltech Retiree Health and Life Benefits Program. Proof of Dependent eligibility will be required by Caltech for any Dependent(s) added or re-added to our plan(s).

Other Eligibility Rules

Retiree Medical Plan Coverage Under the Active or COBRA Plans

A retiree cannot be covered by Caltech's active employee health plan AND by the Caltech Health and Life Benefits Program at the same time.

A retiree cannot be covered by Caltech's active or COBRA **medical** coverage AND be eligible to receive Defined Dollar Credits under the Caltech Health and Life Benefits Program at the same time. However, enrollment in a Caltech COBRA dental or vision plan does not impact eligibility to receive Defined Dollar Credits. For COBRA coverage options for dental and vision, please contact the Campus Benefits Office (Caltech Retirees) or AskHR (JPL Retirees).

You are eligible for a Medicare Special Enrollment Period for Medicare Part B coverage based on your Caltech group medical coverage as an active employee. You have up to eight months after your employment and employer group medical coverage ends to enroll in Medicare Part B without a lifetime penalty. Please note, when applying for Medicare Part B, COBRA is not considered active employer coverage for purposes of a Medicare Special Enrollment Period. Consult your local Social Security office for additional information on Medicare Part B penalties.

When Two or More Family Members Work for the Institute

An active Benefit-Based employee who is a spouse or registered domestic partner of a retiree must be covered as an active employee under the applicable medical, dental, and vision plans available to active employees (and they may not participate in the Caltech Retiree Health and Life Benefits Program).

The Dependent child(ren) of an active Benefit-Based employee who is also a spouse/registered domestic partner or surviving spouse of a retiree must also be covered as a dependent under the employee plan for active employees (and they may not participate in the Caltech Retiree Health and Life Benefits Program).

Upon the loss of active Benefit-Based employee status, the spouse/registered domestic partner, surviving spouse, and/or Dependent Child(ren) of a retiree shall be covered under the Caltech Retiree Health and Life Benefits Program if the eligibility requirements for coverage are satisfied. (See the *Eligibility* section of this SPD for Caltech Retiree Health and Life Benefits Program eligibility).

When both spouses or registered domestic partners who worked for the Institute are retired from the Institute, each may elect coverage as either a retiree OR as an eligible dependent, but in no event can they elect coverage as BOTH a retiree and as the spouse, registered domestic partner, or surviving spouse *of a retiree* at the same time.

Rules for Surviving Spouses/Registered Domestic Partners and Surviving Dependent Children

Upon the death of an employee who is eligible for retiree benefits, or upon the death of a retiree who is receiving benefits under the Caltech Retiree Health and Life Benefits Program, the surviving spouse/registered domestic partner or surviving Dependent child(ren) may receive benefits under the Retiree Benefits Health and Life Program.

A surviving spouse or surviving registered domestic partner of a Caltech Retiree may add a new spouse or registered domestic partner to the plan, however, Caltech will not provide any contributions (Defined Dollar Credits) for the new spouse or registered domestic partner.
If the surviving spouse or registered domestic partner of a deceased Caltech retiree is considered an active Benefit-Based employee of the Institute, he or she, and any eligible dependent(s), shall be covered under the medical, dental, and vision plans available to active employees. Coverage will continue under the plan for active employees, as long as he or she remains an active Benefit-Based employee. Upon retirement or termination of active employment, the surviving spouse or surviving registered domestic partner can join the Caltech Retiree Health and Life Benefits Program as a retiree if they are eligible for the plan, or they can join as the surviving spouse or surviving registered domestic partner of the deceased retiree. **However, in no event, can an individual participate in the Caltech Retiree Health and Life Benefits Program as both a retiree and as a surviving spouse/registered domestic partner at the same time.**

Special Rights for Mothers and Newborn Children

For the mother or newborn child(ren), the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

ENROLLING IN YOUR CALTECH RETIREE BENEFITS

If you are eligible to participate in the Caltech Retiree Health and Life Benefits Program, then you are able to enroll for Caltech benefits as listed below.

Enrolling When First Eligible

- **If you are not yet Medicare eligible when you retire:** You must enroll for medical, dental, and vision insurance coverage within 31 days of your Retirement Date. If you do not enroll for medical, dental, and vision coverage during this time, you must wait until the following Annual Enrollment period, or for a Qualified Life Event to enroll, subject to the Special Enrollment Rules described below. You are automatically enrolled in retiree life coverage. You can also wait and enroll in the Caltech Retiree Health and Life Benefits Program at a later time such as during the Annual Enrollment Period, or when you experience a Qualified Life Event.

- **If you are Medicare eligible when you retire:** You must complete your enrollment in Medicare at least 30 days prior to your Retirement date in order to enroll in one of the Caltech-sponsored health plans offered to Medicare eligible retirees and spouses. If you are retiring on or in the same month as your 65th birthday, you must enroll in Medicare prior to the first of the month of your 65th birthday in order avoid any delay in the effective date of your Medicare benefits. You are automatically enrolled in retiree life coverage. You can also wait and enroll in the Caltech Retiree Health and Life Benefits Program at a later time, such as during Annual Enrollment, or when you experience a Qualified Life Event. Please note, all late enrollments are subject to the Special Enrollment Rules described below.

- **Eligible retirees and their eligible spouse/registered domestic partner may elect to have their entire Defined Dollar Credit deposited into a Health Reimbursement Account (HRA).** By enrolling in the HRA, you can elect to use your Defined Dollar Credits to purchase a non-Institute health plan and pay other eligible health care expenses.

Special Enrollment Rules

Non-grandfathered retirees, spouses, surviving spouses, and other eligible dependents must enroll in the Caltech Retiree Health and Life Benefits Program for medical, dental, and vision coverage within two years of January 1, 2015 or the retiree's Retirement date, whichever is later. This Special Enrollment rule does not apply to life insurance.

When you are ready to enroll in a medical plan through the Caltech Retiree Health and Life Benefits Program, there are special enrollment rules you must follow:

- **If you have other medical coverage** (other than Medicare), you will be able to join the Caltech Retiree Health and Life Benefits Program if that other coverage ends. However, to join the Caltech Retiree Health and Life Benefits Program, you must notify Caltech within 90 days of the date the other coverage ends, and you must provide proof that you have maintained continuous medical coverage since January 1, 2015, or your retirement date, whichever is later. (Be sure to retain records that prove you have other medical coverage, such as annual confirmation statements and premium receipts).
- **If you don't have other medical coverage**, you can join the Caltech Retiree Health and Life Benefits Program for Retirees during Annual Enrollment. However, if you do not enroll

in the Caltech Retiree Health and Life Benefits Program for Retirees within two years of your retirement date, and you did not have other continuous medical coverage (other than Medicare), you will have waived your right to coverage under the Caltech Retiree Health and Life Benefits Program and will no longer be eligible to enroll.

Enrolling During Annual Enrollment

You'll be given the option of enrolling in or changing plans during the Annual Enrollment period each fall; as long as you remain eligible for coverage under the Caltech Retiree Health and Life Benefits Program. If you enroll, change your elections, or dis-enroll from a plan during the Annual Enrollment period, your requested change will be effective on January 1 of the calendar year following the Annual Enrollment period.

Enrolling After a Qualified Life Event

Eligible retirees may add or delete coverage or dependents at times other than the Annual Enrollment period if they experience a Qualified Life Event.

Qualified Life Events include:

- **Changes in legal marital status**— through marriage, death, divorce, legal separation, annulment, or acquiring a qualified registered domestic partner.
- **Changes in the number of your dependents**— through birth, adoption or placement for adoption, loss of legal custody, or death.
- **Changes in a dependent's status**— loss of eligibility because a dependent child reaches the maximum age for coverage, changes in marital status.
- **Employment status change -** for you, your spouse/registered domestic partner, or your Dependent child(ren) — any change in employment status that affects eligibility for benefits coverage (e.g., termination, change from part-time to full-time or vice versa, or starting or returning from unpaid leave of absence).
- **Changes in eligibility for Medicare or Medicaid**—you or a dependent becomes eligible to enroll in Medicare or Medicaid.

When you can make changes

For all of the Qualified Life Events listed above, **except for becoming eligible for Medicare,** you are allowed to make changes to your coverage as long as you make the change within 90 days after the event, and as long as the change is relevant to the Qualified Life Event that prompts the change. If you do not complete your election change within the 90-day election period, you will lose your right to enroll (or make a change) until the next Annual Enrollment period. You will be able to enroll or make a change if you experience a new Qualified Life Event. During this 90-day election period, you may revoke your initial election and make changes as long as it is within the original 90-day election period. For more information about Qualified Life Events, see the *HIPAA Special Enrollment Events* section of this SPD.

When you can make changes if you become eligible for Medicare

When you become eligible for Medicare, you experience what is considered a Qualifying Event that makes you eligible to enroll in one of the Caltech-sponsored medical plans offered to Medicare eligible retirees and spouses (called Medicare Medical Plans). You must be enrolled in Medicare Part B in order to participate in one of the Caltech-Sponsored Medicare Medical plans.

Impact on your Defined Dollar Credit when you become eligible for Medicare
It is important to understand that the Caltech Defined Dollar Credit will be reduced on the first of the month in which you become Medicare eligible, whether or not you take action to enroll in Medicare Part B and in a Caltech-sponsored Medicare Medical plan. To avoid any delays in starting your Medicare coverage, please review the Medicare Initial Enrollment Period rules below and take action to enroll in Medicare Part B prior to the first of the month in which you turn age 65.

Medicare Initial Enrollment Period
Per the Medicare enrollment guidelines, the Initial Enrollment Period (IEP) lasts for seven months during which you can elect Medicare Part B. Your IEP begins on the first day of the third month before you turn age 65 and ends on the last day of the third month after you turn age 65. You will receive a notice from Social Security of your right to elect or decline Medicare Part B.

You can elect both Medicare Part B up to three months prior to the month in which you turn age 65 (during your Medicare Initial Enrollment Period) and also elect to join one of the Caltech-sponsored Medicare Medical plans. However, both your Medicare Part B and your Caltech-sponsored Medicare Medical plan coverage will not begin until the first of the month in which you turn age 65.

As outlined in the following table, if you choose to enroll in Medicare during your Medicare Initial Enrollment Period, but wait until the month in which you turn age 65 (or later) to apply for Medicare Part B, there will be **one or more months** that you do not have Medicare Part B coverage. This is due to the quarterly Medicare enrollment rules. You will not be eligible to enroll in a lower cost Medicare Medical Plan (until your Medicare Part B coverage takes effect) although your Defined Dollar Credit will be reduced based on your eligibility for Medicare Part B. You will have to remain in a Caltech-sponsored non-Medicare retiree medical plan until the first of the month in which your Medicare Part B coverage begins. **It is important you take action before the month you turn age 65 to avoid a delay in moving to one of the Medicare Medical plans**.

Initial Enrollment Period (IEP)	Month you are Eligible for Part B (age 65)	Month you Enroll in Part B	Date Part B Coverage Begins
Example 1	April	January - March	April 1
Example 2	April	April	May 1
Example 3	April	May	July1
Example 4	April	June	September 1
Example 5	April	July	October

How to Make Changes
You have 90 days from the date of a Qualified Life Event to enroll in coverage, make changes to your existing coverage, and/or to add or remove a dependent. The new coverage you choose will begin on the first of the month following your Qualified Life Event, as long as you elect the change within 90 days after the date of the event. Per Medicare rules, if you are electing a Medicare plan, the coverage cannot be retroactive.

The Caltech Retiree Service Center can assist you with electing or changing your benefits coverage and may request you provide documentation to support your request (e.g., marriage certificates, proof of loss of coverage, etc.).

To make an election change, please contact:
The Caltech Retiree Service Center, Phone: 855-251-0910
Hours: Monday - Friday, 5:30 a.m. to 6 p.m. (PT)

WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

Life insurance coverage begins on the day after your retirement date. Medical, dental, and vision coverage begins on the first of the month following your retirement date, or the first of the month following the date you lose other coverage, as long as you enroll by the enrollment deadline as outlined in the section *Enrolling in Your Caltech Retiree Benefits* of this SPD.

When Coverage Ends

Retiree

Life insurance coverage ends on the date of the retiree's death or contract termination, whichever is earlier.

Medical, dental, and vision coverage under the Caltech Retiree Health and Life Benefits Program ends on the earliest of the following dates:

- The date you no longer meet the eligibility requirements for coverage
- The date you rehired as an active benefit-based employee of the Institute
- 60 days following the date you fail to make the necessary contributions toward the cost of coverage
- Upon your death
- The effective date on which Caltech discontinues the plan.

Spouse, Surviving Spouse or Registered Domestic Partner

Coverage for your spouse/registered domestic partner, surviving spouse under the Caltech Retiree Health and Life Benefits Program will end on the earliest of the following dates:

- The date your spouse/registered domestic partner, or surviving spouse dies
- The date your spouse/registered domestic partner, or surviving spouse no longer qualifies for benefits.
- 60 days following the date required contributions toward the cost of coverage for your spouse/registered domestic partner or, surviving spouse are not paid. The effective date on which Caltech discontinues the plan.

Other Dependents

Your eligible dependents' coverage under the Caltech Retiree Health and Life Benefits Program ends on the earliest of the following dates:

- The date your dependents no longer meet the eligibility requirements for coverage
- The date, as provided by applicable Federal or State law, your dependent child(ren) is no longer covered under a QMCSO
- 60 days following the date required contributions toward the cost of your dependent's coverage are not paid
- The effective date on which Caltech discontinues the plan.

What Happens if You Are Rehired After You Retire?
If you are rehired by the Institute in a benefit based or non-benefit-based assignment after you qualified for and enrolled in a retiree medical plan, you and your dependent(s) will return to the active medical plan. Coverage under the active medical plan will be effective the first of the month following your rehire date.

When your service with the Institute ends, any benefit-based years of service will be added to your defined dollar credit calculation and you will receive credit for every year of service as a benefit-based employee, including those earned during the time as a rehired retiree.

Continuing Coverage

When you and your covered dependents' coverage ends, you may be able to continue coverage through COBRA. (See the *Continuing Coverage through COBRA* section of this SPD for more information.)

MEDICAL, DENTAL, VISION, AND LIFE INSURANCE PLANS

The Caltech Retiree Health and Life Benefits Program is designed to provide you with comprehensive benefits while maintaining maximum choice, flexibility, and quality. For medical coverage, you have several plans to choose from, depending on your age and your personal and/or family needs. The plans specifically available to you may vary based on your location.

MEDICAL DENTAL AND VISION PLANS

For a current list of medical, dental, and vision plan options and related costs, refer to the Caltech Retiree Annual Open Enrollment Guide or the Future Retire Guide. You can also find the applicable EOCs or plan documents on the retiree benefits website at www.caltechretireebenefits.com.

Depending on your age and eligibility, there are several medical plans for you to choose from when you enroll in medical coverage through Caltech. To determine the category for which you qualify (Medicare Eligible retiree, Non-Medicare Eligible retiree, Grandfathered Medicare Eligible retiree, or Grandfathered Non-Medicare eligible retiree), see the *Eligibility* section of this SPD.

For more information on how to purchase an Institute-sponsored plan, see the *How to Use Your Defined Dollar Credits to Pay for Coverage* section of this SPD.

For more information about the Health Reimbursement Plan see the *Health Reimbursement Account (HRA)* section of this SPD.

How to Request a Copy of Your Aetna Medical, Dental, or Vision Plan Documents

Refer to the plan documents provided by the insurance company for specific information on the benefits offered under each plan. The plan documents, together with this document, constitute the SPD as required by ERISA. Your Aetna plan documents are available online at **www.aetna.com**. If you are not already a registered user on the Aetna Navigator, please select the "Register" option. After logging into the Aetna Navigator, select the "Coverage and Benefits" tab to view your plan documents.

You can also request a hardcopy of documents by contacting the member services phone number on the back of your plan ID card or by contacting the phone numbers below:

Medicare Eligibility	Phone Number	Hours
Aetna Non-Medicare Medical Plan Members and Traditional Choice – Medicare Integration Plan Members	800-328-9933	8 am-6 pm All Time Zones; Monday – Friday
Aetna Medicare Advantage Members	888-267-2637	8 am-6 pm All Time Zones; Monday – Friday

How to Request a Copy of Your Kaiser Permanente Medical Plan Documents

This SPD provides an overview of the plans available to you as a retiree. Please refer to the Evidence of Coverage (EOC) booklet provided by the insurance company for specific information

on the benefits offered under each plan. The EOC booklets, together with this document, constitute the SPD as required by ERISA. Your Kaiser Permanente plan documents are available online at **www.Kp.org.**

You can also request a hardcopy of your plan documents by contacting the member services phone number on the back of your plan ID card or by contacting Kaiser Permanente at 800-464-4000, 24 hours a day, 7 days a week.

LIFE INSURANCE PLAN

Retiree Life Insurance Plan

The life insurance policy you had as an active employee will end. All Institute retirees receive a basic group life insurance coverage in the amount of $5,000. The life insurance premium is fully paid by the Institute. In the event of a retiree's death, contact the Caltech Retiree Service Center, operated by Mercer. Once all required documentation is received Mercer will submit the initial claim to the life insurance carrier. Payment is usually made by the life insurance carrier within 1 to 14 business days after all documentation has been received and processed. See the *Who to Contact* section of this SPD for contact information for the Caltech Retiree Service Center, operated by Mercer

Defined Terms
Important terms and phrases used in this summary can be found in the glossary. Be sure you understand the meaning of the terms—see the *Glossary*.

Naming Your Beneficiary

A beneficiary is the person you designate to receive life insurance benefits if you should die while you are covered. You may name anyone you wish as your beneficiary, including more than one person. If you name more than one beneficiary, the life insurance benefits will be paid out equally unless you stipulate otherwise. If you're married and live in a State where community property laws apply, those laws may affect the amounts you designate for beneficiaries other than your spouse.

To obtain a beneficiary designation form, contact the Caltech Retiree Service Center, operated by Mercer.

Phone: 855-251-0910 Hours: Monday - Friday, 5:30 a.m. to 6 p.m. (PT).
A beneficiary designation form is also available at **www.caltechretireebenefits.com**.

You may change your beneficiary at any time by contacting The Caltech Retiree Service Center and requesting a beneficiary change form. The beneficiary change will be effective on the date the signed and dated designation form is returned to the Caltech Retiree Service Center. Prior to your death, you are the only person who can name or change your beneficiary. No other person may change your beneficiary on your behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment.

If one of your named primary beneficiaries dies before you, his or her share will be payable in equal shares to any other named primary beneficiaries who survive you. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

If you have not named a beneficiary, multiple beneficiaries, or a contingent beneficiary, or if the person(s) you have named die(s) before you, payment will be made as follows to those who survive you:

- Your spouse
- If there is no spouse, in equal shares to your child(ren)
- If there is no spouse or you have no child(ren), to your parents, equally or to the survivor
- If there is no spouse or you have no child(ren) or parents, in equal shares to your brothers and sisters
- If none of the above survives, to your executors or administrators.

HOW TO USE YOUR DEFINED DOLLAR CREDITS TO PAY FOR COVERAGE

Eligible retirees and their eligible Spouse/Registered Domestic Partner receive Defined Dollar Credits (DDC), which allow you and Caltech to share in the cost of health care, while also providing flexibility and choice to retirees. This program provides a pre-designated amount of money (Defined Dollar Credits) that can be used to pay for medical expenses.

This section details how the Defined Dollar Credits work, including information about how to calculate your credit amount and use your Defined Dollar Credits to pay for coverage and medical expenses.

Defined Terms
Important terms and phrases used in this summary can be found in the *Glossary*. Be sure you understand the meaning of the terms—see the *Glossary.*

DEFINED DOLLAR CREDITS (DDC)

What Are Defined Dollar Credits?

In order to help share the cost of health care coverage with eligible retirees and their eligible Spouse/Registered Domestic Partner, Caltech contributes a pre-designated amount of money (Defined Dollar Credits) that retirees and their qualified spouse/registered domestic partners use to pay for qualified health care expenses. More details on what qualifies is included below.

When you become eligible to enroll in retiree benefits your DDC is calculated by the Institute. You can use your DDC to purchase Institute-sponsored coverage or you can elect to purchase a non-Institute health plan and have all of your DDC deposited into a Health Reimbursement Account (HRA).

Don't Remember Your Years of Service?
You will be informed of your number of Benefit-Based years of service when it is time to enroll for retiree benefits. For questions about your number of Benefit-Based years of service, you can contact the Campus Benefits Office (Caltech Retirees), AskHR (JPL retirees) or you can call The Caltech Retiree Service Center, operated by Mercer. See the *Who to Contact* section for contact information.

Health Reimbursement Account (HRA)

- **If you use your Defined Dollar Credits to purchase Caltech-sponsored coverage** but have left over Defined Dollar Credits after your enrollment, your leftover Defined Dollar Credits will be automatically deposited into a HRA. **OR**

- **You may decide to waive the Caltech-sponsored coverage and place all of your DDC in the HRA**. to pay for eligible medical expenses. For more information about the HRA, see the *Health Reimbursement Account (HRA)* section of this SPD.

Monthly Retiree Benefits Program Defined Dollar Credit Amounts

Retiree DDC is calculated based on retiree status, grandfathered or non-grandfathered, retiree's years of service, and Medicare eligibility. An eligible spouse/registered domestic partner or surviving spouse/registered domestic partner's DDC is calculated based on the retiree's status, grandfathered or non-grandfathered, retiree's years of service, and spouse/registered domestic partner's Medicare eligibility. Future spouses or registered domestic partners (who you marry after January 1, 2015, or who you marry after your retirement date, whichever is later) are eligible for coverage under your medical, dental and/or vision plan; however, Caltech does not provide a DDC for future spouses or registered domestic partners. Eligible dependent child(ren) can be covered under a retiree's medical, dental and/or vision coverage; however, Caltech does not provide a Defined Dollar Credit for child(ren).

See the Annual Open Enrollment Guide or the Future Retiree Guide for the monthly DDC amount for eligible Retirees.

How the Defined Dollar Credits Work for Grandfathered Retirees,

Medicare Eligible

If you are a Grandfathered retiree, or if you are the eligible spouse/registered domestic partner or surviving spouse/registered domestic partner of a Grandfathered retiree (also referred to as grandfathered spouse/registered domestic partner, grandfathered surviving spouse/registered domestic partner), AND if you are Medicare eligible, then you may enroll in the Non-Contributory medical plan.

For the Non-Contributory medical plan, Caltech's Defined Dollar Credit equals the full cost of the plan premium. The Defined Dollar Credit for the Non-Contributory medical plan will always cover the plan's full premium cost and is not related to the Defined Dollar Credits offered for other plans. Currently, the Non-Contributory plan is the Kaiser Senior HMO Advantage plan; however, the plan may change in the future. **It is important to understand that you cannot elect BOTH the Non-Contributory medical plan and also receive Defined Dollar Credits**.

- **If you choose not to enroll in the non-contributory medical plan**, Caltech will give you the maximum Defined Dollar Credit based on 25 years of service. You can use the Defined Dollar Credit toward the premium cost of one the Caltech-sponsored medical plans offered (other than the Non-Contributory plan). If you elect a plan that costs more than your Defined Dollar Credit, you will pay the difference. If you elect a plan that costs less that your Defined Dollar Credits, then any surplus credits will be deposited into an HRA. **OR**

- **You may decide to waive the Caltech-sponsored plan coverage and place all of your Defined Dollar Credits in your HRA**. You can use the HRA funds to pay for eligible medical expenses. For more information about the HRA, see the *Health Reimbursement Account (HRA)* section of this SPD. **OR**

- **You can choose not to elect any of the Caltech-Sponsored medical plans and deposit the monthly Defined Dollar Credits into an HRA** account. You can use the HRA funds to purchase other insurance coverage (on an after-tax basis) or to pay for eligible medical expenses (for more information, see the *Health Reimbursement Account (HRA*) section of this SPD. See the *Monthly Defined Dollar Credits* table in the Annual Open Enrollment Guide or the Future Retiree Guide for the Defined Dollar Credit amount available for you, your eligible spouse, surviving spouse, or registered domestic partner.

Note: If a grandfathered retiree, grandfathered spouse/registered domestic partner, grandfathered surviving spouse/registered domestic partner elects not to enroll in the Non-Contributory medical plan in any given plan year, they can elect to join the Non-Contributory plan in the following plan year during annual enrollment.

Non-Medicare Eligible

If you are considered a grandfathered retiree and you or your spouse/registered domestic partner are not yet Medicare eligible, Caltech will give you or your spouse the maximum DDC based on 25+ years of service.

- **You can use the Defined Dollar Credit** to elect one of the Caltech-sponsored medical plans. **OR**

- **You can waive the Caltech-sponsored medical plans,** have the Defined Dollar Credits deposited into an HRA, and use the HRA funds to purchase other health coverage (on an after-tax basis) or to pay for eligible medical expenses. For more information, see the *Health Reimbursement Account (HRA)* section of this SPD.

How to Use Your Defined Dollar Credits
This section of this Summary Plan Description (SPD) applies to:

- All eligible retirees, spouses, surviving spouses or registered domestic partners, and to
- All eligible Grandfathered retirees, spouses, surviving spouses or registered domestic partners who **do not** enroll in the non-contributory medical plan.

You can use your Defined Dollar Credits to purchase a Caltech-sponsored medical plan or you can waive the Caltech-sponsored plans and choose to deposit your Defined Dollar Credits into a Health Reimbursement Account (HRA). To enroll, call The Caltech Retiree Service Center, operated by Mercer, at 855-251-0910.

Purchasing a Caltech-sponsored Plan

You can use Defined Dollar Credits to purchase Caltech-sponsored medical plans when you first become eligible, during Annual Enrollment, or when you experience a Qualified Life Event. For more information about when to enroll, see the *Enrolling in Your Caltech Retiree Benefits* section of this SPD.

If the cost of your health care coverage is greater than your Defined Dollar Credit amount, then you must pay the remainder of the premium cost. You will receive a monthly bill from the Caltech Retiree Service Center for any premiums you may owe.

Storing Your Surplus Credits

If the cost of the Caltech-sponsored health care coverage you choose is less than the Defined Dollar Credit amount, the remainder of your Defined Dollar Credits will be deposited into an HRA. For more information about the HRA, see *Health Reimbursement Account (HRA)* below.

IMPORTANT
Surplus Defined Dollar Credits are not available to grandfathered retirees (or grandfathered Spouses/Registered Domestic Partners) who enroll **in the Non-Contributory Medical Plan**.

Depositing Credits into a Health Reimbursement Account (HRA)

If you do not want to purchase a Caltech-sponsored plan, you can elect to deposit your Defined Dollar Credits into an HRA. You can use these Defined Dollar Credits to reimburse the cost of purchasing other health coverage (on an after-tax basis), or to reimburse the cost of eligible medical expenses. For more information about the HRA, see *Health Reimbursement Account (HRA)* below.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

This section of this SPD applies to:

- All eligible retirees, spouses, surviving spouses or registered domestic partners, and to
- All eligible Grandfathered Retirees, spouses, surviving spouses or registered domestic partners who **do not** enroll in the non-contributory medical plan.

What is a Health Reimbursement Account (HRA)?

If you don't spend all of your Defined Dollar Credits on a Caltech-sponsored retiree medical plan, and you are not a Grandfathered retiree, or you do not wish to purchase Caltech-sponsored coverage, you can have your unused Defined Dollar Credits made available to you through a Health Reimbursement Account (HRA).

An HRA is also known as a Health Reimbursement Arrangement. It is an employer established benefit plan that provides a tax-advantaged account that is funded solely by an employer. Retirees are reimbursed tax-free for qualified medical expenses.

Reimbursements from an HRA can be made for eligible expenses accrued by the following persons:

- Retirees
- Spouses/Registered Domestic Partners,
- Tax dependent child(ren) of retirees,
- Any person you could have claimed on your tax return, except if:
    - The person filed a joint return,
    - The person had gross income of $3,950 or more, or
    - You (or your spouse if filing jointly) could be claimed as a dependent on someone else's return.
- Your child(ren) under age 27 at the end of your tax year
- Spouses and Dependent child(ren) of deceased retirees.

Eligible Expenses

Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expense deductions as outlined in IRS Publication 502. Qualified medical expenses from your Caltech HRA include the following:

- Amounts paid for health insurance premium on an after-tax basis, including Medicare Part B premiums
- Amounts paid for long term care coverage and expenses
- Amounts for eligible medical, dental and vision expenses that are not covered under another health plan

IRS Publication 502 can be found at **http://www.irs.gov/pub/irs-pdf/p502.pdf.**

You can also log in to your account at **benefitslogin.wexhealth.com** for a complete list of eligible health care expenses.

Remember!
Don't forget to keep your receipts for audit and tax purposes. Make sure the amount and the service date are included.

How to Use Your HRA

Establishing a Health Reimbursement Account (HRA)

Upon enrollment in the HRA, you will receive a welcome kit from the third party HRA administrator, letting you know your HRA has been established, and then you can register online to access your HRA funds and submit claims for reimbursement at **benefitslogin.wexhealth.com**. If you elect the HRA-only option (and do not choose to purchase a Caltech-sponsored plan), or if you have Defined Dollar Credits left over after paying for a Caltech-sponsored medical plan, any Defined Dollar Credit balance will be applied to your HRA account on a monthly basis.

As a Caltech retiree, the HRA will be in your name and include any DDC your spouse/registered domestic partner is eligible to receive, if applicable. To register, go to **benefitslogin.wexhealth.com,** click on "Login" and select "HSA, FSA, HRA & Commuter Login." You'll need to create a username and password and set up security questions.

How to Pay for Health Care Expenses

You can use your HRA to pay for an eligible health care expense by using:

- **WEX debit card**, at the point of sale. Retain receipts in the event WEX asks for transaction substantiation.
- **Your account's online payment feature**, which includes optional automatic payments for recurring expenses such as a monthly Medicare premium, and your account's online claims reimbursement feature.
- **WEX smartphone app** to file claims.
- **Paper Claim Forms**, along with supporting documentation, can be filled out and mailed or faxed to WEX.

Health Reimbursement Account (HRA) Balances

Any unused amounts in the HRA can be carried forward for reimbursements in later years. Caltech is not permitted to refund any part of the balance to you or to provide the Defined Dollar Credits outside of the HRA. These amounts may never be used for anything but reimbursements for qualified medical expenses.

Any unused amounts in the HRA when a retiree passes away will be transferred to the eligible spouse/registered domestic partner. Any unused amounts in the HRA when the surviving spouse/registered domestic partner passes away are forfeited back to the Institute if there are no other surviving tax dependents.

If your payment for coverage under the Caltech Retiree Health and Life Benefit Program is more than 60 days in arrears, you are authorizing the Plan Administrator to reduce from any available Health Reimbursement Account balance, any premium payments due.

Debit Card

You will receive a debit card in the mail from the third party HRA administrator WEX. This debit card can be used at the point of sale for qualified HRA purchases. Always retain your receipt(s) when using your debit card. If substantiation of the purchase is required, you will receive notification from the third party HRA administrator WEX requesting copies of applicable receipt(s).

If you do not provide the requested documentation your debit card will be deactivated, and you will have to submit claims via a hard copy claim form. If you try to purchase an item that is not a qualified expense, the transaction will be denied at the point of sale.

Filing a Claim

You can submit reimbursement claims online at **benefitslogin.wexhealth.com** by logging in to your HRA account. Or you can fax a claim form, with backup documentation, to the third party HRA administrator **WEX.** You can also use the smartphone app to submit claims to **WEX**.

Fax number 866-451-3245

To download the HRA claim form, login to **benefitslogin.wexhealth.com** or the Caltech retiree benefits website at **www.caltechretireebenefits.com.**

PREMIUM REIMBURSEMENT PLAN (FOR RETIREES PERMANENTLY RESIDING OUTSIDE OF THE U.S.)

This section of this Summary Plan Description (SPD) applies to eligible retirees who permanently live outside of the United States, and who do not enroll in one of the Caltech-sponsored retiree medical plans. You are eligible to receive Defined Dollar Credits.

If you live abroad permanently you can still participate in the HRA. In order to be eligible to receive reimbursements from third party HRA administrator you must maintain a United States address and United States bank account. Submit eligible HRA claims to the HRA Administrator on a monthly, quarterly, or annual basis. If you cannot maintain a United States address and/or bank account, please contact the Caltech Benefits Office (Caltech Retirees) or AskHR (JPL Retirees) for assistance.

RULES, REGULATIONS, AND ADMINISTRATIVE INFORMATION

The Federal law known as the Employee Retirement Income Security Act of 1974 (ERISA), as amended, governs certain employee/retiree benefit plans, including some of the plans described in this document. This section of this Summary Plan Description (SPD) discusses your legal rights under ERISA, as well as important administrative information.

PLAN DOCUMENTS

Every effort has been made to ensure the information in this SPD is complete and accurate. However, if there's an inconsistency between any of the terms of the official plan documents or this SPD with respect to the legal compliance requirements under ERISA or any other Federal law, the plan will be enforced consistent with the terms of applicable current law.

Copies of all plan documents are available for review upon written request to the Plan Administrator. To request copies of the plan documents, contact the Campus Benefits Office (see the *Who to Contact* section of this Summary Plan Description (SPD).

YOUR ERISA RIGHTS

This information applies to The Caltech Retiree Health and Life Benefits Program. Refer to the Annual Open Enrollment Guide or Future Retiree Guide for a list of benefit plans:

Your Rights

As a participant in the Caltech Retiree Health and Life Benefits Program, 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 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.

Continuing Coverage through COBRA

Under certain circumstances, if you or your covered dependents lose Caltech-sponsored medical, dental, or vision coverage, you have a right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to a temporary extension of that coverage. You or your dependents may have to pay for such coverage including a 2% administration fee. You'll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable.

Continuing HRA Coverage through an Alternative to COBRA

Under certain circumstances, if you or your eligible spouse or registered domestic partner, are no longer eligible for DDC credits, access to the HRA can continue through an alternative to COBRA. The existing retiree HRA balance will be allocated, based upon legal documentation from the retiree, to the additional account. Under the alternative to COBRA, there is no limit to the number of months the new account is active, and it will not be subject to the 2% COBRA administration fee. The new account will not receive further funding by Caltech and the new account also does not require monthly funding by the account holder to remain active. The new account will be subject to the monthly administration fee for open HRAs with the Caltech administrator.

Prudent Action by Plan Fiduciaries

In addition to creating rights for you, ERISA imposes duties on the people responsible for the operation of retiree 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 documents 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 your plan's EOC or plan documents, available as follows:

- Aetna plan documents at **www.aetna.com**
- Kaiser EOC booklets at **www.Kp.org**

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(ren) 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 the Caltech Retiree Health and Life Benefits Program, contact the Campus Benefits Office (see the *Who to Contact* section of this Summary Plan Description (SPD)). 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, 20220. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of The Employee Benefits Security Administration.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) OF 1998

The act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions, which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.

YOUR HIPAA RIGHTS

Special Enrollment

If you decline enrollment for yourself or your dependents in the medical, dental, and/or vision plan because of other insurance or group plan coverage, you may be able to enroll yourself and/or your dependents in a Caltech retiree medical, dental, and vision plan if you or your dependents lose eligibility for that other coverage (or if another employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 90 days after your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage). Loss of other medical, dental, and/or vision plan coverage qualifies for special enrollment only if all three of the following conditions are satisfied:

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

In addition, if you gain a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents for medical, dental, and vision coverage. You may also

switch between plans (for example from HMO to PPO). However, you must, request enrollment within 90 days after the marriage, birth, or adoption.

If you are enrolling due to a new child(ren), coverage will begin on the child(ren)'s date of birth, adoption, or foster placement. If you are enrolling due to your marriage or loss of other health plan coverage, coverage will be effective on the first day of the month following the date of the Qualifying Event. If a court has ordered that coverage be provided for a spouse, registered domestic partner, or dependent child(ren), enrollment must be requested within 90 days from the date the court order was issued. For more information about Qualifying Events, please see below or contact the Campus Benefits office (see the *Who to Contact* section of this Summary Plan Description (SPD)).

HIPAA Special Enrollment Events

Special Enrollment Events (also known as Qualified Life Events) may enable you to add dependents coverage and/or to enroll yourself as follows:

IF YOU HAVE THIS EVENT	YOU MAY MAKE THE FOLLOWING CHANGE TO YOUR MEDICAL/DENTAL/VISION ELECTION WITHIN 90 DAYS OF THE EVENT
You gain an eligible dependent through marriage, birth, adoption, or fostering	Enroll yourself and/or your dependent(s) and/or change medical plans
You lose other health plan coverage and meet the requirements #1, #2, and #3 for a HIPAA special enrollment	Enroll yourself and/or your dependent(s)
Your dependent loses non-Caltech health plan coverage and meets the requirements #1, #2, and #3 for a HIPAA special enrollment	Enroll yourself and your dependent(s) who lost coverage
You lose Medicaid or Children's Health Insurance Program (CHIP) coverage due to a change in eligibility	Enroll yourself and/or your dependent(s) and/or change medical plans
You later become eligible for a state's premium assistance program under Medicaid or CHIP	Enroll yourself and/or your dependent(s)

The Retiree Benefits Program will allow a Special Enrollment Event if you and/or your eligible dependents:

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

You or your dependents will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in medical and/or dental coverage provided under the Retiree Benefits Program. Note that the 60-day time period only applies to Medicaid/CHIP eligibility changes and not to any other HIPAA Special Enrollment Event changes.

Medical Record Information Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The following

notice will describe how the plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment, or health care operations). In addition, this notice will describe your rights with respect to your health information.

1.1. Definitions

The following definitions shall apply to this Section of the Summary Plan Description:

(A) "HHS Regulations" means the medical privacy regulations entitled "Privacy of Individually Identifiable Health Information" promulgated by the United States Secretary of Health and Human Services which are effective as of April 14, 2003 (or later as amended by the Secretary) and all amendments thereto.

(B) "Individually Identifiable Information" means information that is a subject of health information, including demographic information collected from an individual, and (1) is created or received by a health care provider, health plan, employee, or health care clearinghouse and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or includes information which can be used to identify the individual.

(C) "Protected Health Information" means Individually Identifiable Information which is transmitted or maintained in any form or medium that (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Protected Health Information excludes Individually Identifiable Information in education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g and records described at 20 U.S.C. 1232(a)(4)(B)(iv).

(D) "Summary Health Information" means information that may be Individually Identifiable Information, and; (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer has provided health benefits under a group health plan; and (2) from which the identifying information described at HHS Regulations § 164.515(b)(2)(i) has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit ZIP code.

1.2. Requests for Health Information by Sponsoring Employer.

(E) The sponsoring employer may use and request health information as follows:

(1) Summary Health Information may be disclosed by the Plan to the sponsoring employer (without a certificate described in Section 12.2(B) for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

(2) Protected Health Information may be disclosed to the sponsoring employer for purposes of Plan administration functions, and other uses allowed under the HHS Regulations, provided that the certification requirement in Section 12.2(B) below has been met.

(B) The Plan will not disclose Protected Health Information to the sponsoring employer until it receives a certification by the sponsoring employer that is agrees to:

(3) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(4) Ensure that any agents, including a subcontractor, to whom the sponsoring employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the sponsoring employer with respect to such information;

(5) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the sponsoring employer;

(6) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the appropriate uses or disclosures of such information of which it becomes aware;

(7) Make available Protected Health Information in accordance with the rules on individual access to information pursuant to HHS Regulations § 164.524;

(8) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with HHS Regulations § 164.526;

(9) Make available the information required to provide an accounting of disclosures in accordance with HHS Regulations § 164.528;

(10) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HHS Regulations.

(11) If feasible, return or destroy all Protected Health Information received from the Plan that the sponsoring employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(12) Ensure that the adequate separation required below in Section 12.2(C) is established

(C) Adequate Separation Between Plan and Sponsoring Employer.

(13) Only employees of the sponsoring employer who are part of Human Resources or Information Technology shall have access to Protected Health Information.

(14) Access to Protected Health Information shall be restricted to those individuals listed above in Section 12.2(C)(1) and other such employees of the sponsoring employer who perform plan administration functions.

(15) Any issues of non-compliance by persons listed above in Section 12.2(C) (1) shall be resolved by a retraction of information where appropriate and investigation by the Plan Administrator or the appropriate department of the sponsoring employer. Any recourse for non-compliance shall be determined by in accordance with the findings of the investigation and shall correlate to the severity of the non-compliance.

1.3. Compliance with Security Regulations

(F) ***Effective Date***. This section is effective as of January 1, 2014.

(G) ***Security Agreements of the Employer***. As a condition for obtaining e-PHI from the Plan, it is Business Associates, Insurers, and HMOs, the Employer agrees it will:

(16) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(17) Ensure that the adequate separation between the Plan and the Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(18) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

(19) Report to each affected Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

(20) Upon request from the Plan, the Employer agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification, or destruction of the e-PHI to the extent such information is available to the Employer.

(C) ***E-PHI not Subject to this Amendment***. Notwithstanding the foregoing, the terms of this Amendment shall not apply to enrollment, disenrollment, and summary health information provided to the Employer pursuant to 45 CFR 164.504(f)(l)(ii) or (iii); of e-PHI released pursuant to an authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

(D) ***Definitions***. All capitalized terms within this Amendment not otherwise defined by the provisions of this Amendment shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

(E) ***Copies Effective as Originals***. A copy of the signed and dated original of this Amendment shall be as effective as the original, and either an original or such copy shall be appended to the governing instruments of each Plan and shall be deemed to be a part of such governing instruments.

(F) As required by the Security Rule, the Plan and Business Associate agree to treat a material breach of this Amendment as a breach of the Agreement as a security incident subject to the terms and conditions specified under the Agreement with respect to material breaches.

Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

(1) The names of the individuals whose PHI was involved in the Breach;

(2) The circumstances surrounding the Breach;

(3) The date of the Breach and the date of its discovery;

(4) The information Breached;

(5) Any steps the impacted individuals should take to protect themselves;

(6) The steps the Institute is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

(7) A contact person who can provide additional information about the Breach.

The Plan will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

CLAIMS REVIEW AND APPEALS PROCEDURES OVERVIEW

Claim Procedures and Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.
The Plan recognizes four categories of health benefit claims:

1. Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

2. Pre-service Claims

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

3. Post-Service Claims

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

4. Concurrent Care Claims

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

5. Adverse Benefit Determination

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

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue. In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

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

- the date of service;
- the health care provider;
- the claim amount (if applicable); and
- the denial code.

For Medical claims, the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

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

Health Reimbursement Account and Premium Reimbursement Plan claims are considered non-urgent "post-service" claims.

Claim Determination and Appeal Procedures for the Medical, Dental and Vision Insurance Plans

The procedures for filing claims for your medical, dental, and vision plans are summarized in the respective plan overviews. If you file a claim with one of your plans but are not satisfied with the outcome of your claim, you can ask to have the claim reviewed. You can find your plan's claim review and appeals process in your plan's EOC or plan documents, found online as follows:

- Aetna medical, dental and vision plan documents at **www.aetna.com**
- Kaiser medical EOC's at **www.Kp.org**

Claim Determination and Appeal Procedures for the Life Insurance Plan

You must use and exhaust the Hartford Life Insurance 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.

Claim Determination and Appeal Procedures for the Health Reimbursement Account (HRA) and Premium Reimbursement Plan

The following information applies to the Health Reimbursement Account (HRA) administered by ***WEX***, the third-party administrator, and the Premium Reimbursement Plan administered by Caltech. Claims under these plans are considered post-service claims. If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved.

Your claims appeal may be submitted in writing and mailed to the respective Claims Administrators.

HRA Claim Appeals should be sent to:

WEX PO Box 2926
Fargo, ND 58108-2926

Or your appeal may be faxed to:
Fax Number: 866-451-3245

Premium Reimbursement Claim Appeals should be sent to:

California Institute of Technology
Human Resources, Benefits Department
1200 E. California Boulevard
Mail Code 161-84
Pasadena, CA 91125

You must use and exhaust these plans' administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

Time Frame for Claim Determinations

If you receive an adverse benefit determination (i.e., any denial, reduction, or termination of a benefit, or a failure to provide or make a payment), the Claim Administrator will notify you of the adverse determination within a reasonable period of time, but no later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Claim Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the plan's time frame for making a benefit determination on review is tolled (i.e., stopped) from the date the Claim Administrator sends you the extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

1. The specific reason(s) for the adverse benefit determination;
2. Reference to the specific plan provisions on which the benefit determination is based;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary;
4. A description of the plan's appeal procedures and time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

Procedures for Appealing an Adverse Benefit Determination

You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits.
2. Request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
    i) Was relied upon in making the benefit determination;
    ii) Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
    iii) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
3. A review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The Claim Administrator will notify you of the plan's benefit determination on review within a reasonable period of time, but no later than 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.

NON-ASSIGNMENT OF BENEFITS

Generally, benefits under Caltech's plans may not be sold, transferred, pledged, or assigned except as permitted by law, and any attempt to do so will be void. In certain situations, however, court orders may require benefits to be provided for a certain individual or individuals, typically a retiree's family member. Also, the direct payment of benefits to a health care provider, if any, will be done as a convenience to the covered person and will not constitute an assignment of benefits under the plans.

Qualified Medical Child Support Order (QMCSO)

A qualified medical child support order, also known as a QMCSO, is any judgment, decree, or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under State law, which has the force and effect of law in that State, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. The plan won't provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

If a QMCSO affects you, you should notify the Campus Benefits office (Caltech Retirees) or AskHR (JPL Retirees) so that the order can be handled properly. You and your dependents may obtain a copy of the procedures governing the QMCSO without charge by contacting the Campus Benefits Office or AskHR. If Caltech receives a QMCSO affecting you, you'll be notified.

Caltech will comply with all valid QMCSOs. You and your dependents may receive, upon request to the Plan Administrator and without charge, a copy of the procedures applicable to QMCSOs.

DETERMINING PAYMENT OF BENEFITS

The Plan Administrator has generally delegated to the claim administrators the discretionary authority to:

- Make decisions regarding the interpretation or application of plan provisions;
- Make determinations, including factual determinations, as to the rights and benefits of retirees and participants under a plan;
- Make claims determinations under a plan; and
- Decide appeals of denied claims.

Plan benefits will be paid only if the Plan Administrator, or its delegate, decides in its discretion that the claimant is entitled to them. The decision of the Plan Administrator or its delegate, as applicable, is final and binding.

CHANGE IN OR TERMINATION OF THE PLAN

The Institute expects and intends to continue the Caltech Retiree Health and Life Benefits Program but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time

and for any reason. Any such amendment, modification, suspension, or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP for Business 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.

PLAN INFORMATION

Plan Year, Names and Numbers

The plan year for all plans is January 1 through December 31. The employer identification number assigned to the plan sponsor by the IRS is 95-1643307.

Plan Sponsor

The plan sponsor for all plans is the California Institute of Technology (also called the "Institute" or "Caltech"). 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 Ave.
Pasadena, CA 91125

Plan Funding and Type of Administration

The medical, dental, vision, and life plan benefits are insured as listed below under the "Claims Administrator" section of this Summary Plan Description (SPD). Benefits under the medical, dental vision and life plans are guaranteed under contracts of insurance (see the *Claims Administrator* section of this Summary Plan Description (SPD) for the insurance company customer service phone numbers and policy numbers). The Health Reimbursement Account (HRA) is self-funded by the Institute. Reimbursements for qualified medical expenses under the HRA are processed by the third-party administrator. The claims administrator for the HRA is responsible for determining whether you are entitled to benefits and authorizing payment. Benefits under the reimbursement accounts are not guaranteed by HRA the Claim Administrator under a contract or policy of insurance (see the *Claims Administrator* section of this Summary Plan Description (SPD) for the HRA customer service phone number).

The Premium Reimbursement Account is self-funded by the Institute. Reimbursements for qualified medical expenses under the Premium Reimbursement plan are processed by the Campus Benefits Office (for Campus retirees) or JPL Benefits Office (for JPL retirees). The appropriate Benefits Office is responsible for determining whether you are entitled to benefits and authorizing payment. Benefits under the Premium Reimbursement plan are not guaranteed under a contract or policy of

insurance (see the *Claims Administrator* section of this Summary Plan Description (SPD) for the appropriate Benefits Office phone number).

Source of Contributions

Retirees (including spouses, surviving spouses and registered domestic partners) who participate in the plan, are required to make contributions for certain coverage. The California Institute of Technology (Caltech) in its sole and absolute discretion, shall determine the amount of its Defined Dollar contributions (called Defined Dollar Credits) by establishing Defined Dollar Credits provided under the plan. Caltech may increase or decrease the amount of Defined Dollar Credits provided and thus change the retiree's required contribution at any time. Caltech may provide different Defined Dollar contributions for different classes of retirees, spouses, Surviving spouses, and registered domestic partners. Caltech will notify retirees annually as to the amount of Defined Dollar Credits and as to the premium costs for each medical, dental, and vision plan option. Caltech does not provide Defined Dollar Credit contributions to Dependent Children of Caltech retirees.

If a retiree selects a medical, dental, and/or vision plan option that costs more than the Defined Dollar Credit amount provided by Caltech the retiree/surviving spouse is required to contribute the premium amount in excess of the Defined Dollar Credit. Any experience credits or refunds under a group insurance contract shall be applied first to reimburse Caltech for its Defined Dollar contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Plan Administrator

The Plan Administrator for all plans is Caltech. Caltech has named The Caltech Retiree Service Center, operated by Mercer, to be responsible for enrolling participants. Caltech has named the Sr. Director of Total Rewards, Human Resources to be responsible for performing other duties required for the operation of the plans, including calculating years of benefit-based service and eligibility for the Caltech Retiree Health and Life Benefits Program.

You may contact the Plan Administrators at the following addresses:

Plan Enrollment—The Caltech Retiree Service Center, operated by Mercer

Phone: 855-251-0910
Hours: Monday - Friday, 5:30 a.m. to 6 p.m. (PT)

Plan Operations— Caltech

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 Ave.
Pasadena, CA 91125

Claims Administrator
The benefits are guaranteed under a contract and/or policy of insurance issued by the insurer which provide various administrative services including claims administration.

The Claims Administrator for each plan is as follows:

Claims Administrator	Contact Information
Aetna Medicare Advantage Medical	1-888-267-2637
Aetna Non-Medicare Medical and Traditional Choice Plan – Medicare Integration Plan	1-800-328-9933
Kaiser Foundation Health Plan, Inc.	1-800-464-4000 (English) 1-800-788-0616 (Spanish)
Aetna Dental	1-877-238-6200
Aetna Vision	1-877-973-3238
The Hartford Life Insurance	1-877-320-0484
Health Reimbursement Account HRA (administered by *WEX)*	844-561-1334
Premium Reimbursement Plan (for retirees permanently living outside the U.S.)	Human Resources, Benefits Office, 1200 E. California Blvd., M/C 161-84, Pasadena, CA 91125 JPL Benefits Office 4800 Oak Grove Drive, T-1720 Pasadena, CA 91109

Agent of Legal Process

Any legal correspondence regarding the plans should be sent to:

Office of General Counsel

California Institute of Technology
1200 E. California Blvd.
Mail Code108-31
Pasadena, CA 91125

WHO TO CONTACT

Below are the important phone numbers and websites you may need to locate providers or find answers to your questions.

Campus retirees	**Contact the Campus Benefits Office** If you have any questions about this summary, you can refer to the Retiree benefits website at **www.caltechretireebenefits.com**, or contact the Benefits Office by phone or email.	***Campus Benefits Office*** Phone: 626-395-6443 Email: hrbenefits@caltech.edu
JPL retirees	**Contact AskHR** If you have any questions about this summary, you can refer to the Retiree benefits website at **www.caltechretireebenefits.com**, or contact AskHR.	***AskHR*** Phone: 818-354-4447 Email: humanresources@jpl.nasa.gov

Contact the Caltech Retiree Service Center, operated by Mercer

If you have benefit-specific questions, want to know how much your Defined Dollar Credit amount is, or need assistance enrolling in benefits, contact the Caltech Retiree Service Center, operated by Mercer, by phone.
Phone: 855-251-0910
Hours: Monday - Friday, 5:30 a.m. to 6 p.m. (PT)

Contact Your Plan Carriers

When you have questions about your claims or specific benefit provisions, you may also call the Customer Service Numbers for the respective benefit plan carriers and plan administrators. The customer service phone numbers are also found on your medical ID card.

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

GLOSSARY

This section of this Summary Plan Description (SPD) provides definitions of important technical and benefit-specific terms used throughout the document.

IMPORTANT!
These terms refer to the health care insurance plans. Your providers and other organizations may define these terms differently. Please refer to the material provided by the carriers that describes these types of plans.

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

Adverse Benefit Determination
An "adverse benefit determination" is a denial, reduction, termination of a benefit, or failure to provide or pay for a benefit (in whole or in part). This can also include a denial of participation in the plan. For health coverage, an adverse benefit determination also means a claim denial on the grounds that the treatment is experimental, investigational, or not medically necessary. This also includes concurrent care determinations.

Beneficiary
A "beneficiary" is the person(s) you designate to receive death benefits provided under your individual Life Insurance policy in the event of your death.

Benefit-Based Employees
To qualify for benefits at Caltech, you must be a "Benefit-Based" employee. Service in the following positions qualifies you to be a Benefit-Based employee:

1) "Faculty" (as defined in the *Glossary*).
2) "Other Faculty and Non-Faculty Appointments" (including Postdoctoral Scholars with External Funded Appointments)"
3) Postdoctoral Scholars and Senior Postdoctoral Scholars as appointed by Caltech; and
4) "Staff Employees" as defined in this *Glossary* (including Key Staff Employees and Temporary Staff Employees as defined in this *Glossary*) who are regularly scheduled to work 20 or more hours per week.
    a) Employees with two or more part-time assignments whose combined regularly scheduled hours are equal to 20 or more hours per week.

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

Campus Benefits Office
The Benefits office located on The California Institute of Technology Campus (Campus) is responsible for the administration of the Caltech Benefits Program.

Certificate of Coverage
When your health coverage or COBRA coverage ends, you automatically receive a "certificate of coverage" that:

- Confirms the medical plan and coverage level you had as an enrolled retiree that was continued through COBRA; and
- States how long you were covered.

Change(s)-Qualified Life Events

Refer to page 14 for the list of qualifying "Changes in Status" and other IRS-approved Qualified Life Events that allow you to add, cancel, or change your elections during the plan year. Examples of Qualifying Change(s) in Status Events include:

- Changes in legal marital status—Marriage, death, divorce, legal separation, annulment, or acquiring a qualified registered domestic partner.
- Changes in the number of your dependents—Birth, adoption or placement for adoption, loss of legal custody, or death.
- Changes in employment for you, your spouse, your registered domestic partner, or your dependent—Any change in employment status that affects eligibility for benefits coverage (e.g., termination, change from part-time to full-time or vice versa, or starting or returning from unpaid leave of absence).
- Changes in entitlement to Medicare or Medicaid—you or a dependent becomes entitled to Medicare or Medicaid.

Child (ren)

Your eligible "Child(ren)"as described in this document, include an eligible retiree's:

- Children (natural, step, adopted, foster child(ren), and child(ren) for whom you are a court-appointed guardian) up to the end of the month of their 26th birthday regardless of eligibility for other group coverage subject to applicable state and Federal requirements
- Children age 26 and over who are incapable of employment because of physical or mental disability (subject to insurance carriers' authorization/approval)
- Children who otherwise meet the plan's definition as defined above for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

Caltech adopted the above definitions for eligible Dependents effective June 1, 2010.

Qualified Medical Child Support Orders (QMCSO)

Caltech's plans will extend coverage to your non-custodial child(ren), as required by any QMCSO and as defined in ERISA.

A QMCSO is any judgment, decree, or order issued by a court or through an administrative process established by state law, under which an employee, retiree, or spouse/registered domestic partner must provide medical coverage for a dependent child. This might apply, for example, following a divorce.

Each plan has detailed procedures for determining if an order qualifies as a QMCSO. Participants and beneficiaries can obtain a copy, free of charge, from the Plan Administrator.

Claimant

A "claimant" is the person filing a claim and, depending on the situation or loss, can be you, your beneficiary, or someone acting on your behalf.

COBRA

Under certain circumstances, if you or your covered dependents lose Caltech-sponsored medical, dental, or vision coverage, you may have a right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to a temporary extension of that coverage. See

the *Continuing Coverage through COBRA* section of this Summary Plan Description (SPD) for more information.

Coinsurance
"Coinsurance" is the percentage of eligible expenses you pay for medical or dental services once you meet your deductible or pay your copay.

Contingent Beneficiary
A "Contingent Beneficiary" is a person that you select to receive a life insurance payment in the event that the primary beneficiary or beneficiaries are unable to collect the payment due to unforeseen circumstances, such as death.

Coordination of Benefits (COB)
"Coordination of Benefits (COB)" rules determine how much each plan pays when you or your eligible family members are covered under more than one health care plan. The rules involve two steps:

- Determining which plan pays first (the plan that pays first is your "primary plan"); and
- Determining how much the Caltech-sponsored plan will pay.

Copay
A "Copay" is the charge you're required to pay for certain covered medical, dental, and vision care services when you receive them.

Deductible
A "Deductible" is the amount of covered expenses that must be paid each year before certain benefit plans will pay a portion of eligible expenses. Refer to each benefit plan's Evidence of Coverage (EOC), plan document or Booklet-Certificate for a description of the deductible amount.

Defined Dollar Credits
"Defined Dollar Credits" refers to a pre-designated amount of contributions provided to retirees that can be used to pay for Caltech-sponsored medical, dental, and vision coverage, or that can be deposited into a Health Reimbursement Account (HRA) that retirees can use to pay for other health coverage or eligible medical expenses. For more information about HRA's see "Health Reimbursement Account" in this *Glossary.*

Dependents
Your "Dependents" who may be eligible for health care coverage include:

- Your legally married spouse or registered domestic partner;
- Your or your registered domestic partner's eligible dependent child(ren) up to age 26; and
- Your or your registered domestic partner's unmarried dependent child(ren) of any age who are fully handicapped. To be fully handicapped, your dependent child(ren) must be mentally or physically handicapped and incapable of self-support.

Dependent coverage eligibility is also subject to state and Federal requirements.

Enrollment Period

The “enrollment period” is the period during which a retiree may add or drop certain benefits and add or drop dependents without restriction, subject to each specific benefit plan’s limitation.

ERISA

ERISA stands for the “Employee Retirement Income Security Act of 1974”. This law mandates, among other items, certain reporting and disclosure requirements for group life, health, and retirement plans. Your ERISA rights are summarized in the *Rules, Regulations, and Administrative Information* section. Non-ERISA plans are not subject to the same requirements and mandates.

Evidence of Coverage (EOC)

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

Applicable EOC booklets are posted online at **www.caltechretireebenefits.com.**

Evidence of Insurability (EOI)

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

Faculty

Eligible “Faculty” and “Other Faculty” as described in this document include, but are not limited to individuals with service in the following positions:

- Professorial Faculty
- Research Professor (formerly Senior Research Associate)
- Research Assistant Professor (formerly Senior Research Fellow)
- Director of Athletics
- University Librarian
- Members of Professional Staff
- Members of the Beckman Institute
- Coaches.

Service in the positions listed above qualifies you to be a Benefit-Based employee.

Grandfathered Retiree

A "Grandfathered Retiree" is a retiree who is considered "Grandfathered" by meeting one of the following criteria:

Retired with Caltech medical coverage before January 1, 1991, **OR**
Actively at work on April 1, 1991 with at least 10 years of continuous service **AND,**
At least 55 years old, or
Age plus years of service greater than or equal to 72, or
Years of service plus three times age was greater than or equal to 175.

Health Maintenance Organization (HMO)

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

Health Reimbursement Account (HRA)

A "Health Reimbursement Account (HRA)" is also known as a Health Reimbursement Arrangement. It is an employer established benefit plan that provides a tax-advantaged account that is funded solely by an employer. Retirees are reimbursed tax-free for qualified medical expenses. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expense deductions as outlined in IRS Publication 502. Qualified medical expenses from your HRA include the following:

- Amounts paid for health insurance premium on an after-tax basis, including Medicare Part B premium
- Amounts paid for long term care coverage
- Amounts that are not covered under another health plan.

Reimbursements under an HRA can be made to the following persons:

- Retirees
- Spouses and dependents of retirees
- Any person you could have claimed as a dependent on your return, except if:
  - The person filed a joint return,
  - The person had gross income of $4,300 or more, or
  - You or your spouse if filing jointly could be claimed as a dependent on someone else's return.
- Your child(ren) under age 26 at the end of your tax year
- Spouses and dependents of deceased retirees.

HIPAA

HIPAA is the "Health Insurance Portability and Accountability Act of 1996." To protect your privacy, Federal law sets rules about the proper use and disclosure of your personal health information and gives you certain rights. HIPAA also provides plan participants with special enrollment rights and other benefits-related protections that are applicable to the Caltech Retiree Health and Life Benefits Program.

Ineligible Expense
An "ineligible expense" is one that the plan determines to be ineligible for coverage under the plan provisions, and therefore no benefits will be paid from the plan for the expense.

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

Jet Propulsion Laboratory (JPL)
"Jet Propulsion Laboratory (JPL)" is an operating division of the California Institute of Technology, and a Federally Funded Research and Development Center (FFRDC) under NASA sponsorship.

JPL Benefits Office/AskHR
The Benefits office located at JPL is responsible for the administration of the JPL Benefits Program.

Lump-sum Payment
A "lump-sum payment" is a one-time cash payment.

Non-Benefit Based Employees
As described in this document, the following are considered "Non-Benefit-Based Employees":
- Staff Employees hired on a temporary basis for less than four months;
- Occasional employees;
- Part-time employees regularly scheduled to work less than 20 hours per week; and
- Any individual hired by JPL in the following employment classification:
    - Call Back Student;
    - High School Summer Teacher;
    - Interim Employee Program;
    - Minority Initiative Intern.

Non-Contributory Medical Plan
If you are a Grandfathered retiree, or if you are the spouse/registered domestic partner, or surviving spouse of a Grandfathered retiree, AND if you are Medicare eligible, then you may enroll in the Non-Contributory medical plan. Grandfathered Medicare eligible retirees and their Medicare eligible spouses/registered domestic partners, or surviving spouses pay no monthly premium for the Non-Contributory medical plan. The Non-Contributory medical plan and insurer is determined by Caltech and may change from year to year.

Out-of-network Provider
An "out-of-network provider" is a licensed doctor, nurse, therapist, hospital, lab, or other health care facility, as well as a licensed mental health and chemical dependency provider such as a licensed psychiatrist or psychologist, who doesn't participate in the network. When you use a provider who doesn't participate in the network, you receive a lower level of benefit, and your out-of-pocket expenses are higher. If you use an out-of-network provider under an HMO plan your expenses may not be covered at all.

Plan Administrator
The “Plan Administrator” is Caltech or its designee in charge of administering the plan.

Plan year
The “plan year” is January 1 through December 31 of each year.

Preferred Provider Plan (PPO)
A “PPO” is a group of health care professionals and/or hospitals, labs and other health care facilities that contract with an employer or insurance company to provide medical care to a specified group of patients at discounted rates.

Postdoctoral Scholar or Senior Postdoctoral Scholar
As described in this document, “Postdoctoral Scholar” or “Senior Postdoctoral Scholar” is a Caltech or JPL Research appointee sponsored by professorial faculty who is eligible to participate in all plans available to Benefit-Based Employees.

Primary Plan
When a person is enrolled in two plans from two separate sources, the “primary plan” is the plan that pays for benefits first. Generally, the primary plan is the person’s employer-sponsored plan.

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

Reasonable and Customary Charge Limits
Most plans pay benefits only up to “reasonable and customary charge” limits. If your provider is charging fees for treatment and services which fall within a range that is similar to providers that have similar training and experience in your geographic area, the fees are considered reasonable and customary. You’re responsible for any charges in excess of reasonable and customary charge limits.

When you visit an in-network provider, eligible expenses you incur are automatically considered to be within reasonable and customary charge limits. However, keep in mind that reasonable and customary charge limits apply anytime you see an out-of-network provider.

Registered Domestic Partners
In this document “registered domestic partners” refers to both Registered Domestic Partners and Same-Gender registered domestic partners. See below for additional information about eligible Same-Gender registered domestic partners and Registered Domestic Partners.

Same Gender Registered Domestic Partner
Under the Caltech Retiree Health and Life Benefits Program described in this document, “Same-Gender registered domestic partners” are two adults of the same-sex who have a Certification of Registered Domestic Partnership on file with the Campus Benefits office

and who have registered with the California Secretary of State, or other applicable state agencies. Same-Gender Registered Domestic Partners and their dependents may be enrolled as dependents in a retiree's medical, dental, and vision insurance plans, provided the general terms and conditions of coverage for the respective plans are met.

Registration with a state agency is not required for those enrolled prior to January 1, 2011.
Same-Gender Registered Domestic Partners and their covered dependents are eligible for continuation of medical, dental, and vision benefits similar to COBRA and have similar conversion rights under medical coverage. Contact the Campus Benefits office regarding Same-Gender registered domestic partner certification, termination, and rates. See the *Who to Contact* section of this Summary Plan Description (SPD).

Opposite Sex Registered Domestic Partner
Under the Caltech benefits program described in this document, opposite sex registered domestic partners are two adults of the opposite sex who have a certification of Registered Domestic Partnership on file with the California Secretary of State, or other applicable state agencies. Registered Domestic Partners and their dependents may be enrolled as dependents in a retiree's medical, dental, or vision plan, provided the general terms and conditions of coverage for the respective plans are met. Registered domestic partners and their covered dependents are eligible for continuation of medical, dental, and vision benefits similar to COBRA and have similar conversion rights under medical and vision coverage.

Contact the Campus Benefits Office regarding registered domestic partner certification, termination, and rates. See the *Who to Contact* section of this Summary Plan Description (SPD).

Contact AskHR office regarding registered domestic partner certification, termination, and rates. See *Who to Contact* section of this Summary Plan Description (SPD).

Retiree
A "retiree" as described in this document means an Institute employee who retires from active employment at the Institute and who has attained the required age and years of service in a Benefit-Based position in order to be eligible to participate in the Caltech Retiree Health and Life Benefits Program.

Retirement date
The first of the month following termination of employment.

Secondary Plan
The "secondary plan" is the plan that pays benefits after the primary plan has paid its benefits.

Spouse/Surviving Spouse
As described in this document a "spouse" refers to your husband or wife under a legally valid marriage. The term "surviving spouse" described in this document refers to the

"spouse" (as defined above) of a deceased retiree. Spouses and their dependents may be enrolled as dependents in a retiree's medical, dental, and vision plans, provided the general terms and conditions of coverage for the respective plans are met.

Staff Employees

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

Summary Plan Description (SPD)

A "Summary Plan Description (SPD)" is a description of a benefits plan or program available to persons covered by those plans as required by the Employee Retirement Income Security Act (ERISA). The SPD consists of both the Caltech Retiree Health and Life Benefits Program document and the Evidence of Coverage (EOC) booklets or plan documents issued by the insurance carrier for your medical, dental, and vision plans.

Tax-Qualified Dependent

A "tax-qualified dependent" is a dependent, registered domestic partner or child of your registered domestic partner, as applicable, who meets the requirements of Section 152 of the Internal Revenue Code.

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

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

Subject to the terms of eligibility under a Caltech benefits plan, if coverage is provided to a registered domestic partner or child of your registered domestic partner, as applicable, who are not your tax-qualified dependents, the amount of that coverage will be subject to imputed income, and you will not be able to pay for their coverage on a pre-tax basis. You may wish to consult with your tax advisor to determine if your dependent qualifies as a tax-qualified dependent.

Temporary Staff Employees

As described in this document "Temporary Staff Employees" are employees who are regularly scheduled to work 20 or more hours per. The date the Temporary Staff Employee is first scheduled to work 20 or more hours per week will be used in determining the benefit coverage effective date

Unmarried Child(ren)

"Unmarried child(ren)" includes natural child(ren), stepchild(ren), child(ren) being placed for adoption, child(ren) under permanent legal guardianship, and child(ren) for whom you have a qualified medical child support order (QMCSO).

You / Your

In this document, “You” and “your” refer to retirees who meet the required age and years of service requirements and are eligible for the Caltech Retiree Health and Life Benefits Program.