YOUR CALTECH MEDICAL PLANS

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

PPO Plans

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

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

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

Health Maintenance Organizations (HMOs)

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

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

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

ANTHEM BLUE CROSS PPO AND HIGH-DEDUCTIBLE PPO PLANS

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

HOW THE ANTHEM BLUE CROSS PPO PLAN WORKS

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

Most covered charges are subject to an annual Deductible, applicable copayments, and benefit maximums. Refer to the current *Comparison of Health Plan Benefits* for a summary of specific information on each medical plan.

HOW THE ANTHEM BLUE CROSS HIGH-DEDUCTIBLE PPO WORKS

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

Most covered charges are subject to an annual Deductible, applicable copayments, and benefit maximums. Refer to the current *Comparison of Health Plan Benefits* for a summary of specific information on each medical plan.

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

WHEN YOU NEED CARE

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

Filing Claims

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

Covered Services

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

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

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

COST-CONTAINMENT PROCEDURES

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

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

Please refer to the Medical section of the Caltech benefits website, benefits.caltech.edu (under the Health tab) especially if you or a covered Dependent needs surgery, a hospital stay, or has a lengthy, ongoing illness. **There are significant penalties for not complying with the procedures established by Anthem Blue Cross.**

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

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

COORDINATION OF BENEFITS

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

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

How Coordination Works

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

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

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

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

Which Plan Is Primary?

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

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

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

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

3. When a person is covered as a Dependent under two or more plans of parents who are either married, not separated, or have a court decree which awards joint custody without specifying that one parent has the responsibility to provide health care coverage the following applies:

   - The plan which covers a Dependent child of the person whose birthday is earlier in the calendar year will generally be primary to a plan which covers a Dependent child of a person whose birthday is later in the calendar year. For example, if your birthday is in May and your spouse's birthday is in October, your plan is considered primary for your Dependent child, regardless of which spouse is older in actual years.

     If both parents have the same birthday, the plan which covered one of the parents longer will be primary to the plan which covered the other parent for a shorter period of time.

   - If the other plan does not have a rule based on birthdays similar to this rule, then the rule in the other plan will determine which plan is primary.

4. The rules that are used to find out which plan is primary and which plans are secondary when a person is covered as a Dependent under two or more plans of divorced or separated parents are as follows:

   - The plan of the parent with custody will be primary to a plan of the parent without custody. Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:

     ⇨ The plan of the parent with custody will pay benefits first.

     ⇨ The plan of the stepparent with custody will pay benefits next.

     ⇨ The plan of the parent without custody will pay benefits next.

     ⇨ The plan of the stepparent without custody will pay benefits next.

   - There may be a court decree which has specific terms giving one parent financial responsibility for the medical, dental or other health expenses of the Dependent child. The plan of the parent should have actual knowledge of the court decree. The plan which covers the parent with financial responsibility is primary to any other plan which covers that Dependent child.

- A plan may cover a person as an active employee, or as a Dependent of that employee. This plan will be primary to any plan which covers the person as a laid-off or retired employee or as a Dependent of that employee. The other plan may not have a rule for laid-off or retired employees similar to this rule. In this case, this rule will not apply.

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

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

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

COORDINATION WITH MEDICARE

Benefits for Individuals Who are Entitled to Medicare

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

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

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

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

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

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

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

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

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

- **AnthemBlue Cross HMO (Advantage network)** — a network of Participating Medical Groups (PMGs). Some are privately-owned medical groups which have contracted with Anthem Blue Cross, and others are Independent Practice Associations (IPAs). An IPA is an association of independent physicians and other providers who have contracted with Anthem Blue Cross HMO as a group. When

you enroll in the Anthem Blue Cross HMO, you must choose a PMG, and in some cases, you must also choose a "primary care physician" for yourself and each member of your family from your PMG's provider listing.
You can find Anthem Blue Cross HMO providers at http://www.anthem.com/ca/caltech (search the Advantage HMO network).

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

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

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

HOW THE HMOs WORK

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

Specialist Referrals

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

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

Emergency Services

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

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

Contact your HMO for specific details on emergency services.

Out-of-Area Treatment

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

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

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

Note: HMOs are not required to cover out-of-area care except for services which are authorized by the HMO.

This is just a brief description of the benefits offered by the various Caltech medical plans. Please refer to the HMO booklets (also called Evidence of Coverage or EOC) for specific information on the benefits offered by each HMO. Together with this Handbook, they constitute the SPD as required by ERISA.

YOUR CALTECH DENTAL PLANS

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

PPO Plan

- ⇨ Delta Dental *(http://www.deltadentalins.com/caltech)*

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

Dental Health Maintenance Organization (DHMO)

- ⇨ MetLife DHMO (Safeguard) *(http://www.safeguard.net/custom_sites/caltech/caltech.htm)*

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

HOW THE PLAN WORKS

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

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

DELTA DENTAL PLAN BENEFITS

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

* Prosthodontics are a benefit only following six months of continuous coverage. Coverage under another Institute-sponsored dental plan will count toward this six-month period.

PAYMENT OF BENEFITS

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

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

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

Pre-Determination

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

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

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

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

METLIFE DHMO (SAFEGUARD)

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

HOW THE PLAN WORKS

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

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

METLIFE DHMO (SAFEGUARD) BENEFITS

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

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

Second Opinions

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

PAYMENT OF BENEFITS

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

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

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

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

VISION

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

TERMS YOU SHOULD KNOW

Basic Services

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

Crowns and Cast Restorations

Caps, veneers, inlays, and onlays.

Diagnostic Services

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

Endodontics

Treatment of the tooth pulp.

Orthodontia

Treatment for the correction of dental malocclusion.

Periodontic Services

Treatment of gums and bones that support the teeth.

Preventive Services

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

Prosthodontic Services

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

Usual, Reasonable, and Customary Charges

Charges for a particular service that fall within the parameters of the average or commonly charged fee for that service within the community where treatment is received.

Table of Contents

Section 3: Medical,Dental and Vision

YOUR CALTECH MEDICAL PLANS 3.1
Additional Information 3.1

ANTHEM BLUE CROSS PPO 3.2

ANTHEM BLUE CROSS HIGH-DEDUCTIBLE PPO 3.2

HOW THE PLANS WORK 3.2

WHEN YOU NEED CARE 3.3
Filing Claims 3.3
Covered Services 3.3

COST-CONTAINMENT PROCEDURES 3.4

COORDINATION OF BENEFITS 3.4
How Coordination Works 3.4
Which Plan Is Primary? 3.5

COORDINATION WITH MEDICARE 3.6
Benefits for Individuals Who are Entitled to Medicare 3.6

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) 3.6

HOW THE HMOs WORK 3.7
Specialist Referrals 3.7
Emergency Services 3.8
Out-of-Area Treatment 3.8

YOUR CALTECH DENTAL PLANS 3.9

HOW THE PLAN WORKS 3.10

DELTA DENTAL PLAN BENEFITS 3.10

PAYMENT OF BENEFITS 3.11
Pre-Determination 3.11

METLIFE DHMO (SAFEGUARD) PLAN 3.12

HOW THE PLAN WORKS 3.12

METLIFE DHMO (SAFEGUARD) DENTAL BENEFITS 3.12

PAYMENT OF BENEFITS 3.12

VISION 3.13

TERMS YOU SHOULD KNOW 3.14