

retiree benefits @ Caltech

2018 Benefits Summary Plan Description
For JPL Retirees



Caltech

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2018 BENEFITS SUMMARY PLAN DESCRIPTION

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CALTECH RETIREE HEALTH AND LIFE BENEFITS PROGRAM FOR JPL RETIREES

Want to find out more information about the retiree benefits available from Caltech? Then, you've come to the right place!

This Summary Plan Description (SPD) is the first place you should turn to when you have a question about your Caltech Retiree Health and Life Benefits Program.

This 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 *Contact Information* for important phone numbers and websites. Or, you can contact the JPL Benefits office with any questions you may have.

This Summary Plan Description (SPD) provides a brief description of the benefits offered by the various plans included in the Caltech Retiree Health and Life Benefits Program for JPL Retirees (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.

Please refer to the plan booklets (also called Evidence of Coverage Booklets, or EOCs) or plan documents available at www.caltechretiree.hrintouch.com for specific information 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 for JPL Retirees 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.

This Summary Plan Description (SPD) contains only highlights of Caltech's retiree benefit plans. Plan documents and insurance contracts contain full 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 or plan documents, will govern.

How to Use This Document

This document is divided into sections based on the benefits available to Caltech 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 JPL Benefits Office, Aetna Marketplace (the plan enrollment administrator), or your plan insurance carriers
- 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 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; and
- Any trust agreement pursuant to which the assets of a plan are held.

If you would like to review the official Retiree Benefits Program Wrap Around Plan Document, you can request a copy by contacting the JPL Benefits office.

ABOUT THE BENEFIT PLANS

The Institute expects and intends to continue the Caltech Retiree Health and Life Benefits Program for JPL Retirees but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension, or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP for Business & Finance or Human Resources, as applicable. 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 *Participating in the Caltech Retiree Health and Life Benefits Program for JPL Retirees* on page 6 for eligibility information.

UPDATED INFORMATION

The benefits described in this Summary Plan Description (SPD) are effective January 1, 2018. 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 retiree benefits website at www.caltechretiree.hrintouch.com, or contact the JPL Benefits office by phone or email. You can also direct any enrollment or benefit-specific questions to the plan enrollment administrator, Aetna Marketplace.

Aetna Marketplace

For questions regarding plan enrollment, billing calculation, and adding or removing dependents from coverage.

Phone: 844-210-8389

Hours: Monday-Friday, 5 a.m. to 6 p.m. (PT)

Benefits Office — JPL

Phone: 818-354-3760

Email: benefits@jpl.nasa.gov

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 *Glossary* on page 55.

BENEFITS AT A GLANCE

This section contains brief tables that highlight the key features of the Caltech Retiree Health and Life Benefits Program. For more information about the plans outlined in the section, see the *Medical, Dental, Vision, and Life Insurance* sections of this Summary Plan Description (SPD).

SUMMARY OF ELIGIBILITY AND ENROLLMENT IN BENEFITS

Below is key information about participating in the Caltech Retiree Health and Life Benefits Program. See *Participating in the Caltech Retiree Health and Life Benefits Program for JPL Retirees* on page 6 for more detailed information.

Who's Eligible	Eligibility for the plans varies based on your retiree status. For more information, see <i>Eligibility</i> on page 6.
How and When to Enroll	<p>You must enroll for medical, dental, and/or vision insurance coverage within 31 days of your Retirement date. If you do not enroll for coverage during this time, you must wait until the following Annual Enrollment period to enroll, or you also may enroll if you experience a Qualified Change in Status event.</p> <p>Additionally, If You Are Medicare Eligible If you are eligible for Medicare Parts A and B, you must enroll in Medicare Part B prior to the effective date of coverage. You will be able to enroll in benefits no later than the first of the month of your 65th birthday, or upon retirement, whichever is later.</p> <p>To enroll, contact the Aetna Marketplace at www.caltechretiree.hrntouch.com or at 844-210-8389. For more information about benefits enrollment, see <i>Enrolling in Your Caltech Retiree Benefits</i> on page 13.</p>
Who Pays for Coverage	<p>The cost of coverage is shared between you and the Institute using the Defined Dollar Credits provided by Caltech.</p> <p>At the time of enrollment or during Annual Enrollment each subsequent year, you will be provided with an amount of Defined Dollar Credits determined by Caltech, based on your age and years of service. You can use your Defined Dollar Credits to purchase coverage under Institute-sponsored benefit plans, to purchase other coverage or to pay for eligible medical expenses through the establishment of a Health Reimbursement Account (HRA).</p> <p>For more information about the Defined Dollar Credits, see <i>How to Use Your Defined Dollar Credits to Pay for Coverage</i> on page 24.</p>

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When Coverage Begins	If you enroll when you first become eligible, your coverage begins on the first of the month after your Retirement date. If you enroll during Annual Enrollment, your coverage begins on the first of January following Annual Enrollment. If you enroll during a Qualified Change in Status event, your coverage is effective the first of the month following the Qualified Change in Status.
How and When You Can Change Your Coverage	You can change your coverage during Annual Enrollment or when you experience a Qualified Change in Status event. You have 90 days from the date of a Qualified Change in Status event to enroll in or change your health care coverage. The new coverage you choose will begin as of the date that the event took place, as long as you elect the change within 90 days after the date of the event. To make a change, contact the Aetna Marketplace at 844-210-8389 to request an enrollment form.
When Coverage Ends	Generally, coverage ends when (1) you or your covered dependents are no longer eligible for coverage under the terms of the plan, (2) you drop your coverage, (3) you don't pay your required contributions, (4) Caltech discontinues the plan, or (5) you die. In the event of your death, your dependents' coverage may continue under <i>Rules for Surviving Spouses, Surviving Domestic Partners and Surviving Dependent Children</i> , listed on page 9. For more information on when coverage ends, see <i>When Coverage Begins and Ends</i> on page 16.

PARTICIPATING IN THE CALTECH RETIREE HEALTH AND LIFE BENEFITS PROGRAM

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 “Benefits-Based” employee. Service in the following positions qualifies you to be a Benefits-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

“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* on page 55.

Definitions of Faculty, Postdoctoral Scholars and Senior Postdoctoral Scholars, Staff Employees, Key Staff Employees and Temporary Staff Employees are included in the *Glossary* beginning on page 55.

Non-Benefit Based Employees

The following are considered Non-Benefit-Based Employees:

1. Staff Employees hired on a temporary basis for less than 90 days;
2. Occasional employees;
3. Part-time employees regularly scheduled to work less than 20 hours per week; and
4. Any individual hired by JPL in the following employment classification:
 - Call Back Student;
 - High School Summer Teacher;

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 Benefits team or you can call Aetna Marketplace. See *Who to Contact* on page 53 for contact information.

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- Interim Employee Program;
- Minority Initiative Intern.

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 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 medical plan options.

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 participate in the Caltech Retiree Health and Life Benefits Program, though are not eligible for Life Benefits. Eligible Dependents are defined as follows:

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

- Your legally married spouse, surviving spouse, or your domestic partner (including Same Gender domestic partner and Registered domestic partner)
- Your or your domestic partner's eligible dependent Children up to age 26; and
- Your or your domestic partner's unmarried Children of any age who are fully handicapped. To be fully handicapped, your dependent child must be mentally or physically handicapped and incapable of self-support (subject to the insurance company's authorization/approval).

Dependent coverage eligibility is also subject to state and Federal requirements. For additional information on how the plan defines eligible spouse, surviving spouse, domestic partner, or Dependent Child(ren) see the *Glossary* starting on page 55.

Spouse/Domestic Partner Eligibility

An eligible retiree's legally married spouse, surviving spouse, or domestic partner is eligible to participate in the Caltech Retiree Health and Life Benefits Program for JPL Retirees provided that

proof of the relationship is submitted to Caltech within 31 days of the date the dependent is added or enrolled in to the retiree benefits program.

For anyone retiring on or after January 1, 2015, only the current spouse, surviving spouse, or domestic partner at the time of death or retirement will be covered under the Caltech Retiree Health and Life Benefits Program. If a retiree in this category re-marries following retirement, the new spouse or 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.

Dependent Child(ren) Eligibility

Children, as defined below and in the *Glossary* on page 55, are eligible to participate in the Caltech Retiree Health and Life Benefits Program for JPL Retirees (regardless of eligibility for other group coverage subject to applicable State and Federal requirements), provided that provide proof of the relationship is provided to Caltech within 31 days of the date the dependent is added or re-added to the Retiree Benefits Program.

Dependent children can be enrolled in the retiree benefits program offered by Caltech; however, Caltech will not provide any subsidy (Defined Dollar Credits) for dependent children.

Unless otherwise noted, your eligible children include an eligible retiree's:

- Children (natural, step, adopted, foster children, and children for whom you are a court-appointed guardian) up to 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).

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).

Qualified Medical Child Support Orders (QMCSO)

Caltech's plans will extend coverage to your non-custodial child, 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/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.

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

Important

You must at all times give accurate information about your family status and your Dependents 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 Dependents could result in

termination of coverage under the benefits program. Proof of Dependent eligibility will be required by Caltech for any dependents 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.

Generally, a retiree cannot be covered by Caltech's COBRA coverage AND by the Caltech Health and Life Benefits Program at the same time. For COBRA coverage options for dental and vision, please contact the JPL Benefits office

When Two or More Family Members Work for the Institute

An active Benefit-Based employee who is a spouse or 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 Health and Life Benefits Program).

Dependent children of an active Benefit-Based employee who is also a spouse or 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 loss of active Benefit-Based employee status, the spouse, or domestic partner or surviving spouse of a retiree and any Dependent Children shall be covered under the Caltech Retiree Health and Life Benefits Program for JPL Retirees if the eligibility requirements for the Caltech Retiree Health and Life Benefits Program for JPL Retirees coverage are satisfied. (See *Eligibility* above on page 6 for Retiree Benefits Program eligibility).

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

Rules for Surviving Spouses, Surviving Domestic Partners and Surviving Dependent Children

Upon the death of an employee who is eligible for retiree medical benefits, or upon the death of a retiree who is receiving benefits under the Retiree Health and Life Benefits Program, the surviving spouse, domestic partner, or surviving Dependent child may receive benefits under the Retiree Benefits Health and Life Program and make most allowable plan changes permitted to similarly-situated retirees.

A surviving spouse or surviving domestic partner of a Caltech Retiree may add a new spouse or domestic partner to the plan, however, Caltech will not provide any contributions (Defined Dollar Credits) for the new spouse or domestic partner.

If the surviving spouse or domestic partner of a deceased Caltech retiree is considered an active Benefit-Based employee of the Institute, he or she, and any eligible dependents, 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 domestic partner can join the Caltech Retiree Health and Life Benefits Program for JPL Retirees as a retiree if they are eligible for the plan, or they can join the Caltech Retiree Health and Life Benefits Program for JPL Retirees as the surviving spouse or surviving domestic partner of the deceased retiree. **However, in no event, can an individual participate in the Caltech Retiree Health and Life Benefits Program for JPL Retirees as both a retiree and as a surviving spouse, or surviving domestic partner at the same time.**

Special Rights for Mothers and Newborn Children

For the mother or newborn child, 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).

MEDICAL PLANS

Following is key information about the medical plans available to Caltech retirees. For more detailed information, you can find the applicable EOCs or plan documents on the benefits website at www.caltechretirees.hrintouch.com.

Retiree Medical Plan Options	
Medical Plans for Non-Medicare Eligible Retirees and Grandfathered Retirees	<p>If you are a retiree or Grandfathered retiree who is not Medicare eligible, you meet the plan eligibility requirements listed in the <i>Eligibility</i> section on page 6, then you may use your Defined Dollar credits to choose from the following medical plans:</p> <ul style="list-style-type: none"> • Aetna Open Choice PPO – High Option Network • Aetna Open Choice PPO – Mid Option Network • Aetna Aexcel Plus Open Access Managed Choice– Low Option Network • Aetna Open Choice Open Access Managed Choice – Low Option Network • Aetna – Low Option Out-of-Area Indemnity • Aetna HMO • Kaiser Permanente Traditional HMO • Health Reimbursement Account (HRA) • Premium Reimbursement Plan (only available to retirees permanently residing outside the U.S.)
Medical Plans for Medicare Eligible Retirees	<p>If you are Medicare eligible and you meet the plan eligibility requirements as listed in <i>Eligibility</i> on page 6, then you may use your Defined Dollar Credits to choose from the following medical plans:</p> <ul style="list-style-type: none"> • Aetna Traditional Choice Plan – Medicare Integration Plan • Aetna Medicare Plan (PPO) with ESA – Premier (available to retirees who either reside or don't reside in the network service area) • Aetna Medicare Plan (PPO) – Medium • Aetna Medicare Plan (PPO) – Value • Aetna Medicare Plan HMO • Kaiser Permanente Senior Advantage HMO (currently non-contributory for grandfathered retirees) • Aetna Medicare Plan (PPO) with ESA – Medium (For retirees who reside outside of the network area) • Aetna Medicare Plan (PPO) with ESA – Value (For retirees who reside outside of the network area) • Health Reimbursement Account (HRA) • Premium Reimbursement Plan (only available to retirees permanently residing outside the U.S.)
Medical Plans for Medicare Eligible Grandfathered Retirees Only	<p>If you are Medicare eligible, you meet the plan eligibility requirements, and you are considered a Grandfathered retiree or you are the spouse, domestic partner, or surviving spouse of a Grandfathered retiree as listed in <i>Grandfathered Retiree Eligibility</i> on page 7, (refer to page 26 for the Defined Dollar credits for Grandfathered retirees), then you may choose from:</p> <ul style="list-style-type: none"> • The Non-Contributory Kaiser Permanente Senior Advantage HMO Plan. (Note: If you elect the Non-Contributory medical plan, you will pay no monthly premium for the plan for you or for your Medicare eligible spouse). OR • If you decide not to enroll in the Non-Contributory plan, you may use your Defined Dollar Credits to purchase one of the following: <ul style="list-style-type: none"> – Any of the Aetna Medicare Medical Plans listed in this table under <i>Medical Plans for Medicare Eligible Retirees</i>, – Health Reimbursement Account (HRA) – Premium Reimbursement Plan (only available to retirees permanently residing outside the U.S.)

Retiree Medical Plan Options	
Bundled Plans	<p>Certain medical plans have other benefits, such as dental or vision benefits, bundled within the plan. The following plans have certain bundles, as listed:</p> <ul style="list-style-type: none"> • Kaiser Permanente Traditional HMO Plan – Includes both medical and vision coverage. This plan does not include dental coverage. • Kaiser Permanente Senior Advantage HMO Plan – Includes medical, dental, and vision coverage.

DENTAL AND VISION PLANS

Below is key information about your dental and vision plan options. For more information about these plans, visit www.Aetna.com to download the applicable plan documents, or Members can contact Dental Member Services at 1-877-238-6200 or Aetna Vision Member Services at 1-800-328-9933 to request a copy.

Retiree Dental and Vision Plan Options	
Dental Plan	Eligible retirees and their eligible dependents have the option of enrolling in a Caltech-sponsored dental plan, the Aetna Dental PPO plan, which covers preventive, basic, and major dental procedures.
Vision Plan	Eligible retirees and their eligible dependents have the option of enrolling in a Caltech-sponsored vision plan, the Aetna Vision Preferred plan, which covers eye exams, lenses, frames, and/or contact lenses.
Bundled Plans	<p>Certain medical plans have other benefits, such as dental or vision benefits, bundled within the plan. If you are enrolled in one of these plans you are automatically covered for the bundled benefits. The following plans have bundled coverage, as listed:</p> <ul style="list-style-type: none"> • Kaiser Permanente Traditional HMO Plan – Includes both medical and vision coverage. This plan does not include dental coverage. • Kaiser Permanente Senior Advantage HMO Plan – Includes medical, dental, and vision coverage

LIFE INSURANCE

Life Insurance Coverage

Following is key information about the retiree life insurance plan. See *YOUR LIFE INSURANCE PLAN OPTION* on page 21 for more detailed information.

Retiree Life Insurance	
How Life Insurance Coverage Works	All Institute retirees will receive basic group life insurance coverage in the amount of \$5,000. If a retiree dies from any cause, the retiree's designated beneficiary will be paid \$5,000. The retiree life insurance premium is fully paid by the Institute.
When Benefits Are Paid	Life insurance benefits are paid in one lump sum to the beneficiary of record. Payment is usually made within 10 days after all the proper documentation has been received.
How to File a Claim	Contact the JPL Benefits office and provide a copy of the death certificate. Once this required documentation is received, the Benefits office will submit the initial claim to the life insurance carrier. See <i>Who to Contact</i> on page 53 for the JPL Benefits office.

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 Change in Status 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 for JPL Retirees at a later time such as during Annual Enrollment, or when you experience a Qualified Change in Status event; however, all late enrollments are subject to the Special Enrollment Rules described below.
- **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 medical 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 to avoid any delay in the effective date of your Medicare Medical plan benefits. You are automatically enrolled in retiree life coverage. You can also wait and enroll in the Caltech Retiree Health and Life Benefits Program for JPL Retirees at a later time, such as during Annual Enrollment, or when you experience a Qualified Change in Status event; however all late enrollments are subject to the Special Enrollment Rules described below.

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 JPL Retirees 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 Retiree Benefits Program if that other coverage ends. However, to join the Retiree 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 from Caltech, 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 JPL Retirees during Annual Enrollment. However, if you do not enroll in the Caltech Retiree Health and Life Benefits Program for JPL Retirees within two years of your retirement, and you did not have other continuous medical coverage (other

than Medicare), you waive your right to coverage under the Retiree 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. 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 Change in Status

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

Qualified Changes in Status include:

- **Changes in legal marital status**—death, divorce, legal separation, annulment, or acquiring a qualified domestic partner.
- **Changes in the number of your dependents**—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 employment** for you, your spouse, your domestic partner, or your Dependent child—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 Changes 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 Change in Status 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 Change in Status. 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 Change in Status events, see *HIPAA Special Enrollment Events* on page 35.

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

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Medicare Medical plan benefits, 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, you have a special Initial Enrollment Period (IEP) that lasts for seven months during which you can elect Medicare Part B. Your IEP begins on the first day of the third month before the month 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 and also elect to join one of the Caltech-Sponsored Medicare Medical plans up to three months prior to the month in which you turn age 65 (and become eligible for Medicare Part B), 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 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 non-Medicare retiree medical until the first of the month in which your Medicare Part B coverage begins. **So it is important that 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	July 1
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 Change in Status to enroll in, or change your health care coverage, or to add or remove a dependent. The new coverage you choose will begin as of the date that the event took place, as long as you elect the change within 90 days after the date of the event.

The Aetna Marketplace team will assist you with electing a change in your benefits coverage, and may request that you provide documentation to support your request, such as a marriage certificates, or documentation that other coverage you were enrolled in has ended. To make an election change, please contact:

Aetna Marketplace Customer Service Center

Phone: 844-210-8389

Hours: Monday - Friday, 5 a.m. to 6 p.m. (PT)

WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

For life insurance, coverage begins on the day after your Retirement date. For 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 in a timely manner as outlined in *Enrolling in Your Caltech Retiree Benefits* on page 13.

When Coverage Ends

For You

For life insurance, coverage ends on the earlier of date of death or contract termination.

For medical, dental, and vision coverage, coverage ends as follows:

Your coverage ends on the earliest of the following dates:

- The date you no longer meet the eligibility requirements for coverage
- 90 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.

For Your Spouse, Surviving Spouse or Domestic Partner

Coverage for your spouse, surviving spouse or surviving domestic partner will end on the earliest of:

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

For Your Other Dependents

Your eligible dependents' coverage 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 is no longer covered under a QMCSO
- 90 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.

Continuing Coverage

When you and your covered dependents' coverage ends, you may be able to continue coverage through COBRA. (See *Continuing Coverage through COBRA* on page 34 for more information.)

What Happens if You Are Rehired After You Retire?

For medical, dental, vision coverage only, if you are rehired as an active Benefit-Based employee after you have qualified for benefits under the Caltech Retiree Health and Life Benefits Program, you and your dependents will be eligible to enroll in the Institute's medical, dental, and vision plans available to active employees. Coverage under the active benefit program will be effective the first of the month following your rehire date. When your service as a rehired retiree in active Benefit-Based position ends, and you again terminate from the Institute, your years of service and your defined dollar credit amount will be recalculated and you will receive credit for every year of service as a Benefit-Based employee, including those earned as a rehired retiree.

For medical, dental and vision coverage only, if you are rehired as a non-benefit based employee after you have qualified for the Caltech Retiree Health and Life Benefits Program, you and your dependents may continue in, or be eligible to enroll in the Caltech Retiree Health and Life Benefits

MEDICAL, DENTAL, VISION, AND LIFE INSURANCE PLANS

Your Caltech Retiree Health and Life Benefits Program for JPL Retirees is designed to provide you with comprehensive benefits while maintaining maximum choice, flexibility, and quality. For most coverages, you have a choice of plans to choose from, depending on your age and your personal and family needs. The plans specifically available to you may also vary based on your location.

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* on page 55.

This section covers your medical, dental, vision, and life insurance plan options, including brief summaries of coverage, information about how plans work and how to pay for care when you receive it. For information on how to pay for your coverage, see *How to Use Your Defined Dollar Credits to Pay for Coverage* on page 24.

YOUR MEDICAL PLAN OPTIONS

Depending on your age and eligibility, there are several medical plans for you to choose from when you enroll for medical coverage through Caltech. In order 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 Summary Plan Description (SPD) on page 6.

Plans for Non Medicare Eligible Retirees

If you are not Medicare eligible, and you meet the eligibility requirements listed in the *Eligibility* section on page 6, you can choose from the following medical plans:

- Aetna Open Choice PPO – High Option Network
- Aetna Open Choice PPO – Mid Option Network
- Aetna Aexcel Plus Open Access Managed Choice– Low Option Network
- Aetna Open Choice Open Access Managed Choice – Low Option Network
- Aetna Traditional Choice – Low Option Out-of-Area Indemnity
- Aetna HMO
- Kaiser Permanente Traditional HMO
- Health Reimbursement Account (HRA)
- Premium Reimbursement Plan (for Retirees Permanently Residing Outside of the U.S.)

Plans for Medicare Eligible Retirees

If you are Medicare eligible, and you meet the eligibility requirements as listed in *Eligibility* on page 6, then you can choose from the following medical plans:

- Aetna Traditional Choice Plan – Medicare Integration Plan
- Aetna Medicare Plan (PPO) with ESA – Premier (for retirees who either reside or don't reside in the network service area)
- Aetna Medicare Plan (PPO) – Medium
- Aetna Medicare Plan (PPO) – Value
- Aetna Medicare Plan HMO
- Kaiser Permanente Senior Advantage HMO (Currently non-contributory for grandfathered retirees)

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- Aetna Medicare Plan (PPO) with ESA – Medium (For retirees who reside outside of the network area)
- Aetna Medicare Plan (PPO) with ESA – Value (For who reside retirees outside of the network area)
- Health Reimbursement Account (HRA)
- Premium Reimbursement Plan (for Retirees Permanently Residing Outside of the U.S.)

Plans for Non Medicare Eligible Grandfathered Retirees

If you are a Grandfathered retiree who is not Medicare eligible, and you meet the plan eligibility requirements listed in the *Eligibility* section on page 6, then you may choose to purchase any of the medical plans listed in this section under *Plans for Medicare Eligible Retirees* on page 18. You will use the Defined Dollar Credits provided by Caltech to toward the cost of these plans.

Plans for Medicare Eligible Grandfathered Retirees

If you are a **Grandfathered Retiree**, or you are the spouse, domestic partner, or surviving spouse of a Grandfathered Retiree, and you meet the eligibility requirements listed in *Eligibility* on page 6) **AND you are Medicare Eligible**, then you and your eligible dependents are eligible to enroll in:

- The Non-Contributory Medical Plan (which is currently the Kaiser Permanente Senior Advantage HMO Plan).
 - Note: If you elect the Non-Contributory medical plan, you will pay no monthly premium for the plan for you, your Medicare eligible spouse, domestic partner, or surviving, spouse. However, if you elect to cover a dependent child on the Non-Contributory Medical plan, you will have to pay the premium for the child's coverage. **OR**
- If you decide not to enroll in the Non-Contributory plan, you may use the Defined Dollar Credits provided by Caltech toward the purchase of one of the following medical plans:
 - Any of the Aetna Medicare Medical Plans listed in this section under *Plans for Medicare Eligible Retirees* on page 18
 - Health Reimbursement Account (HRA)
 - Premium Reimbursement Plan (only available to retirees permanently residing outside the U.S.)

Learn More

You can find more details about your medical, dental, and vision coverage in the Evidence of Coverage (EOC) booklets or plan documents provided by Aetna and Kaiser. To find out how to get copies of the EOCs or plan documents, see *How to Request Your Copies of Your Plan Documents*, below.

For more information on how to purchase an Institute-sponsored plan, see *How to Use Your Defined Dollar Credits to Pay for Coverage* on page 24.

For more information about the Health Reimbursement Plan see *Health Reimbursement Account (HRA)* on page 30.

For more information about the Premium Reimbursement Plan see *Premium Reimbursement Plan (For Retirees Permanently Residing Outside of the U.S.)* on page 31.

How to Request a Copy of Your Aetna Medical Plan Documents

This SPD provides an overview of the plans available to you as a retiree. Please 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.

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 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 contacting Kaiser Permanente at 800-464-4000, 24 hours a day, 7 days a week.

YOUR DENTAL PLAN OPTION

If you are a Medicare Eligible retiree, Non Medicare Eligible retiree, Grandfathered Medicare Eligible retiree, or Grandfathered Non Medicare Eligible retiree, and you meet the plan eligibility requirements listed in the *Eligibility* section on page 6, then you and your eligible dependents, may enroll in the Aetna Dental PPO plan, administered by Aetna. This is a voluntary plan and if you elect this plan you will pay the monthly premium cost for the plan. If you have excess Defined Dollar Credits available after enrolling in your medical coverage, they will be applied toward the cost of the dental plan premium.

Remember!
 You don't need a dental plan if you enroll in the Kaiser Permanente Senior Advantage HMO plan. This plan provides dental coverage.

With the Aetna Dental PPO plan you can choose to see any dentist, or a dental hygienist under the supervision and direction of a dentist of your choice. You also receive preventive dental care and financial assistance toward the expense of major dental work.

For more information about how the dental plan works and how to pay for care when you receive it, go to the Aetna Navigator website at www.aetna.com.

How to Request a Copy of Your Aetna Dental Plan Documents

This SPD provides an overview of the plans available to you as a retiree. Please 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 dental plan documents are available through Aetna Navigator at www.aetna.com. If you are not already a registered user on Aetna Navigator, please select the “Register” option. After logging into Aetna Navigator, select the “Coverage and Benefits” tab to view your plan documents.

If you do not have access to Aetna Navigator, you can request a hardcopy of your plan documents by contacting the member services phone number on the back of your plan ID card or contacting Aetna Dental at 877-238-6200, Monday – Friday, 8 a.m. to 6 p.m.

YOUR VISION PLAN OPTION

If you are a Medicare Eligible retiree, Non Medicare Eligible retiree, Grandfathered Medicare Eligible retiree, or Grandfathered Non Medicare Eligible retiree, and you meet the plan eligibility requirements listed in the *Eligibility* section on page 6, then you and your eligible dependents may enroll in the Aetna Dental PPO plan, administered by Aetna. This is a voluntary plan and if you elect this plan, you will pay the monthly premium cost for the plan. If you have excess Defined Dollar Credits available after enrolling in your medical and/or dental coverage, they will be applied toward the cost of the dental plan premium.

Caltech’s vision coverage is administered by Aetna. If you enroll in the Aetna Vision Preferred plan, you will have coverage for eye exams and glasses or contact lenses. Discounts are available on frames and lenses and some other services when you use an Aetna Vision Preferred network provider.

For a summary of coverage, information about how the vision plan works and how to pay for vision care when you receive it, go to Aetna’s website at www.aetna.com to see your plan documents. For more information on how to pay for your vision insurance coverage, see *How to Use Your Defined Dollar Credits to Pay for Coverage* on page 24.

How to Request a Copy of Your Aetna Plan Documents

This SPD provides an overview of the vision plans available to you as a retiree. Please 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 through Aetna Navigator at www.aetna.com. If you are not already a registered user on Aetna Navigator, please select the “Register” option. After logging in to Aetna Navigator, select the “Coverage and Benefits” tab to view your plan documents.

If you do not have access to Aetna Navigator, you can request a hardcopy of your plan documents by contacting the member services phone number on the back of your plan ID card or contacting Aetna Vision at 800-328-9933, Monday – Friday, 8 a.m. to 6 p.m.

YOUR LIFE INSURANCE PLAN OPTION

Retiree Life Insurance Plan

If you retire from active employment at the Institute, the life insurance policy you had as an active employee will end. However, you will automatically be enrolled in a \$5,000 retiree life insurance policy paid for by Caltech.

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* on page 55.

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 name your beneficiary, contact the Aetna Marketplace plan administration team.

Aetna Marketplace Customer Service Center

Phone: 844-210-8389

Hours: Monday - Friday, 5 a.m. to 6 p.m. (PT)

You may change your beneficiary at any time by contacting the Aetna Marketplace. The beneficiary change will be effective on the date you complete the new beneficiary designation. 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 beneficiaries dies before you, his or her share will be payable in equal shares to any other named 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 children
- If there is no spouse or you have no children, to your parents, equally or to the survivor
- If there is no spouse or you have no children or parents, in equal shares to your brothers and sisters
- If none of the above survives, to your executors or administrators.

How to File a Claim

Contact the Aetna Marketplace to submit a life insurance claim.

Contact the JPL Benefits office and provide a copy of the death certificate. Once this required documentation is received, the Benefits office will submit the initial claim to the life insurance carrier. See *Who to Contact* on page 53 for the JPL Benefits office.

You may also contact:

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Aetna Marketplace Customer Service Center

Phone: 844-210-8389

Hours: Monday - Friday, 5 a.m. to 6 p.m. (PT)

Claim-Filing Deadline

All claims should be reported promptly. The deadline for filing a claim is 20 days after the date of the loss, or as soon thereafter as is reasonably possible. Notice given on your behalf to Aetna, or to any authorized agent of Aetna, with information sufficient to identify the insured, shall be deemed notice to Aetna.

Payment of Benefits

Life insurance benefits are paid in one lump sum to the beneficiary of record. Payment is usually made within 10 days after all the proper documentation has been received.

HOW TO USE YOUR DEFINED DOLLAR CREDITS TO PAY FOR COVERAGE

Eligible retirees receive Defined Dollar Credits, 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* on page 55

DEFINED DOLLAR CREDITS

What Are Defined Dollar Credits?

In order to help share the cost of health care coverage with eligible retirees, Caltech contributes a pre-designated amount of money (Defined Dollar Credits) that retirees and their spouses can use to pay for health care, dental, and vision coverage or for medical expenses.

When you become eligible to enroll in retiree benefits your Defined Dollar Credits are calculated. You can use your Credits to purchase Institute-sponsored coverage on Caltech's online enrollment website, www.caltechretiree.hrntouch.com, or you can elect to have all of your Credits transferred to a Health Reimbursement Account (HRA).

How to Enroll in the HRA?

- **If you use your Defined Dollar Credits to purchase Caltech-sponsored coverage** but have leftover Credits after your enrollment, your leftover Credits will be automatically transferred to your 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 purchase other health insurance coverage (on an after-tax basis) or to pay for eligible medical expenses. For more information about the HRA, see *Health Reimbursement Account (HRA)* on page 29.

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 Benefits Office or you can call Aetna Marketplace. See *Who to Contact* on page 53 for contact information.

2018 Monthly Retiree Benefits Program Defined Dollar Credit Amounts

Your Defined Dollar Credits are calculated based on your grandfathered retiree status, age, and your years of service. See the table on page 25 for the monthly Defined Dollar Credit amount for you and your eligible spouse.

Spouses, Surviving Spouses and Domestic Partners

Your eligible spouse, surviving spouse and domestic partner (DP) may receive a Defined Dollar Credit that is equal to a percentage of their retiree's Defined Dollar Credit. See the table below for the monthly Defined Dollar Credit amount for eligible spouses, surviving spouses and DPs. Future spouses or DPs

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(who you marry after January 1, 2015 or who you marry after you retire) are eligible for coverage under your medical plan; however, Caltech does not provide monetary subsidy or Defined Dollar Credits for these future spouses or DPs.

Other Dependents

Eligible children can be covered under a retiree's medical coverage; however, Caltech does not provide monetary subsidy or Defined Dollar Credits toward this coverage. Dependent children are not eligible for a Defined Dollar contribution.

2018 Monthly Defined Dollar Credits				
Retirees			Spouse/Surviving Spouse/Domestic Partner	
Years of Service	Medicare Eligible	Non-Medicare Eligible	Medicare Eligible	Non-Medicare Eligible
10	\$114	\$255	\$68	\$153
11	\$126	\$281	\$75	\$169
12	\$137	\$306	\$82	\$184
13	\$148	\$332	\$89	\$199
14	\$160	\$357	\$96	\$215
15	\$171	\$383	\$103	\$230
16	\$183	\$408	\$109	\$245
17	\$194	\$434	\$116	\$261
18	\$206	\$459	\$123	\$276
19	\$217	\$485	\$130	\$291
20	\$228	\$510	\$137	\$307
21	\$240	\$536	\$144	\$322
22	\$251	\$561	\$150	\$337
23	\$263	\$587	\$157	\$353
24	\$274	\$612	\$164	\$368
25+	\$285	\$638	\$171	\$383

Defined Dollar Credit Calculation Examples

Below are two examples of how retiree Defined Dollar Credits are used to purchase a Caltech-Sponsored medical plan.

Example 1:

Daphne is a 67-year-old retiree and is Medicare eligible. She worked at Caltech for 22 years before retiring. From the table above, her monthly Defined Dollar Credit amount is \$251. She elects the Aetna Medicare HMO at a monthly cost of \$300.18. Daphne will get a monthly bill of \$49.18 for the difference between the cost of the plan and her Defined Dollar Credit ($\$300.18 - \$251.00 = \$49.18$).

Example 2:

Carlos is a 63-year-old retiree and is not eligible for Medicare. He worked at Caltech for 18 years before retiring. From the table above, his monthly Defined Dollar Credit amount is \$459. He elects the Aetna Open Access Managed Choice Low Option plan at a monthly cost of \$704.60. Carlos will get a monthly bill of \$245.60 for the difference between the cost of the plan and his Defined Dollar Credit ($\$704.60 - \$459.00 = \$245.60$).

How the Defined Dollar Credits Work for Grandfathered Retirees, Medicare Eligible

If you are a Grandfathered retiree, or if you are the eligible spouse, domestic partner (DP), or Surviving spouse of a Grandfathered retiree (also referred to as Grandfathered spouse, Grandfathered surviving spouse or Grandfathered 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 than 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 purchase other health insurance coverage (on an after-tax basis) or to pay for eligible medical expenses. For more information about the HRA, see *Health Reimbursement Account (HRA)* on page 29 **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

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expenses (for more information, see *Health Reimbursement Account (HRA)* on page 29). See the table titled *2018 Monthly Defined Dollar Credits* on page 25 for the monthly Defined Dollar Credit amount available for you, your eligible spouse, surviving spouse, or domestic partner.

Note: If a Grandfathered retiree, Grandfathered spouse, Grandfathered surviving spouse, or Grandfathered domestic partner (DP) 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 are not yet Medicare eligible, then Caltech will give you or your spouse the maximum Defined Dollar Credit 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 in an HRA, and use the HRA funds to purchase other health coverage or to pay for eligible medical expenses. For more information, see *Health Reimbursement Account (HRA)* on page 29.

See the following table for the monthly Defined Dollar Credit amount available to you and your spouse, surviving spouse or domestic partner.

2018 Monthly Defined Dollar Credits Grandfathered Retirees				
Retirees			Spouse/Surviving Spouse/Domestic Partner	
Plan	Medicare Eligible	Non-Medicare Eligible	Medicare Eligible	Non-Medicare Eligible
Non-Contributory Medical Plan (Currently Kaiser Senior HMO Advantage)	Credit = Cost of plan*	\$638	Credit = Cost of plan*	\$383
All Other Plans	\$285	\$638	\$171	\$383

*For the Non-contributory medical plan, Caltech’s Defined Dollar Credit equals the full cost of the plan premium. The credit for the non-contributory medical plan will always cover the full premium cost and is not related to the Defined Dollar Credits. Currently, the non-contributory medical plan is the Kaiser Senior HMO Advantage plan. The non-contributory medical plan provider and plan could change in the future.

Calculation Examples

Below are two examples of how retiree Defined Dollar Credits are used to purchase coverage for Grandfathered retirees.

Example 1:
 Robert is an 83-year-old grandfathered retiree who is Medicare eligible. He worked at Caltech for 21 years before retiring in 1990. From the table above, Robert’s monthly Defined Dollar Credit amount is \$285.00. He elects the Aetna Medicare PPO – Premier Plan at a monthly cost of \$322.53. Robert will get a monthly bill of \$37.53 for the difference between the cost of the plan and his Defined Dollar Credit ($\$322.53 - \$285.00 = \$37.53$).

Example 2:
 Arthur is a 72-year-old grandfathered retiree who is Medicare eligible. He worked at Caltech for 35 years before retiring in 1989. He elects the Kaiser Senior HMO Advantage for himself at a monthly cost of \$0 (since the Kaiser Senior HMO Advantage Plan is currently the non-contributory medical plan for Medicare eligible grandfathered retirees). Robert will not receive a monthly bill since he elected the non-contributory medical plan.

How to Use Your Credits

This section applies to:

- All eligible retirees, spouses, surviving spouses or domestic partners, and to
- All eligible Grandfathered retirees, spouses, surviving spouses or 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). You can use Caltech's online enrollment website, www.caltechretiree.hrintouch.com, to enroll, or call the Aetna Marketplace Customer Service Center at 1-844-210-8389.

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 Change in Status. For more information about when to enroll, see *Enrolling in Your Caltech Retiree Benefits* on page 13.

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 billing administrator 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 you are eligible to receive, then the remainder of your Credits will be deposited into an HRA. For more information about the HRA, see *Health Reimbursement Account (HRA)* on page 29.

IMPORTANT

Surplus defined dollar credits are not available to grandfathered retirees (or grandfathered spouse) who enroll **in the Non-Contributory Medical Plan**.

Depositing Credits into a Health Reimbursement Account (HRA)

If you do not want to purchase one of the Caltech-sponsored plans available to you, you can have your Defined Dollar Credits deposited into an HRA. You can use these Credits to purchase other health coverage (on an after-tax basis), or to pay for eligible medical expenses. For more information about the HRA, see *Health Reimbursement Account (HRA)* below.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

This section applies to:

- All eligible retirees, spouses, surviving spouses or domestic partners, and to
- All eligible Grandfathered retirees, spouses, surviving spouses or 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, 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 under an HRA can be made to the following persons:

- Retirees
- Spouses, and Dependent children of retirees
- Any person you could have claimed as a dependent on your return, except that:
 - 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 under age 27 at the end of your tax year
- Spouses and Dependent children 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 www.wageworks.com for a complete list of your eligible health care expenses.

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 www.wageworks.com. If you elect the HRA-

Remember!

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

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 Defined Dollar Credit amount your spouse is eligible to receive, if applicable. To register, go to www.wageworks.com, click on "Login/Register" and select "Employee Registration." You'll need to answer a few simple questions and create a username and password.

How to Pay for Health Care Expenses

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

- **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.
- **The WageWorks® EZ Receipts smartphone app.**

Use the EZ Receipts WageWorks App

You can use your smartphone to file claims. Go to www.wageworks.com/myezreceipts to learn more.

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. These amounts may never be used for anything but reimbursements for qualified medical expenses.

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

Filing a Claim

You can submit reimbursement claims online on <https://www.wageworks.com/> by logging in to your HRA account. Or you can fax or mail a claims form to WageWorks:

- Fax number (877)-353-9236 (Toll-Free)
- Address for HRA Claim Filing:
Claims Administrator
PO Box 14053
Lexington, KY 40512

To download the HRA claims form, login to <https://www.wageworks.com/> and select "Paying for Your Plan" at the top of the page. Under the heading Health Reimbursement Arrangement, you will find a link that allows you to download to the Pay Me Back Claim Form.

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

For Retirees Who Live Outside of the United States

This section applies to eligible retirees and eligible grandfathered retirees who permanently live outside of the United States, and who do not enroll in one of the Caltech-sponsored retiree medical

plans offered to retirees. You are eligible to receive Defined Dollar Credits, which allow Caltech to share in the cost of your health care coverage. When you purchase non-Caltech-sponsored medical, dental, and vision coverage (excluding Medicare premiums) for you and/or your eligible dependents, you will be reimbursed for the cost of your insurance plan premiums up to your monthly Defined Dollar Credit amount.

To request reimbursement under this plan, retirees must submit a completed reimbursement request form to the JPL Benefits office, as well as proof of your medical coverage expense in the form of a canceled check, pay stub, or a bank statement. Please contact your JPL Benefits office for reimbursement request forms.

The deadline for requesting reimbursement for any year's medical premiums is March 31 of the following year. You may submit your requests as often as you would like—for example, on a monthly-, quarterly-, or annual-basis—as long as you submit them by the March 31 deadline.

Submit reimbursement requests to:

JPL Benefits Office

Jet Propulsion Laboratory
4800 Oak Grove Drive, T1720-B
Pasadena, CA 91109

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 discusses your legal rights under ERISA, as well as important administrative information.

PLAN DOCUMENTS

Every effort has been made to ensure that 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 JPL Benefits office (see *Who to Contact* on page 53).

YOUR ERISA RIGHTS

This information applies to The Caltech Retiree Health and Life Benefits Programs for JPL retirees and includes the following benefit plans:

- Aetna Open Choice PPO – High Option Network
- Aetna Open Choice PPO – Mid Option Network
- Aetna Aexcel Plus Open Access Managed Choice– Low Option Network
- Aetna Open Access Managed Choice– Low Option Network
- Aetna Traditional Choice – Low Option Out-of-Area Indemnity
- Aetna HMO
- Kaiser Permanente Traditional HMO
- Aetna Medicare Plan (PPO) with ESA – Premier
- Aetna Traditional Choice Plan – Medicare Integration Plan
- Aetna Medicare Plan (PPO) – Medium
- Aetna Medicare Plan (PPO) – Value
- Aetna Medicare Plan HMO
- Kaiser Permanente Senior Advantage HMO
- Aetna Medicare Plan (PPO) with ESA – Medium
- Aetna Medicare Plan (PPO) with ESA – Value
- Health Reimbursement Account (HRA)
- Premium Reimbursement Plan (for Retirees Permanently Residing Outside the U.S.)
- Aetna Dental PPO
- Aetna Vision Preferred
- Aetna Retiree Life Insurance

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. You'll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable.

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

Under ERISA, there are steps you can take to enforce these rights.

For example: If you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the reason you do not receive them is beyond the administrator's control.

If you have a claim for benefits denied or ignored in whole or in part, you may file suit in a state or Federal court, but only after you have exhausted the plan's claims and appeals procedures, as described in your plan's EOC, 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 support order, you may file suit in a Federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court decides who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your benefits program, contact the JPL Benefits Office (see *Who to Contact* on page 53). If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC, 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of The Employee Benefits Security Administration.

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
- Prosthesis
- 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 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, coverage will begin on the child'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, domestic partner, or dependent child, 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 JPL Benefits office (see *Who to Contact* on page 53).

HIPAA Special Enrollment Events

Special Enrollment Events (also known as “qualifying events or “change in status 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 on page 34	Enroll yourself and/or your dependent(s)
Your dependent loses non-Caltech health plan coverage and meets the requirements #1, #2, and #3 on page 34	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)
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:

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- 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 it 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

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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 benefits 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.

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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 EOC’s at www.Kp.org

Claim Determination and Appeal Procedures for the Life Insurance Plan

You must use and exhaust the Aetna 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 WageWorks, 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:

WageWorks Claims Appeal Board
PO Box 991
Mequon, WI 53092-0991

Or your appeal may be faxed to:
Fax Number: 1-877-220-3248

Premium Reimbursement Claim Appeals should be sent to:

JPL Benefits Office
Jet Propulsion Laboratory
4800 Oak Grove Dr., T1720-B
Pasadena, CA 91109

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 JPL Benefits office 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 JPL Benefits office. 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 for JPL Retirees but reserves the right to amend, modify, suspend, or terminate it, in whole or in

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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.

The official names of the plans and their plan numbers are shown below. All plans listed are subject to ERISA.

Plan Name	Plan Number
<p>Caltech Retiree Health and Life Benefits Program for JPL Retirees which includes the following:</p> <ul style="list-style-type: none"> • Aetna Open Choice PPO – High Option Network • Aetna Open Choice PPO – Mid Option Network • Aetna Aexcel Plus Open Access Managed Choice– Low Option Network • Aetna Open Access Managed Choice – Low Option Network • Aetna Traditional Choice- Low Option Out-of Area Indemnity • Aetna HMO • Kaiser Permanente Traditional HMO • Aetna Traditional Choice Plan Plan – Medicare Integration • Aetna Medicare Plan (PPO) with ESA – Premier Plan • Aetna Medicare Plan (PPO) – Medium Plan • Aetna Medicare Plan (PPO) – Value Plan • Aetna Medicare Plan HMO • Kaiser Permanente Senior Advantage HMO • Aetna Medicare Plan (PPO) with ESA – Medium Plan • Aetna Medicare Plan (PPO) with ESA – Value Plan • Health Reimbursement Account (HRA) Plan • Premium Reimbursement Plan (for Retirees Permanently Residing Outside the U.S.) • Aetna Dental PPO Plan 	<p>603</p>

Plan Name	Plan Number
<ul style="list-style-type: none"> • Aetna Vision Preferred Plan • Aetna Retiree Life Insurance Plan 	

Plan Year

The plan year for all plans is January 1 through December 31.

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. Benefits under the medical, dental vision and life plans are guaranteed under contracts of insurance (see the *Claims Administrator* section for the insurance company customer service phone numbers and policy numbers on page 52). 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 for the HRA customer service phone number on page 52).

The Premium Reimbursement Account is self-funded by the Institute. Reimbursements for qualified medical expenses under the Premium Reimbursement plan are processed by the JPL Benefits Office. The 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 *Claims Administrator* for the JPL Benefits Office phone number on page 52).

Source of Contributions

Retirees (including spouses, surviving spouses and 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

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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 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 Aetna Marketplace 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—Aetna Marketplace

Phone: 844-210-8389

Hours: Monday - Friday, 5 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
Aetna Life Insurance	1-800-523-5065
Health Reimbursement Account HRA (administered by Wage Works)	1-844-319-7858
Premium Reimbursement Plan (for retirees permanently living outside the U.S.)	JPL Benefits Office, Jet Propulsion Laboratory, 4800 Oak Grove Dr., T1720-B, 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 Code 108-31
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.

Contact the JPL Benefits Office

If you have any questions about this summary, you can refer to the retiree benefits website at www.caltechretiree.hrintouch.com, or contact the Benefits Office by phone or email.

JPL Benefits Office

Phone: 818-354-3760

Email: benefits@jpl.nasa.gov

Contact the Aetna Marketplace

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 Aetna Marketplace service team by phone.

Phone: 844-210-8389

Hours: Monday - Friday, 5 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. See the chart on the following page for a list of customer service phone numbers and plan contract numbers for each plan.

2018 BENEFITS SUMMARY PLAN DESCRIPTION

Plan	Customer Service	Contract Numbers
Aetna Non-Medicare Medical Plans		PPO Plans (For plans 1, 2 and 3)
<ol style="list-style-type: none"> 1. Aetna Open Choice PPO – High Option Network 2. Aetna Open Choice PPO – Mid Option Network 3. Aetna Aexcel Plus Open Access Managed Choice– Low Option Network 4. Aetna Open Access Managed Choice – Low Option Network 5. Aetna Traditional Choice – Low Option Out-of-Area Plan 6. Aetna HMO 	1-800-328-9933	<ul style="list-style-type: none"> • 866280-3 (High and Mid Open Choice PPO, Low Aexcel Open Access Managed Choice, Low Open Access Managed Choice, and Traditional Choice – Low Option Out-of-Area in all States except LA) • 866280-LA (High and Mid Open Choice PPO and Low Option Open Access Managed Choice in Louisiana) <p>HMO Plan (For plan 4)</p> <ul style="list-style-type: none"> • 869104 (Aetna HMO)
Aetna Medicare Medical Plans		
<ol style="list-style-type: none"> 7. Aetna Medicare PPO with ESA—Premier Plan 8. Aetna Medicare PPO—Medium Plan 9. Aetna Medicare PPO with ESA—Medium Plan 10. Aetna Medicare PPO —Value Plan 11. Aetna Medicare PPO with ESA—Value Plan 12. Aetna Medicare HMO Plan 13. Aetna Traditional Choice Plan- Medicare Integration Plan 	1-888-267-2637	<ol style="list-style-type: none"> 5. AE466304 (Medicare PPO with ESA—Premier Plan) 6. AE466301 (Medicare PPO—Medium Plan) 7. AE466303 (Medicare PPO with ESA—Medium Plan) 8. AE0466300 (Medicare PPO—Value Plan) 9. AE0466305 (Medicare PPO with ESA—Value Plan) 10. US466299 (Medicare HMO Plan) 11. 866280-3 (Traditional Choice) - Medical) AE466694 (Traditional Choice - Pharmacy)
Kaiser Permanente	1-800-464-4000 1-800-788-0616 (Spanish)	101829-04
Dental Plan Aetna Dental PPO	1-877-238-6200	866280-3 (Dental PPO all States except LA) 866280-LA (Dental PPO in LA)
Vision Plan Aetna Vision Preferred	1-877-973-3238	866280 (Vision) 866280-LA (Vision LA)
Health Reimbursement Account (HRA) Claim Administrator (WageWorks)	1-844-319-7858	33785
Group Life Insurance Aetna Life Insurance OR JPL Benefits Office	Aetna 1-800-523-5065 Benefits Office 1-818-354-3760	866280 (Life Insurance Plan)
Premium Reimbursement Plan	Benefits Office	N/A

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JPL Benefits Office	1-818-354-3760	
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GLOSSARY

This section provides definitions of important technical and benefit-specific terms used throughout the document.

A

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.

IMPORTANT!

These terms refer to Caltech’s 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.

B

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 “Benefits-Based” employee. Service in the following positions qualifies you to be a Benefits-Based employee:

- 1) “Faculty” (as defined on page 57);
- 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 on page 62 (including Key Staff Employees as defined on page 59 and Temporary Staff Employees as defined on page 62) 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 qualify as Benefit-Based.

C

Caltech

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

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) in Status Events

Refer to page 14 for the list of qualifying “Changes in Status” and other IRS-approved 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 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 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 children, and children for whom you are a court-appointed guardian) up to 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, 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/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 have a right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to a temporary extension of that coverage. See *Continuing Coverage through COBRA* on page 33 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 beneficiary or beneficiaries that you have selected 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.

D

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” are Caltech’s cost sharing program. Caltech provides a pre-designated amount of money, called Defined Dollar Credits, 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 the *Glossary* on page 55.

Dependents

Your “Dependents” who may be eligible for the health care coverage include:

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

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

Domestic Partners

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

Same Gender Domestic Partner

Under the Caltech benefits program described in this document, “Same-Gender domestic partners” are two adults of the same-sex who have a Certification of Domestic Partnership on file with the JPL Benefits office and who have registered with the California Secretary of State, or other applicable state agencies. Same-Gender 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 domestic partners and their covered dependents are eligible for continuation of medical, dental, and vision insurance benefits similar to COBRA and have similar conversion rights under medical coverage. Contact the JPL Benefits office regarding Same-Gender domestic partner certification, and termination, rates. See *Who to Contact* on page 53.

Registered Domestic Partner

Under the Caltech benefits program described in this document, “Registered domestic partners” are two adults of the opposite sex, one of whom is at least age 62 and covered under Medicare, or Same-Gender domestic partners 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. Domestic partners and their covered dependents are eligible for continuation of medical, dental, and vision insurance benefits similar to COBRA and have similar conversion rights under medical and vision coverage. Contact the JPL Benefits office regarding domestic partner certification, and termination. See *Who to Contact* on page 53.

E

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 on pages 33. 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.caltechretiree.hrintouch.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.

F

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
- Long-term lecturers
- Members of Professional Staff
- Members of the Beckman Institute
- Coaches.

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

G

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.

H

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 that:
 - 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 under age 27 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.

I

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.”

J

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.

K

Key Staff Employee

A “Key Staff” employee is a person who is regularly scheduled to work 20 or more hours per week in any one of the following categories:

- 1) A campus employee promoted to or hired in a classification of:
 - Member of the Professional Staff;
 - Librarian;
 - Associate Librarian;
 - Member of Beckman Institute.

The above is not applicable to JPL employees on and after March 17, 1997.

- 2) On or after the following effective dates, a “Key Staff” employee is a Benefit-Based employee (but not a Postdoctoral Scholar) who is receiving Regular Salary equal to at least the “Minimum Compensation Level”. The Minimum Compensation Level, which is indexed annually, is \$103,948 as of October 1, 2014.

L

Lump-sum Payment

A “lump-sum payment” is a one-time cash payment.

M

N

Non Benefits Based Employees

As described in this document, the following are considered “Non-Benefit-Based Employees”:

5. Staff Employees hired on a temporary basis for less than four months;
6. Occasional employees;
7. Part-time employees regularly scheduled to work less than 20 hours per week; and

8. 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, surviving spouse, or domestic partner 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, surviving spouses, or domestic partners 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.

O

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.

P

Patent

A “patent” is a license that is applied to an invention. Brand name prescription drugs often have patents to prevent others from making, using, or selling the drug without the pharmaceutical company’s authorization. A patent license applies for a set amount of time. If a prescription drug’s patent expires, it will then no longer be considered “brand name” or protected, and can then be reproduced by any company as a “generic” drug.

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.

Q

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.

R

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.

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 Benefits-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.

S

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 for JPL Retirees document and the Evidence of Coverage (EOC) booklets or plan documents issued by the insurance carrier for your medical, dental, and vision plans.

T**Tax-Qualified Dependent**

A “tax-qualified dependent” is a dependent, domestic partner or child of your 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 citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or a child 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 domestic partner or child of your 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 week in an assignment that is expected to last at least 90 days qualify as Benefit-Based. 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

U

Unmarried Children

“Unmarried children” include natural children, stepchildren, children being placed for adoption, children under permanent legal guardianship, and children for whom you have a qualified medical child support order (QMCSO).

V

X

Y

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.

Z