About the Benefit Plans
The Caltech benefits program is designed to provide quality, comprehensive benefits that support the needs of our employees. This Summary Plan Description (SPD) is the first place you should turn to when you have a question about your Caltech benefits program.

How Can We Help You?
Click the links below to get to the information you need.

I want/need information about my Health and Welfare Benefits. [Click Here! ›]

I want/need information about my Retirement Plans. [Click Here! ›]

The Institute expects and intends to continue the Caltech benefits program but reserves the right to amend, modify, suspend or terminate it, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP of Administration and Chief Financial Officer and/or Associate VP of 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. Any payment of benefits depends on your eligibility to receive them.
Help Related to Your Health Benefits

To open the 2018 Health and Welfare Benefits SPD, click here.

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Help Related to Retirement Plans

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2018 Benefits Summary Plan Description

This SPD describes the benefits available to you and is intended to help you use each benefit more effectively. This section of the SPD contains highlights of the H&W benefit plans. Plan documents/insurance contracts contain supplemental information. If there is a discrepancy between the information in this SPD and in plan documents/insurance contracts, the plan documents/insurance contracts, including Evidence of Coverage Forms (EOCs), will govern. This SPD, together with plan documents/insurance contract and your EOCs, describe the benefits provided under the Caltech H&W Benefit Plan effective January 1, 2018, and constitutes the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA). The benefits included in this document that are not subject to ERISA are so indicated.

Copies of all plan documents/insurance contracts and/or EOCs are available for review upon written request to the Plan Administrator. Contact the Campus or JPL Benefits Office (see Contacts).

How Can We Help You?

Click the links below, on the left, or across the top to get to the information you need about your Health and Welfare (H&W) Benefits:

- Medical
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Flexible Spending Account (HCSA)
- Dependents Care Flexible Spending Account (DCSA)
- Disability Insurance (Basic LTD, Supplemental LTD and STD)
- Life (Basic and Supplemental)
- Personal Accident Insurance (PAI)
- Business Travel Accident Insurance
- Extra-Hazardous Duty Insurance
- International SOS Medical Assistance
- Medical Evacuation and Repatriation (MER)
- Employee Assistance Program (EAP)
- Voluntary Benefits (Long-term Care Insurance and Non-Medical Insurance Policies)
- Aetna Life Essentials Program

The Institute expects and intends to continue the Caltech benefits program (including health and welfare plans and retirement plans) 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 of Administration and Chief Financial Officer and/or Associate VP of 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 provided 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.
Eligibility and Enrolling

Employee Eligibility

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

1. Faculty

2. Other Faculty and Non-Faculty Appointments (including Postdoctoral Scholars with External Funded Appointments):
   - Other Faculty and Non-Faculty Appointments (including Postdoctoral Scholars with External Funded Appointments) are eligible to participate in the Medical, Dental and Vision plans available to Benefit-Based Employees and their Dependents. However, premium cost sharing by the Institute for the Medical, Dental and Vision plans is limited to individuals either receiving a minimum monthly compensation of $1,000 paid by Caltech, or having designated external funding as an Institute allowance for this purpose.

3. Postdoctoral Scholars and Senior Postdoctoral Scholars, with Caltech-funded appointments:
   - Postdoctoral Scholars and Senior Postdoctoral Scholars are eligible to participate in all plans available to Benefit-Based Employees and their Dependents. Premium cost sharing by the Institute is limited to individuals who are paid by Caltech.

4. Staff Employees, Key Staff Employees and Temporary Staff Employees:
   - 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 a Benefit-Based Employee.
   - Temporary Staff Employees are employees who are regularly scheduled to work 20 or more hours per week. The date the Temporary Staff Employee was first regularly scheduled to work 20 or more hours per week will be used in determining coverage effective dates of when benefits begin.
   - Reference the glossary for the Key Staff Employee definition.

For more information on your Retirement benefits, go to the Retirement Benefits Homepage.
Download a Printable Version of this SPD.
Eligibility under the Affordable Care Act

If you do not meet the definition of a Benefit-Based Employee, you may become eligible for medical coverage if you meet certain criteria based on your job classification or the number of hours you have worked. Each year, the Institute will calculate how many hours of service you have worked and inform you if you are eligible for medical benefits.

Non-Benefit-Based Employees

Non-Benefit-Based Employees are only eligible for Business Travel Accident Insurance, Extra-Hazardous Duty Insurance, and the Employee Assistance Program (EAP). The following are considered Non-Benefit-Based Employees:

- Occasional employees and/or Interim Employee Program employees
- Part-time employees regularly scheduled to work less than 20 hours per week

Note: An “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.
Dependent Eligibility

Certain coverage is provided to your eligible dependents. Unless otherwise noted, for all benefits except the spending account(s), your eligible dependents include your:

- Legal spouse
- Registered domestic partner
- Children up to their 26th birthday (including your natural, step, adopted and foster children, and children for whom you are a court-appointed guardian)
- Children age 26 and over who are incapable of employment because of physical or mental disability (subject to carriers’ authorization/approval)
- Children who otherwise meet the definition of dependent, as defined above, for whom you are required to provide coverage under a “Qualified Medical Child Support Order (QMCSO)”

For the definition of eligible dependent for the Dependent Day Care Spending Account, click here.

Please Note: You must at all times give accurate information about your family status and your Dependents, regarding eligibility for benefits under the Caltech benefits program. Misrepresentation of information about your family status and/or your Dependents could result in disciplinary action, including immediate termination of employment from Caltech. Proof of Dependent eligibility will be required by the Institute for any Dependents added or re-added to our plan(s). All family members must be covered under the same Medical, Dental and Vision plans.
Enrolling in Your Health Benefits

If you are eligible to participate in the Caltech benefits program, you can enroll in your health benefits at the following times:

- When you first become benefit eligible
- When you have a Qualified Life Event
- During annual open enrollment

When You First Become Benefit Eligible

If you are a new Benefit-Based Employee or become eligible for benefits, you must enroll in your health benefits within 31 days of your date of hire as a Benefit-Based Employee or when you attain status as a Benefit-Based Employee.

When You Have a Qualified Life Event

You must enroll in or change your health benefits within 31 days of a Qualified Life Event (QLE). Click here to learn more about Qualified Life Events (QLEs).

During Annual Open Enrollment

You may enroll or disenroll yourself and/or your Dependents in any medical plan, dental or vision plan; switch among medical plans; switch between dental plans; or enroll or reenroll in the spending account(s) during the annual open enrollment period, which usually occurs in October or November.

How to Enroll in Benefits

For Caltech: Log in at MyBenefits.caltech.edu or click MyBenefits in access.caltech. For JPL: Log in at JPL Space and select the “MyBenefits” icon.

- If enrolling as a new Benefit-Based Employee, click on the orange icon titled “Get Started”
- If enrolling as a QLE, click on “Life Change”

Note: New faculty members should contact the Faculty Records Office regarding initial enrollment in benefit plans.
Enrolling or Making Changes to Your Health Benefit Elections During the Year

You can enroll or change your Supplemental Life Insurance, Personal Accident Insurance (PAI), Health Savings Account (HSA), and medical evacuation repatriation (MER) at any time. However, if you are changing your Supplemental Life Insurance election, you could be subject to an EOI determination that may impact your coverage options. Reference the Disability and Supplemental Life Insurance sections for more information on EOI.

You may be able to change your Medical, Dental, Vision, and Health Care Flexible Spending Account or Dependent Day Care Flexible Spending Account elections during the plan year if you experience a Qualified Life Event. Please note that in order to change your benefit elections due to a Qualified Life Event (QLE), you must notify the Institute within 31 days of the QLE and you may be required to show proof verifying that these events have occurred (e.g., copy of marriage certificate, birth certificate, or divorce decree). These rules apply to elections you make for your Medical, Dental, and Vision coverages and Health Care and Dependent Care Flexible Spending Accounts. The following is a list of Qualified Life Events that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status**: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Change in registered domestic partnership status**: Commencement or dissolution of a domestic partnership (you may be asked to show proof of your domestic partnership status);
- **Number of eligible dependents**: Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status**: Any event that changes your or your eligible dependents’ employment status that results in gaining or losing eligibility for coverage. These include:
  - Beginning or ending employment;
  - Changing from part-time to full-time employment or vice versa;
  - A change in work location; and
  - A strike or lockout.
- **Dependent status**: Any event that causes your dependents to become eligible or ineligible for coverage because of age or similar circumstances;
- **Residence**: A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan’s network service area;
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA) (see below).
Consistency Requirements for Change in Status

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be “on account of and correspond with” the event. To satisfy the “consistency rule,” both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent’s employer. This includes anytime you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent children who may benefit from coverage under the Plan.

- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) lose(s) eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

HIPAA Special Enrollment Events

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 the Caltech medical, dental, and vision plan if you or your dependents lose eligibility for that other coverage (or if another employer stops contributing toward your or your dependent’s other coverage). However, you must enroll within 31 days after your or your dependent’s 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 (see the Eligibility section in the SPD);
2. You (or your dependents) were covered under a group insurance plan or insurance coverage when coverage under the Caltech plan was last offered; and
HIPAA Special Enrollment Events (continued)

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 i) 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. If you
are gaining a dependent due to any of the following reasons, you may be able to enroll yourself and your dependent(s)
for medical, dental, and vision coverage.

- Birth or adoption of a new child, coverage will begin on the child’s date of birth, adoption, or foster placement.
- 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.
- Court-ordered coverage for a spouse, registered domestic partner, or dependent child, enrollment must be requested
  within 31 days from the date the court order was issued.

If you experience a Qualified Life Event, you must notify the Institute within 31 days of the event in order to make
changes to your elections.
When Coverage Begins for Your Health Benefits

Initial Benefit Eligibility and Qualified Life Events

**Benefit-Based Employees**

If you enroll when you become a Benefit-Based Employee or have a Qualified Life Event, the following coverage begins on the first of the month following your date of hire, the date you changed to Benefit-Based Employee status, or the date of the Qualified Life Event:

- Medical
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Spending Account (HCSA)
- Dependent Day Care Spending Account (DCSA)
- Life Insurance (Basic and Supplemental)
- Personal Accident Insurance (PAI)
- Disability Insurance (Basic LTD, Supplemental LTD and STD)
- Medical Evacuation Repatriation (MER)

If you become benefit eligible on the first of the month then benefits will begin on that date.

Benefits will begin on the date of the birth or adoption when adding dependents by using a Qualified Life Event (QLE).**

**All Employees**

For all employees, the following benefits begin on your date of hire:

- Business Travel Accident Insurance*
- Extra-Hazardous Duty Insurance
- Employee Assistance Program (EAP)
- International SOS

Except for coverage under the Medical, Dental and Vision plans, you must be “actively at work” in order for any new benefits to go into effect. If you are not actively at work, coverage begins on the first of the month coincident with or following the day you begin or return to work as a Benefit-Based Employee. Any benefit coverage changes related to salary increases will become effective on the first payroll period of your new salary.

*If you have accepted in writing an employment offer with Caltech and travel on Institute-related business prior to your first day of employment, as a prospective employee, you will be covered by the Business Travel Accident Insurance Plan.

**If you are not enrolled in medical, dental, or vision and would like to add a newborn to your benefits, the effective date will be the first of the month following the newborn’s birth date. If the birth date is on the first of the month then benefits will begin on that date.
Annual Open Enrollment
Changes you request, in most cases, will be effective on January 1 of the calendar year following the annual open enrollment period.

If an annual open enrollment period occurs while you are on an FMLA or military leave, you will be able to change your elections under the same terms and conditions permitted for employees Actively at Work. Any changes to your Life, AD&D or Disability Plans (Basic LTD, Supplemental LTD and STD) will not take effect until you return to work for one full day or approved by the carrier. Additionally, if an annual open enrollment period occurs while you are receiving COBRA coverage, you will be able to change your health plan elections under the same terms and conditions permitted for similarly situated employees Actively at Work. If you are on an unpaid leave and not Actively at Work during the annual open enrollment period due to other than FMLA or military leave, you will have an opportunity to change your benefits upon your return to work as a Benefit-Based Employee.
What Coverage Costs for Your Health Benefits

The benefits you choose to enroll in will determine how much you will need to pay for your and your Dependents’ coverage. For some benefits, such as Medical, Dental and Vision coverage, in most cases* you and Caltech share the cost of Medical, Dental, and Vision coverage for you and your enrolled Dependents.

*Premium cost sharing by the Institute for the Medical, Dental and Vision coverages is limited to individuals either receiving a minimum monthly compensation of $1,000 paid by Caltech, or having designated external funding as an Institute allowance for this purpose. This usually applies for postdoctoral scholars and visiting associates.

Costs

Log into MyBenefits for the costs of the plans. The following benefits are provided by the Institute at no cost:

- Basic Life Insurance
- Basic Long-term Disability (Basic LTD)
- Employee Assistance Program (EAP)
- Business Travel Accident Insurance
- International SOS Medical Assistance
- Extra-Hazardous Duty Insurance

You will pay 100% of the cost of

- Supplemental Life
- Supplemental LTD
- HSA, HCSA, DCSA
- Voluntary Benefits

For more information on your Retirement benefits, go to the Retirement Benefits Homepage.

Download a Printable Version of this SPD.
Pre-tax or After-Tax Contributions

When you enroll in Medical, Dental or Vision coverage provided by Caltech, any contributions for your health benefits will automatically be deducted from your pay on a pre-tax basis. You may elect to make your contributions on an after-tax basis within 31 days of becoming a Benefit-Based Employee or during the annual open enrollment period. For all other benefits requiring a contribution, you pay the full cost of coverage, at group rates, on an after-tax basis.

Although the pre-tax contributions you make for health care coverage will lower your pay for tax purposes, they will not lower your pay for determining pay-related Caltech benefits. Participation in the plans may, however, have a slight effect on your Social Security benefits at retirement, since you do not pay Social Security taxes on any pre-tax deductions from your pay. If your taxable income is less than the Social Security wage base, your future Social Security benefits, which are based on the Social Security tax you pay, could be somewhat reduced.

If you are covering a Domestic Partner and/or children of a Domestic Partner, these contributions will be on a post-tax basis, unless your Domestic Partner or his or her child is a “tax-qualified dependent” as defined by the IRS. Additionally, if your Domestic Partner or his or her children do not qualify as tax dependents, the amount Caltech contributes for coverage on their behalf will be added to your taxable income.
When Your Health Benefits Coverage Ends

All benefit coverage, except for the EAP, Long-term Disability (Basic LTD and Supplemental LTD), Business Travel Accident Insurance and Extra-Hazardous Duty Insurance, for you and your Dependents ends on the earliest of the following dates:

- The end of the month in which you or your Dependents no longer meet the eligibility requirements for coverage
- You fail to make the necessary contributions toward the cost of coverage
- The date the plan is terminated

Long-term Disability (Basic LTD and Supplemental LTD), Business Travel Accident Insurance and Extra-Hazardous Duty Insurance will end on your last day of work.

You and your Dependents may continue participation in the EAP at no cost for the same period you would have been entitled to continue your health coverage under COBRA (see below for coverage duration for you and your Dependents).

Continuing Your Health Benefits Coverage

When coverage ends, you may be able to continue Medical, Dental, Vision and HCSA coverage through COBRA or by converting your coverage to an individual policy with the carrier.

Duration of Coverage

You (and your covered Dependents) are eligible for up to 18 months of COBRA coverage after one of the following events:

- You voluntarily leave or retire from Caltech
- You no longer are eligible for Caltech benefits
- Caltech ends your employment for any reason, unless you were terminated because of gross misconduct

Your covered Dependents are eligible for up to 36 months of COBRA coverage after one of the following events results in a loss of coverage for your Dependent:

- You are divorced or legally separated
- Your death
- Your Dependent no longer qualifies as a covered Dependent (for example, when your Dependent child reaches age 26)
Costs for Continuing Coverage

Your cost for COBRA coverage is 100% of the full group rate plus an additional 2% administrative fee. Log into MyBenefits to see the 2018 COBRA rates.

How to Continue Coverage

Contact the COBRA administrator, WageWorks, for information about your options and how to enroll. You must elect COBRA coverage within 60 days from the later of the day you receive notification of COBRA rights OR coverage is lost due to the qualifying event.

If you or your dependents would like to convert all or part of your Group Life Insurance policies (Basic and Supplemental) or Personal Accident Insurance (PAI) into an individual policy, you may do so within 31 days of the end of coverage or if your coverage is reduced. For information about your options and costs contact the plan carrier.
Health Benefits Coverage During Leaves of Absence

The Institute continues to provide you with healthcare coverage while you are on an approved leave of absence. You may continue certain benefits depending on the type of leave. The type of leave you are on will also determine your cost share for continued coverage. See below to learn more about the different types of leaves:

Paid Leaves of Absence

- During a paid leave of absence, payroll deductions for benefits and coverage will continue the same as if you are Actively At Work.

Unpaid Family and Medical Act Leave (“FMLA”) / California Family Rights Act (“CFRA”)

- During FMLA/CFRA Leave, you may continue the benefits in which you are enrolled for up to 12 weeks.

Unpaid Disability Leave (Non-FMLA)/CFRA

- Institute contributions for your medical, dental, vision, basic life and basic LTD coverage continue as if you were an active employee for the first six months of leave. The six-month period is measured from the first day of leave, including FMLA/CFRA leave, paid or unpaid. During that time, if you decide to continue your medical, dental and vision coverage, you will be required to pay the employee portion of the cost.

- For any other benefit that you decide to continue during this period, including supplemental life, supplemental LTD, Personal Accident Insurance (PAI), Health Care Spending Account (HCSA) and/or Health Savings Account (HSA) coverage, you will be required to pay 100% of the cost of coverage, including the employer portion, if applicable.

- After the first six months of leave, you are required to pay 100% of the published rates, including the employer portion, for any benefits that you continue, up to a maximum of 24 months from the first day of leave.

Unpaid Personal Leave

- You may continue benefits for the first 12 months of an approved, unpaid leave of absence and you will be responsible to pay 100% of the cost of coverage, including the employer portion. Eligibility for LTD and DCSA (if applicable) coverage will terminate at the beginning of the leave. You will become eligible for LTD and DCSA (if applicable) coverage the first of the month following the date that you returned to work as a Benefit-Based Employee.
Military Leave Uniform Services Employment and Re-employment Rights Act ("USERRA")

- Under USERRA, whether your leave is for active duty or for training, you are entitled to continue medical, dental, vision and Healthcare Spending Account (HCSA) coverage for up to 24 months. If the entire length of the leave is less than 6 months, you will not be required to pay any more for your medical, dental and vision coverage than you paid before your leave.
- If your USERRA leave extends beyond six months, you may be required to pay up to 102% of the entire amount (including both Institute and employee contributions plus 2%) necessary to cover an active employee.

What Happens When You Return From a Leave of Absence?

- When you return from an unpaid leave of absence as a Benefit-Based Employee, your benefit elections will generally be reinstated and you may commence payment of your benefit elections through payroll on a pre-tax basis.
- If you waived any benefits while on your unpaid leave of absence, you will need to re-enroll upon your return to work. Your benefits will be reinstated on the first of the month following your return to work.

Contact the Campus or JPL Benefits Office within 31 days of your return from leave in order for your benefits to be reinstated or if you have any questions.
# About Your Health Benefits

This section includes brief summaries of the following benefits and plan options such as information about how plans work, and how to pay for care when you receive it. Click on the plan option below to go directly to that page.

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Anthem Blue Cross High-Deductible PPO

How the Plan Works

You can see any doctor or provider you want, but you pay more when you see providers outside the Anthem Blue Cross PPO network. If you visit an out-of-network provider, you will be responsible for paying any amounts in excess of the “eligible charges” based on the customary and reasonable rate as determined by the plan. You can find Anthem Blue Cross PPO providers at [www.anthem.com/ca/caltech](http://www.anthem.com/ca/caltech).

Along with the flexibility of choosing providers, you may also consider this plan because it has a lower premium and you have the option of signing up for a Health Savings Account (HSA) where you can set aside pre-tax money for eligible medical, dental and vision expenses. You can have your preventive exam once a year that is covered 100% in-network and that is not subject to a deductible or coinsurance. When the time comes to use other services such as an emergency room visit or surgery, you can use your HSA for the deductible and coinsurance.

Health Savings Account (HSA)

You can enroll in the HSA if you are enrolled in the Anthem Blue Cross High Deductible PPO. This is a bank account that lets you set aside pre-tax money to pay for eligible medical, dental and vision expenses. The money in your HSA is yours to keep, even when the plan year ends or if you leave the Institute. Your balance will roll over from year to year and earn interest. If your balance reaches $1,000, you can invest your balance in available mutual funds. You can adjust your elections anytime by going into MyBenefits.

Keep in mind that the HSA has special eligibility rules. To be eligible to contribute to an HSA, you cannot be:

- Covered under another medical plan that provides coverage for the same types of benefits, unless that plan is also considered an IRS-qualified high-deductible health plan.
- Claimed as a dependent on another person’s tax return.
- Enrolled in any part of Medicare Part A or B, or if you are age 65 or older and receiving Social Security income.

For more information about the HSA, including what expenses are eligible, how to file a claim and how to manage your account, visit [www.healthequity.com](http://www.healthequity.com). Additional details are also available on MyBenefits.
Anthem Blue Cross High-Deductible PPO (continued)

Paying for Care

Eligible in-network preventive care visits is covered at 100% and in-network preventive prescriptions have a copayment, even before you meet the deductible.

Log into MyBenefits to learn about the co-insurance and copayments costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:

1. You pay for services that are subject to the deductible until you reach the annual deductible. In most cases, the services you pay for will apply toward the deductible.
2. Once the deductible is satisfied, the plan begins to pay coinsurance, which means that you pay a percentage and Anthem pays a percentage.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum for the rest of the year. However, if you receive services from an out-of-network provider, you are responsible for paying the difference between the covered or allowable charges and the billed charges.

Additional Services

- **Anthem Concierge** – Your on-site Anthem personal health advocate who can help you with claims, find doctors or selecting the plan that is best for you. See contacts for contact information.
- **Grand Rounds** – Grand Rounds provides Anthem Blue Cross High Deductible PPO members a second medical opinion, help selecting doctors and more, at no charge. Learn more by visiting www.grandrounds.com/caltech.
- **Live Health Online** – Lets you have face-to-face conversations with a doctor on your computer or mobile device. It is medical advice the moment you need it. Learn more by visiting www.livehealthonline.com.

More Information

For more detailed information about the Anthem Blue Cross High-Deductible PPO, click here to see the Evidence of Coverage.
Anthem Blue Cross HMO

How the Plan Works
When you enroll in the Anthem Blue Cross HMO, you choose a Participating Medical Group (PMG) and a Primary Care Physician (PCP). You must be referred by your PCP to specialists and receive authorization from your assigned PMG for any medical services. If you need urgent care services and you are inside the HMO’s service area, contact your PMG to find the contracted urgent care that you would need to use. The only exceptions are emergency room visits OR urgent care visits when you are outside the HMO’s service area and within the USA. You can find Anthem Blue Cross HMO providers at www.anthem.com/ca/caltech (search in the Advantage HMO network).

Paying for Care
The plan pays 100% for eligible preventive care services when you use Anthem HMO providers. Log into MyBenefits to learn about the copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:
1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum for the rest of the year. Treatment obtained without the authorization of your primary care physician is generally not covered.

Additional Services
Anthem Concierge – Your on-site Anthem personal health advocate who can help you with claims, finding doctors or selecting the plan that is best for you. See contacts for contact information.

Live Health Online – Lets you have face-to-face conversations with a doctor on your computer or mobile device. It is medical advice the moment you need it. Learn more by visiting www.livehealthonline.com.

More Information
For more detailed information about the Anthem Blue Cross HMO, click here to see the Evidence of Coverage.
Kaiser Permanente (California) HMO

How the Plan Works
When you enroll in the Kaiser Permanente (California) HMO, you must receive all your care from doctors and hospitals affiliated with Kaiser. Unlike other HMOs, you don’t have to choose a primary care doctor. However, you must get a referral to specialists. The only exceptions are emergency room visits OR urgent care visits when you are outside Kaiser’s service area and within the USA. To find Kaiser locations, visit my.kp.org/caltech.

Paying for Care
The plan pays 100% for eligible preventive care services when you use Kaiser providers. Log into MyBenefits to learn about copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:
1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum for the rest of the year. Treatment obtained without the authorization of your primary care physician is generally not covered.

More Information
For more detailed information about the Kaiser Permanente (California) HMO, click here to see the Evidence of Coverage.
Medical Plans Outside of Southern CA

Anthem Blue Card PPO

How Do I Qualify? If you are assigned to work outside of California at the request of the Institute, you and your Dependents may be able to enroll in coverage under the Blue Card Plan with Anthem Blue Cross. If you had coverage under one of the Institute’s medical plans prior to the commencement of the job assignment and waived Caltech medical coverage, including coverage under the Blue Card Plan with Anthem Blue Cross, you and your Dependents may be eligible for an out-of-area medical premium reimbursement to cover a portion of the cost to purchase individual medical coverage. Before you leave, contact the Campus or JPL Benefits Office for further details.

How the Plan Works You can see any doctor or provider you want, but you pay more when you see providers outside the Anthem Blue Cross PPO network. If you visit an out-of-network provider, you will be responsible for paying any amounts in excess of the “eligible charges” based on the customary and reasonable rate as determined by the plan. You can find Anthem Blue Cross PPO providers at www.anthem.com/ca/caltech.

Paying for Care Eligible preventive care visits at in-network providers is covered at 100%. Log into MyBenefits to learn about copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:

1. If applicable, you pay for services that are subject to the deductible until you reach the annual deductible. In most cases, the services you pay for will apply toward the deductible.

2. Once the deductible is satisfied, the plan begins to pay coinsurance, which means you pay a portion and Anthem pays a portion.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum for the rest of the year. However, if you receive services from an out-of-network provider, you are responsible for paying the difference between the covered or allowable charges and the billed charges.

More Information For more detailed information about the Anthem Blue Card PPO, click here to see the Evidence of Coverage.
### Anthem Owens Valley PPO

#### How Do I Qualify?
You must be an employee working in the Owens Valley service area.

#### How the Plan Works
You can see any doctor or provider you want, but you pay more when you see providers outside the Anthem Blue Cross PPO network. If you visit an out-of-network provider, you will be responsible for paying any amounts in excess of the “eligible charges” based on the customary and reasonable rate as determined by the plan. You can find Anthem Blue Cross PPO providers at [www.anthem.com/ca/caltech](http://www.anthem.com/ca/caltech).

#### Paying for Care
Eligible preventive care visits at in-network providers are covered at 100%. Log into *MyBenefits* to learn about copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:

1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

#### More Information
For more detailed information about the Anthem Owens Valley, click here to see the Evidence of Coverage.
Kaiser Permanente (Washington) HMO

How Do I Qualify?
You must be an employee working in the Kaiser Permanente (Washington) HMO service area.

How the Plan Works
When you enroll in the Kaiser Permanente (Washington) HMO, you must receive all your care from doctors and hospitals affiliated with Kaiser. Unlike other HMOs, you don’t have to choose a primary care doctor. However, you must get a referral to specialists. The only exceptions are emergency room visits OR urgent care visits when you are outside Kaiser’s service area and within the USA. To find Kaiser locations, visit my.kp.org/caltech.

Paying for Care
The plan pays 100% for eligible preventive care services when you use Kaiser providers. Log into MyBenefits to learn about copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:
1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum for the rest of the year. Treatment obtained without the authorization of your primary care physician is generally not covered.

More Information
For more detailed information about Kaiser Permanente (Washington) HMO, click here to see the Evidence of Coverage.
**Kaiser Permanente (Mid-Atlantic) HMO**

**How Do I Qualify?**  
You must be an employee working in the Kaiser Permanente (Mid-Atlantic) HMO service area.

**How the Plan Works**  
When you enroll in the Kaiser Permanente (Mid-Atlantic) HMO, you must receive all your care from doctors and hospitals affiliated with Kaiser. Unlike other HMOs, you don’t have to choose a primary care doctor. However, you must get a referral to specialists. The only exceptions are emergency room visits OR urgent care visits when you are outside Kaiser’s service area and within the USA. To find Kaiser locations, visit [my.kp.org/caltech](http://my.kp.org/caltech).

**Paying for Care**  
The plan pays 100% for eligible preventive care services when you use Kaiser providers. Log into MyBenefits to learn about copayment costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.). Below are the general steps on paying for medical services:

1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year for the rest of the year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum. Treatment obtained without the authorization of your primary care physician is generally not covered.

**More Information**  
For more detailed information about Kaiser Permanente (Mid-Atlantic) HMO, click here to see the plan documents.
Delta Dental PPO

How the Plan Works

With the Delta Dental PPO, you can choose to see any licensed dentist, but to maximize your savings, visit a dentist in the PPO network. These dentists have agreed to reduced fees, and you won’t get charged more than your expected share of the bill. If you can’t find a PPO dentist, Delta Dental Premier dentists offer the next best opportunity to save. Unlike non-Delta Dental dentists, they have agreed to set fees, and you won’t get charged more than your expected share of the bill. To find a participating dentist, visit [www.deltadentalins.com/caltech](http://www.deltadentalins.com/caltech).

Paying for Care

The plan provides 100% coverage for diagnostic and preventive care (limited to two cleanings per calendar year). The deductible does not apply to these services. Basic and Major services are subject to the annual deductible. Once the deductible is satisfied, the plan will pay the designated coinsurance (up to the plan’s annual maximum), and you will be responsible for your portion of the coinsurance. Log into MyBenefits to learn about coinsurance costs for all dental services (fillings, root canal, crowns, etc.). Below are the general steps on paying for dental services:

1. You pay for services that are subject to the deductible until you reach the annual deductible. In most cases, the services you pay for will apply toward the deductible.
2. Once the deductible is satisfied, the plan begins to pay coinsurance, which means that you pay a percentage and Delta Dental pays a percentage (up to the plan’s maximum allowable benefit).

More Information

For more detailed information about the Delta Dental PPO, [click here](http://www.deltadentalins.com/caltech) to see the Evidence of Coverage.
MetLife DHMO (Safeguard Dental)

How the Plan Works
With the MetLife DHMO, you must choose your dentist from the MetLife DHMO (Safeguard) directory by going to [www.metlife.com/MyBenefits](http://www.metlife.com/MyBenefits). Each family member may choose a different dentist. If necessary, your dentist will refer you to a Safeguard specialist for certain types of care, such as endodontics, periodontics, oral surgery and orthodontia. Except for some emergency situations, you won’t receive a benefit for out-of-network services.

Paying for Care
The plan provides 100% coverage for diagnostic and preventive care. Log into MyBenefits to learn about copayment costs for all dental services (fillings, root canal, crowns, etc.). Below are the general steps on paying for dental services:
1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest.

More Information
For more detailed information about the MetLife DHMO (Safeguard), click here to see the Evidence of Coverage.
Vision Service Plan (VSP)

How the Plan Works

You can receive eye services and supplies from any vision care provider you choose, but you save money when you use VSP providers. VSP provides coverage for eye exams, glasses or contact lenses. Discounts are available on frames and lenses and some other services when you use VSP Signature network providers. To search for a VSP Signature network provider, visit www.vsp.com.

Paying for Care

Log into MyBenefits to learn about copayment costs for all vision services (eye exam and vision care material.). Below are the general steps on paying for vision services.

When you receive care from a VSP provider:
1. You do not pay a deductible.
2. You pay the applicable copayment and the plan pays for the rest (up to the plan’s maximum allowable benefit).

If you receive care from a non-VSP provider:
1. You pay the full amount out of pocket.
2. You submit a claim form and itemized receipt to VSP for reimbursement of your eligible expenses (up to the plan’s maximum allowable benefit).

More Information

For more detailed information about vision coverage, click here to see the Evidence of Coverage.
Flexible Spending Accounts (FSAs)

How the Plan Works

Flexible spending accounts help you pay for eligible expenses with pre-tax contributions. You put aside a portion of your pay on a before-tax basis to cover eligible out-of-pocket health care or dependent day care expenses. That portion of your pay is not subject to federal, Social Security, and, in most cases, state or local income taxes. Then, when you or your dependent incurs an eligible expense, the flexible spending account reimburses you for the expenses that you have paid.

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<th>Ineligible Expenses</th>
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<td>• Certain over-the-counter medications</td>
<td>• Certain over-the-counter medications</td>
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Flexible Spending Accounts (FSAs) (continued)

**Dependent Day Care FSA (DCSA)**

Set aside pre-tax dollars to pay for childcare for children under 13 or day care expenses for an incapacitated dependent, while you and your spouse or domestic partner work or go to school. Here are some examples of what’s covered and what’s not under the DCSA:

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<tr>
<th>Eligible Expenses</th>
<th>Ineligible Expenses</th>
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</thead>
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<td>• Elder/dependent care facility</td>
<td>• Expenses for care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled</td>
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<td>• Nursery school or preschool</td>
<td>• Transportation to and from a dependent care location</td>
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<tr>
<td>• Day camp</td>
<td></td>
</tr>
</tbody>
</table>

**Contribution Limits**

The IRS limits how much you can contribute to your flexible spending accounts each year:

- Health Care FSA: $120 – $2,600 per year
- Dependent Day Care FSA: $120 – $5,000 per year ($2,500 if married and filing separately)

Per IRS regulations, there are rules on how money left in your account at the end of the plan year is handled:

- **HCSA**: You can carry over up to $500 of unused funds remaining in your account at the end of the calendar year for a duration of one calendar year. The carryover is automatic and can only carry over for one year. The carryover will occur for employees who are eligible (benefit based at the time of carryover) and not contributing in a Health Savings Account for that calendar year. You forfeit any unused funds remaining above the $500 carryover amount.
- **DCSA**: You forfeit any unused funds remaining in your account at the end of the calendar year.
Flexible Spending Accounts (FSAs) (continued)

Filing a Claim

Claims for expenses must be for services you receive when your spending account is in effect. You need to file a claim to be reimbursed through your FSA(s) for eligible expenses. When you file your claim, you must include proof of payment. You have until March 31 of the following calendar year to submit claim forms for eligible health care and dependent day care expenses.

- HCSA: Claims for eligible expenses will be paid in full — up to the amount of your annual contribution — regardless of how much you have actually contributed to your Health Care FSA at the time you submit your claim.
- DCSA: Claims for eligible expenses will be paid up to the balance of your account contributions at the time you submit the claim. If you ask to be reimbursed for an expense that is greater than the amount in your Dependent Care FSA account, the excess expense will be carried over until you have sufficient funds in your account to cover it.

More Information

For more detailed information about the FSAs, go to [www.healthequity.com](http://www.healthequity.com).

For more information on your Retirement benefits, go to the Retirement Benefits Homepage >

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Disability Benefits

Short-term Disability (STD)

If you are an employee in California, you may be eligible for California State Disability Insurance (SDI) benefits administered by the Employment Development Department of the State of California. For more information about SDI, visit [http://www.edd.ca.gov/Disability](http://www.edd.ca.gov/Disability) or contact State Disability Insurance at 1-800-480-3287 (English) or 1-866-658-8846 (Spanish).

If you work outside of California, in a state without mandatory state disability insurance benefits, the Institute offers voluntary short-term disability (STD) coverage through Aetna. You have 31 days from your hire date or the date you become eligible to purchase STD coverage. If you enroll in the STD plan after the 31 days, you will be subject to Evidence of Insurability (EOI). Plan benefits are similar to the CA SDI benefits. STD coverage is voluntary and employee-paid.

Long-term Disability (LTD)

Long-term disability (LTD) insurance protects you against the loss of income that can accompany a long-term leave due to illness or injury. The Institute offers both Basic and Supplemental LTD coverage through Aetna.

Basic LTD

Basic LTD provides you with 40% of your basic monthly earnings minus other income benefits to a maximum monthly benefit of $10,000.

Supplemental LTD

If you enroll and have been approved for participation in the Supplemental LTD Plan, your combined basic and supplemental plan benefits provide you with 60% of your basic monthly earnings minus other income benefits to a maximum monthly benefit of $17,500. You have 31 days from your hire date to purchase Supplemental LTD coverage without being subject to approval by the insurance carrier’s Evidence of Insurability (EOI) process. The upcoming section Evidence of Insurability (EOI) has more information on the EOI process.

Continued
Disability Benefits (continued)

Paying for Coverage

You are automatically enrolled in the Basic LTD plan, and the Institute pays for your coverage. Supplemental LTD coverage is voluntary and employee-paid.

Filing a Claim

- **State Disability Insurance**: If you work in California or another state with a mandatory state disability insurance program, you will contact the state to learn how to apply for benefits. Contact California’s Employment Development Department at [http://www.edd.ca.gov/Disability](http://www.edd.ca.gov/Disability) or contact State Disability Insurance at 1-800-480-3287 (English) or 1-866-658-8846 (Spanish).

- **STD**: If you are enrolled in the voluntary STD plan and will be disabled for longer than seven calendar days, Caltech/JPL will contact the carrier to initiate your STD claim. Aetna will contact for information regarding your disability and will determine if you qualify for benefits. If approved, STD benefits begin on the eighth day of disability.

- **LTD (Basic and Supplemental)**: After approximately four months of disability, Caltech/JPL will contact you to help you initiate your LTD claim with the carrier. The carrier will contact you for information regarding your disability to determine if you qualify for benefits.

More Information

For more detailed information about the STD or LTD plan, [click here](http://www.edd.ca.gov/Disability) to see the Evidence of Coverage, or contact the Campus or JPL Benefits Office.
### Life Insurance (Basic and Supplemental) and Personal Accident Insurance (PAI)

#### How the Plans Work

Life Insurance (Basic and Supplemental) provides a benefit in the event of your death or the death of a covered family member. Personal Accident Insurance (PAI) provides financial protection for you and your loved ones in the event of an accidental death or serious injury.

<table>
<thead>
<tr>
<th>Basic Life Insurance</th>
<th>The Institute provides Basic Life Insurance to you at one times your annual salary, up to $50,000, at no cost to you. Your benefit will be paid to your beneficiary(ies) in the event of your death.</th>
</tr>
</thead>
</table>
| Supplemental Life Insurance | You can elect to enroll yourself, your spouse/domestic partner, and child(ren) in optional Supplemental Life Insurance in the following levels of coverage:  
  - **For yourself:** 1, 2, 3, 4 or 5 times your annual salary rounded to the next higher $10,000, up to $1,000,000 maximum  
  - **For your Spouse or Domestic Partner:** Units of $10,000, up to 100% of the total of the employee’s (Basic and Supplemental) Life Insurance coverage through the Institute, or $200,000, whichever is less  
  - **For your Dependent children up to age 26:** $10,000 per child  
  In most cases, you must go through the insurance carrier’s Evidence of Insurability (EOI) process for Supplemental Life Insurance. The upcoming section Evidence of Insurability (EOI) has more information on the EOI process. |

### Life Insurance Reduction at Ages 65 and 70

Basic and Supplemental Life Insurance for employees and their Spouse/Domestic Partner is reduced to 65% of the original amount on January 1 following attainment of age 65. It will reduce again on January 1 following attainment of age 70 to 40% of your original amount. At that time, you have 31 days to convert the difference to an individual plan.
Life Insurance (Basic and Supplemental) and Personal Accident Insurance (PAI) (continued)

Evidence of Insurability (EOI)

Life (Basic and Supplemental) and Disability Insurance (Basic LTD and Supplemental LTD) requires applicants to provide evidence of good health before insurance coverage begins. In the insurance industry, evidence of good health is referred to as Evidence of Insurability (EOI).

The insurance company will provide a health care questionnaire to help an applicant through the EOI process. Based on the information the applicant provides on the questionnaire, additional information may be requested from the applicant’s physician. In some cases, the applicant will be required to complete a physical examination and submit the results of the exam to the insurance company. Insurance coverage will be either approved or denied as based on the information provided by the EOI process.

Log into MyBenefits to learn when EOI will apply.

Personal Accident Insurance

You can choose to enroll in the Personal Accident Insurance (PAI) for yourself and/or your dependents. The PAI plan provides a benefit to you if you suffer a serious accident or injury (e.g., loss of a limb, eyesight, speech or hearing) or to your beneficiary if you die because of an accident.

You may purchase PAI Insurance at a minimum of $10,000 in coverage up to a maximum of $500,000 in coverage in increments of $25,000. If you elect more than $150,000 in coverage, your benefit cannot be more than 10 times your annual salary.
## Life Insurance (Basic and Supplemental) and Personal Accident Insurance (PAI) (continued)

### Naming Your Beneficiary

You must name a beneficiary to receive your Basic Life and Supplemental Life Insurance benefit should you die while you are covered. The beneficiary for Personal Accident Insurance (PAI) will be the same as the beneficiary for Basic Life. Go to the MyBenefits website to designate a beneficiary. You can change your beneficiary at any time.

Please note: In California and other community property states, your spouse/domestic partner must sign a waiver if you name someone other than your spouse/domestic partner as your beneficiary for 50% or more of your benefit. Reference the Evidence of Coverage (EOC) for payment distributions when you do not have a beneficiary on file.

### More Information

For more detailed information about Life and Accident Insurance, click here to see the Evidence of Coverage.
Additional Benefits

Business Travel Accident Insurance

Business Travel Accident Insurance provides a benefit for loss as a result of a covered accidental injury for death, dismemberment or loss of movement while traveling for Institute business. If you die, your beneficiary will receive a benefit of up to $250,000 under this policy. If you are injured, you will receive all or a percentage of your benefit if you suffer certain specific losses from an injury sustained in the accident.

Your beneficiary will be the same beneficiary named for your Basic Life Insurance, unless otherwise specified.

Extra-Hazardous Duty Insurance

Extra-Hazardous Duty Insurance may provide a benefit if you die or are seriously injured as the result of certain testing activities performed by JPL in connection with any Caltech contracts. If you die, your beneficiary will receive a benefit of up to $25,000 under this policy. If you are injured, you will receive all or a percentage of your benefit if you suffer certain specific losses from an injury sustained in the accident.

Your beneficiary will be the same beneficiary named for your Basic Life Insurance, unless otherwise specified.

More Information

For more detailed information about Business Travel Accident Insurance or Extra-Hazardous Duty Insurance, click here to see the Evidence of Coverage or contact the Campus or JPL Benefits Office.
### Additional Benefits (continued)

<table>
<thead>
<tr>
<th>International SOS Medical Assistance</th>
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<tbody>
<tr>
<td>International SOS is your very own personal and medical assistance advisor for emergencies, as well as routine advice when you are traveling on Institute business outside your home country. Reach out to International SOS if you need a routine referral, lose your medication or have a medical crisis. Visit <a href="http://www.internationalsos.com">www.internationalsos.com</a> and enter your membership number (11BCMA000180) to learn more about your benefits.</td>
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<tr>
<th>Medical Evacuation Repatriation (MER)</th>
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<tbody>
<tr>
<td>If you travel extensively, especially abroad, you may want to supplement your medical emergency transportation coverage by enrolling in the Medical Evacuation and Repatriation (MER) Plan. The MER Plan provides medical and travel assistance when you are more than 100 miles away from your home. Log into MyBenefits to learn about what MER covers.</td>
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<tr>
<th>Employee Assistance Program (EAP)</th>
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<tbody>
<tr>
<td><strong>Caltech</strong> - Access to the Caltech Staff and Faculty Consultation Center (SFCC) which provides professional, confidential, brief consultation to active faculty, staff, postdocs and their Dependents at no cost to the user.</td>
</tr>
</tbody>
</table>

| JPL – JPL uses LifeMatters/Empathia as our Employee Assistance Program/Work-Life Resource. LifeMatters provides counseling and other support for emotional well-being, as well as resources for help with health, financial and legal issues. Assistance is available 24/7 by calling LifeMatters at 1-800 367-7474 or visiting [mylifematters.com](http://mylifematters.com) (company password: jpl). |

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For more information on your Retirement benefits, go to the Retirement Benefits Homepage >

Download a Printable Version of this SPD >
### Additional Benefits (continued)

#### Voluntary Benefits

- **Long-term Care (LTC) Insurance** — Covers costs for in-home care, nursing home care or residential facility care when you need care that is not covered by your health insurance.
  
  Caltech employees: Visit Genworth.com/Caltech (JPL employees: Visit Genworth.com/JPL to learn who is eligible, what it covers and how to enroll.
  
  - **Non-medical insurance policies** — MetLife offers auto, homeowner, renter’s insurance and more. For cost and enrollment, call MetLife at 1-800-438-6388. Be sure to identify yourself as one of our employees to receive the Caltech group rates.

#### Aetna Life Essentials Program

If you are enrolled in Basic or Supplemental Life Insurance coverage, you also get access to tools and services at no cost or discounted rates:

- Legal and Financial Services
- Estate Planning
- Grief Counseling
- Funeral Planning Services

To learn more about the program, visit [www.aetalifeessentials.com](http://www.aetalifeessentials.com).

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For more information on your Retirement benefits, go to the Retirement Benefits Homepage.

Download a Printable Version of this SPD.
What Happens If…
You can make an election or make changes to your benefit elections outside of the annual open enrollment period if you experience a Qualified Life Event. Click the links below to learn more about making mid-year changes.

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<th>Qualified Life Events</th>
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<td><strong>Family or Personal Events</strong></td>
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<td>• Birth, Adoption or Legal Guardianship</td>
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<tr>
<td>• Marriage or Domestic Partnership</td>
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<tr>
<td>• Divorce, Legal Separation, or Termination of Domestic Partnership</td>
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<tr>
<td>• Leaves of Absence</td>
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<td>• Death of a Child, Spouse, or Employee</td>
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<td>• Transferring Between Campus and JPL or Other Areas of the Institute</td>
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<td>• Leaving Caltech or JPL</td>
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<tr>
<td><strong>Coverage or Eligibility Events</strong></td>
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<tr>
<td>• Child Turns 26 or Gains Coverage Elsewhere</td>
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<tr>
<td>• Employee and/or Dependent Gain or Lose of Coverage</td>
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<td>• CHIP/Medicaid Eligibility or Loss of Eligibility</td>
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<tr>
<td>• Significant Cost or Coverage Changes</td>
</tr>
</tbody>
</table>

Visit MyBenefits to view the full life events checklists and to take action during a Qualified Life Event.
About Qualified Life Events and What You Need to Do

You may make changes to your benefit elections—including adding or removing coverage or dependents—during the annual open enrollment period each fall. To make changes to your benefit elections outside of annual open enrollment, you must experience a Qualified Life Event.

You must make the change within 31 days after the event. If you do not complete your election change within the 31-day election period, you will lose your right to enroll (or make a change) until the next annual open enrollment period. The change must be relevant to the Qualified Life Events. During this 31-day election period, you may revoke your initial election and make changes as long as it is still within the original 31-day election period. You may make changes to your Health Savings Account (HSA), Supplemental Life Insurance, Personal Accident Insurance, and Medical Evacuation and Repatriation (MER) elections at any time during the year.

For more information about Qualified Life Events, including when your change in benefits will go into effect, see Enrolling In Your Health Benefits in 2018 Benefits Summary Plan Description – For Your Health and Welfare Benefits.

How to Enroll in Benefits

For Caltech: Log in at MyBenefits.caltech.edu or click MyBenefits in access.caltech.

For JPL: Log in at JPL Space and select the “MyBenefits” icon.

Need Help?

If you experience a Qualified Life Event and are not sure what coverage changes to make, contact the Caltech or JPL Benefits Office to discuss your options. Coverage options to consider include:

- Adding your dependent to your medical, dental and vision coverage;
- Modifying your life insurance (employee, spouse/domestic partner, child);
- Adding or changing health care and dependent care flexible spending account (FSA) elections;
- Adding or changing Health Savings Account (HSA) elections, if enrolled in the High Deductible PPO; and
- Updating your retirement benefits.
Family and Personal Events

Adding a New Dependent
Follow the steps below to add a new dependent—including through birth or marriage—to your coverage.

### Birth, Adoption, or Legal Guardianship

1. **Prepare for Your New Arrival**
   - If you are having a baby, contact the Social Security Administration at [www.ssa.gov](http://www.ssa.gov) to obtain a new Social Security number for your child.
   - Research parent and dependent care benefits on the MyBenefits website.
   - Notify your manager if you will be absent from work due to the arrival of your child. Discuss your plans for short-term disability (if giving birth), Family Medical Leave of Absence (FMLA), parental leave, and vacation.

2. **Add Your New Dependent to Caltech Benefits**
   - Add your new dependent to your Caltech benefits through the MyBenefits enrollment page.
   - You must add your new dependent(s) to your coverage within 31 days of the event. Coverage will begin on the child’s date of birth, adoption or foster placement.
   - For newborn children, you have 90 days from the birth of the child to also provide a valid Social Security number, but you must report the child’s enrollment within 31 days of birth.
   - If you fail to enroll your new dependent within 31 days, your next opportunity to enroll him or her for coverage is during annual open enrollment for elections that take effect as of January 1 of the following calendar year, or if there is a qualified change in status event that would allow for the child to be added to your coverage.

Continued
### Adding a New Dependent (continued)

**Marriage or Domestic Partnership**

1. **Update Your Information**
   - Contact the Social Security Administration at [www.ssa.gov](http://www.ssa.gov) to obtain a new Social Security card if you are changing your name.
   - Update your name, home/mailing address and/or phone number(s) with Caltech.

2. **Add Your New Dependent Spouse or Domestic Partner to Caltech Benefits**
   - Add your new dependent to your Caltech benefits through the MyBenefits enrollment page.
   - You must add your new dependent to your coverage within 31 days of the event.
   - If you fail to enroll your new dependent within 31 days, your next opportunity to enroll him or her for coverage is during annual open enrollment for elections that take effect as of January 1 of the following calendar year, or if there is a qualified change in status event that would allow for the dependent to be added to your coverage.
Dropping Dependent Coverage

Follow the steps below to remove a dependent from your coverage during a qualified change in status. If your child is losing Caltech coverage due to turning age 26, click here.

**Divorce, Legal Separation, or Termination of Domestic Partnership**

1. Update Your Information
   - Contact the Social Security Administration at [www.ssa.gov](http://www.ssa.gov) to obtain a new Social Security card if you are changing your name.
   - Update your name, home/mailing address and/or phone number(s) with Caltech.

2. Remove Your Spouse or Domestic Partner from Caltech Benefits
   - Once the divorce or termination of domestic partnership is final, remove your former spouse or domestic partner from your Caltech benefits through the MyBenefits enrollment page.
   - You must make changes to your coverage within 31 days of the divorce, legal separation, or termination of domestic partnership.

**Continuing Coverage and Divorce**

If, in anticipation of a divorce, you drop your spouse’s coverage during annual open enrollment or due to a change in status, under certain circumstances, your spouse will be offered COBRA continuation coverage from the date of divorce. The Campus or JPL Benefits Office must be notified when the divorce becomes final in order for COBRA to be available. Coverage will not be available from the date the spouse’s coverage was dropped until the date of divorce. This means there could be a lapse in coverage. For information about converting a plan to an individual policy, contact the plan carrier.
Continuing Coverage and Divorce (continued)

It is your legal responsibility to inform Caltech within 31 days of the date the qualified beneficiary loses coverage when divorce or a legal separation results in your spouse’s, domestic partner’s or dependents’ loss of eligibility for coverage, or when a child loses dependent status under the program or there is a termination of a relationship with your domestic partner. You must supply Caltech with a current address for your former spouse or domestic partner. Caltech will then notify you, your spouse, your domestic partner or your children of their rights under COBRA, supplying coverage, cost, and enrollment information.

Death of a Child, Spouse, or Employee

1. Resources for You and Your Family
   • Contact the Employee Assistance Program (EAP) for information about and assistance with bereavement and counseling services in your community.

2. Remove Your Spouse, Domestic Partner, or Dependent Child from Caltech Benefits
   • Remove your spouse, domestic partner or dependent child from your Caltech benefits through the MyBenefits enrollment page.
   • You must make changes to your coverage within 31 days of the death.

Leaves of Absence

You may be able to continue your benefits during a leave of absence.

Leaves of Absence

Plan Your Leave
   • Contact the Campus or JPL Benefits Office for more information on your rights to a leave and the options for benefit continuation, if permissible.

Transferring Between Campus and JPL or Other Areas of the Institute

If you transfer within the calendar year, your insurance and retirement benefits and costs remain the same, assuming your status, salary and/or hours do not change. Please contact the Campus or JPL Benefits Office for details.
Leaving Caltech or JPL
You may be able to continue your benefits when you leave Caltech or JPL.

### Leaving Caltech or JPL

**1. Prepare to Leave**
- Notify your manager.

**2. Plan Your Leave**
- Except for in the case of termination due to gross misconduct, you and your dependents may be eligible to continue your medical, dental, vision and health care flexible spending account coverage under COBRA. For more information about COBRA, contact the Campus or JPL Benefits Office.
- For information about converting a plan to an individual policy, contact the plan carrier.
- For information on converting your group life insurance coverage, contact the Campus or JPL Benefits Office.
Coverage or Eligibility Events

Child Turns 26 or Gains Coverage Elsewhere
Follow the checklist below if your child turns age 26 or gains coverage elsewhere.

Child Turns 26 or Gains Coverage Elsewhere

Change Your Caltech Benefits
- Remove your child from your Caltech benefits through the MyBenefits enrollment page.
- You must make changes to your coverage within 31 days to remove your child.
- If your child is losing Institute-sponsored coverage because he or she is no longer eligible, you can elect to continue coverage for your child through COBRA.

See Dropping Dependent Coverage for additional information about removing a dependent from your Institute-sponsored benefits.

Loss of Coverage or New Eligibility Elsewhere
Follow the steps below to update your coverage.

Employee and/or Dependent Gain or Lose of Coverage

Change Your Caltech Benefits
- You must make changes to your coverage within 31 days of when you and/or your dependent gain or loses coverage. If you fail to make changes within 31 days of losing coverage, your next opportunity to make changes will be during annual open enrollment. Elections will take effect January 1 of the following calendar year.

CHIP/Medicaid Eligibility or Loss of Eligibility

Change Your Caltech Benefits
- Make changes to your Caltech benefits through the MyBenefits enrollment page.
- You must make changes to your coverage within 31 days of losing eligibility for Children’s Health Insurance Program (CHIP) or Medicaid coverage. Coverage will be effective on the first day of the month following the date of the qualifying event.
- If you fail to enroll your eligible dependent within 31 days of losing or gaining coverage under another plan, your next opportunity to make changes will be during annual open enrollment. Elections will take effect January 1 of the following calendar year.
Significant Cost or Coverage Changes

If you experience a significant cost or coverage change during the year, this is considered a qualified life event. This includes:

- Substantial increases or decreases in cost charged to Benefit-Based Employees
- New benefit option introduced during the plan year
- Substantial decrease or change in network providers
- Significant reduction in benefit plan options
- Significant change in salary
- Open enrollment period of your spouse’s or domestic partner’s employer’s plan that is at a different time than Caltech’s annual open enrollment period

(Note: This does not apply to your enrollment in flexible spending accounts.)

Follow the steps below to update your coverage:

### Significant Cost or Coverage Changes

**Change Your Caltech Benefits**

- You must make changes to your coverage within 31 days of your significant cost or coverage change. Please contact the Campus or JPL Benefits Office for approval and directions.
Frequently Asked Questions

Eligibility and Enrolling

I am a new benefit eligible employee or I just had a Qualified Life Event, when do my benefits start and how do I enroll?
The majority of the benefits will start first of the month following the hire date or Qualified Life Event date, click here to learn more about when benefits start. To enroll in benefits in our benefit system, MyBenefits, click here to learn how to access the system.

Can I change my benefits mid-year?
You can change your benefits if you experience certain life events, such as a marriage, birth, divorce, or if your spouse/registered domestic partner gains or loses other coverage. When you have a major life event, it’s important to keep your benefits in mind and make updates as needed. If you want to make any changes or add a dependent after a life event, you must do so within 31 days of the event. Click here to learn more.

My dependent child is turning 26 and will no longer be covered on my plan. What are my options?
You child will be eligible for COBRA coverage for up to 36 months; click here to learn more.

When is the annual open enrollment?
Annual open enrollment will be announced each year, typically in the fall. During annual open enrollment, you can change your benefit plans, or add or delete family members without a Qualified Life Event.

What happens to my benefits when I resign or retire?
All benefit coverage, except for Long-term Disability (Basic LTD and Supplemental LTD), Business Travel Accident Insurance and Extra-Hazardous Duty Insurance, for you and your Dependents end at the end of the month of your last day worked. The other benefits listed will end on your last day of work. Click here to learn more.

I am an active employee who is at least age 65 and enrolled in a Health Savings Account, what happens if I choose to enroll in Medicare?
Medicare is not considered a high deductible medical plan. Even if you still are enrolled in the Caltech High Deductible Plan, you would no longer be eligible to make contributions into the HSA as long as you are enrolled in Medicare.
Am I eligible for retiree medical benefits?
You are eligible for retiree benefits when you are age 55 or older with 10 or more years of continuous benefit-based service with the Institute. You may also be retirement eligible when you are age 55 or older with 20 years of total service as long as you are a benefit-based employee during the last 12 months of your employment. [Click here](#) to learn more.

What happens if you are rehired after you retire?
If you are rehired as a Benefit-Based Employee after you have qualified for retiree health benefits, you and your Dependents will be covered under the Institute Medical, Dental and Vision plans available to active employees. Coverage will be effective the first of the month coincident with or next following your rehire date.

If you are rehired as a non-Benefit Based Employee after you have qualified for retiree health benefits, you and your Dependents may be covered under the Institute health plans offered to retirees.

What happens if my spouse, domestic partner, or parent is a Caltech retiree?
A Benefit-Based Employee who is a Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a Caltech retiree must be covered as a Benefit-Based Employee under the applicable benefit plans. Dependent children of a Benefit-Based Employee who is also a Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a Caltech retiree must also be covered as a Dependent under the plan for Benefit-Based Employees. Upon loss of Benefit-Based Employee status, the Spouse or Domestic Partner or surviving Spouse or Domestic Partner of a retiree and any Dependent children shall be covered under the retiree medical plan if the eligibility requirements for retiree medical plan coverage are satisfied.
About Your Benefits

How do I get an ID card? (medical, dental, vision, international SOS, MER, etc.)

Not all benefits will have an ID card. Please reference the below list of which benefits have ID cards and how you can receive it.

- **Medical, Dental, and Health Savings Account** – An ID/debit card will be sent from the carrier about 2-3 weeks after enrolling in benefits.
- **Medical Evacuation & Reparation and International SOS** – Contact the Campus or JPL Benefits Office to obtain an ID Card.
- **Vision** – An ID card is not provided. If you are seeing an in-network provider, the provider will use their online system. If you are seeing an out of network provider, the provider can contact VSP’s customer service team at 1-800-877-7195 to verify eligibility and benefits.
- **Employee Assistance Program** – An ID card is not provided. For Campus, please use your Caltech ID at the Staff and Faculty Consultation Center (SFCC). For JPL, please use the company password jpl with LifeMatters (1-800-367-7474 or mylifematters.com).
- **Disability Insurance, Life Insurance, Personal Accident Insurance, Business Travel Accident Insurance, and Extra Hazardous Duty Insurance** – An ID Card is not provided. Please contact the Campus or JPL Benefits Office to file a claim.
- **Health Care & Day Care Flexible Spending Accounts** – A debit card is not provided. Please go to [www.healthequity.com](http://www.healthequity.com) to seek reimbursement for eligible expenses.
How do I get reimburse through HSA, DCSA or HCSA?

- If your insurance claims appear in the ‘Claims & Payments’ section of the member portal automatically, you do not have to create additional claims for them.
- HSA has a card which you can use for reimbursement while the other spending accounts do not.
- For a dependent care reimbursement account (DCRA), many providers do not offer receipts. You can request reimbursement via the DCRA Reimbursement Form and include the provider’s signature as documentation.
- Reimbursements are typically processed within three business days.
- **Note:** You must seek reimbursement from your HCRA by March 31 of the following calendar year in order to be reimbursed.

To reimburse yourself:

1. Under the ‘Claims & Payments’ tab of the HealthEquity member portal, click ‘Add Claim.’
2. Select the account you would like to be reimbursed from and click ‘Next.’
3. Select ‘Reimburse Me’ and click ‘Next.’
4. Choose the expense type (‘New’ or ‘Existing’).
5. If it is a new expense, enter the required ‘Record Keeping Information’ and click ‘Next.’
   a. Provider name
   b. Name of person who incurred the expense
   c. Date expense was incurred
   d. Claim type
   e. Claim details
6. Enter the amount to be reimbursed.
7. Select the ‘Reimbursement Type’ and click ‘Next.’
   a. Mail me a check
   b. Electronic deposit into a bank account

Review the claim information, check the box that you authorize the reimbursement and click ‘Submit.’

FSA and DCRA: You must also add documentation that details your expenses. See [this page](#) for requirements. To add a document:

1. Select ‘Upload New Image.’ If you have uploaded the image to the documentation library already, you can choose ‘Link Existing Image’ and select it from the list that appears.
2. Click ‘Choose File’ and select the document from a location on your computer.
3. Enter the date of the document and document type. You can also enter any notes to support your claim.
4. Check the box to confirm your document and click ‘Submit.’
Health and Welfare Plan Disclosures and Administration

About This Summary Plan Description (SPD)

This summary should be read in combination with the insurance contracts, certificates of coverage or Evidence of Coverage documents (together and individually referred to as “EOCs”) provided by the HMOs, insurance companies and service providers.

The EOCs are intended to describe the benefits available to you, and, when read with this summary, are intended to meet ERISA’s SPD requirements.

Please see the EOCs for details of plan benefits.

For additional information or for copies of the EOCs, please contact the Campus or JPL Benefits Office.

Important Disclosures

Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
Women's Health and Cancer Rights Act

The plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse and your dependent child(ren).

- If the covered person receives benefits under the plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the plan.
Health and Welfare Claims and Appeal Process

Filing a Health and Welfare Plan Claim

This section provides general information about the claims and appeals procedure applicable to the plan under ERISA. The claims filing procedures are set forth in the EOCs. In general, any participant or beneficiary under the plan (or his or her authorized representative) may file a written claim for health and welfare benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrator. When the Claims Administrator receives your claim, it will be responsible for reviewing the health and welfare claim and determining how to pay it on behalf of the plan.

To ensure proper filing of health and welfare claims, refer to the claims filing procedures that are set forth in the EOCs. See the list of [Claims Administrators](#).

Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the EOCs for more information. If there are any discrepancies between the claims and appeals procedures in this summary and the applicable EOCs, then the EOCs will govern.

- For claim and appeal rules & for notice of Grandfathered Status for the Kaiser Permanente (Mid Atlantic) HMO plan, log into [MyBenefits](#).

For claim and appeal rules for your Health & Welfare Benefits, review the below:

- In the event of an adverse claim determination for a claim under health or disability benefits, the notice will also include:
  - 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; and
  - 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 (for health and disability benefit claims only).

Continued
Filing a Health and Welfare Plan Claim (continued)

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

- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the time frame for the expedited process, as long as written notice is provided no later than three days after the oral notice;
- Information sufficient to identify the claim involved (including the date of service, the health care provider and the claim amount, if applicable);
- 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 Care Flexible Spending Account and HRA claims are considered non-urgent “post-service” claims.

<table>
<thead>
<tr>
<th>Medical, Dental, Vision, Employee Assistance Plan, HRA &amp; Health Care Flexible Spending Account Plans</th>
<th>Short-Term &amp; Long-Term Disability</th>
<th>Life, AD&amp;D, Business Travel &amp; Voluntary Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Claims</strong>&lt;br&gt;Notice of determination (whether adverse or not) must be provided by the plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the plan shall provide notice as soon as possible, taking into account medical exigencies, but no later than 24 hours after receipt of the claim. Provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.</td>
<td>Notice of adverse determination (whether adverse or not) must be provided by the plan within a reasonable period of time, but no later than 30 days.</td>
<td>Notice of adverse determination must be provided within a reasonable period of time, but no later than 90 days.</td>
</tr>
<tr>
<td><strong>Non-Urgent “Pre-Service” Claims</strong>&lt;br&gt;Notice of determination (whether adverse or not) must be provided by the plan within a reasonable period of time, but no later than 15 days.</td>
<td><strong>“Concurrent Care” Decision to Reduce Benefits</strong>&lt;br&gt;Notice of adverse determination must be provided in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.</td>
<td>Notice of adverse determination must be provided by the plan within a reasonable period of time, but no later than 45 days.</td>
</tr>
<tr>
<td><strong>Non-Urgent “Post-Service” Claims</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Time frame for Providing Notice**

- **Urgent Care Claims**: Notice of determination (whether adverse or not) must be provided by the plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the plan shall provide notice as soon as possible, taking into account medical exigencies, but no later than 24 hours after receipt of the claim. Provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- **Non-Urgent "Pre-Service" Claims**: Notice of determination (whether adverse or not) must be provided by the plan within a reasonable period of time, but no later than 15 days.

- **Non-Urgent "Post-Service" Claims**: Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.

- **"Concurrent Care" Decision to Reduce Benefits**: Notice of adverse determination must be provided in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.

**Time Frames for Initial Claims Decisions**

- **Urgent Care Claims**: Notice of determination (whether adverse or not) must be provided by the plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the plan shall provide notice as soon as possible, taking into account medical exigencies, but no later than 24 hours after receipt of the claim. Provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- **Non-Urgent "Pre-Service" Claims**: Notice of determination (whether adverse or not) must be provided by the plan within a reasonable period of time, but no later than 15 days.

- **Non-Urgent "Post-Service" Claims**: Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.

- **"Concurrent Care" Decision to Reduce Benefits**: Notice of adverse determination must be provided in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.
### Period for Claimant to Complete Claim

<table>
<thead>
<tr>
<th>Product/Concept</th>
<th>Period for Claimant to Complete Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claims</td>
<td>You have at least 45 days to provide any missing information.</td>
</tr>
<tr>
<td>Non-Urgent &quot;Post-Service&quot; Claims</td>
<td>You have at least 45 days to provide any missing information.</td>
</tr>
<tr>
<td>&quot;Concurrent Care&quot; Decision to Reduce Benefits</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Other Related Notices

<table>
<thead>
<tr>
<th>Product/Concept</th>
<th>Other Related Notices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claims</td>
<td>Notice that your claim is improperly filed or that information is missing must be provided by the plan as soon as possible (no later than 24 hours after receipt of the claim by the plan).</td>
</tr>
<tr>
<td>Non-Urgent &quot;Post-Service&quot; Claims</td>
<td>Notice that your claim is improperly filed must be provided by the plan as soon as possible (no later than five days after receipt of the claim by the plan).</td>
</tr>
<tr>
<td>&quot;Concurrent Care&quot; Decision to Reduce Benefits</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the plan that the claim is missing information.
Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the Filing a Claim section of this SPD. If you don’t appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.
Appealing a Claim (continued)

For medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert’s reputation for outcomes in contested cases, rather than based on the professional’s qualifications.

Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon or generated by the plan (or at the direction of the plan) in connection with the medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the plan’s control, if the error occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the medical benefit plan, you may begin an expedited external review before the plan’s internal appeals process has been completed.
Appealing a Claim (continued)

The Claims Administrator will provide you with written notification of the plan’s determination on review, within the time frames described in the Time Frames for Appeals Process section of this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the plan and the claimant by telephone, fax or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the plan on which the determination is based;
- 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 the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health or disability benefit under the plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were 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.

For medical claim adverse benefit determinations, the notice will also include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider and the claim amount, if applicable);
- 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.
Appealing a Claim (continued)
The time periods for providing notice of the benefit determination on review depend on the type of claim, as provided in the above chart.

Unless the right to an external review applies under the medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review
For medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator’s decision and provide you with a written determination, as described in the Benefits Booklets.

The external review decision is binding on you and the plan, except to the extent other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

Legal Action
Before pursuing legal action for benefits under the plan, you must first exhaust the plan’s claim, review and appeal procedures. Additionally, any lawsuit you bring for plan benefits must be filed within 36 months of the date on which your claim is incurred under the plan, and must be filed in the U.S. District Court with jurisdiction over the claim.

For more information on your Retirement benefits, go to the Retirement Benefits Homepage >
Download a Printable Version of this SPD >
Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile or other available expeditious method. References to “days” mean calendar days. The plan can require two levels of mandatory appeal review.

<table>
<thead>
<tr>
<th>Medical, Dental, Vision, Employee Assistance Plan, HRA &amp; Health Care Flexible Spending Account Plans</th>
<th>Short-Term &amp; Long-Term Disability</th>
<th>Life, AD&amp;D, Business Travel, Legal &amp; Voluntary Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Period for Filing Appeal</strong></td>
<td><strong>Urgent Care Claims</strong>*</td>
<td><strong>Non-Urgent Care Pre-Service Claims</strong>*</td>
</tr>
<tr>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
<td>You have at least 180 days.</td>
</tr>
<tr>
<td><strong>Time frame for Providing Notice of Benefit Determination on Review</strong></td>
<td>As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.</td>
<td>Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.</td>
</tr>
</tbody>
</table>
### Time Frames for Appeals Process (continued)

<table>
<thead>
<tr>
<th></th>
<th>Medical, Dental, Vision, Employee Assistance Plan, HRA &amp; Health Care Flexible Spending Account Plans</th>
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<th>Life, AD&amp;D, Business Travel, Legal &amp; Voluntary Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Claims</strong></td>
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<tr>
<td><strong>Non-Urgent Care</strong></td>
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<tr>
<td><strong>Pre-Service Claims</strong></td>
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<tr>
<td><strong>Post-Service Claims</strong></td>
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<tr>
<td><strong>Extensions</strong></td>
<td>None.</td>
<td>None.</td>
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<td>None.</td>
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<td></td>
<td></td>
<td>None.</td>
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<td></td>
<td></td>
<td><strong>Additional 45 days if special circumstances require extension (with period “tolled” until you respond to any information request from the plan).</strong></td>
<td><strong>Additional 60 days if special circumstances require extension.</strong></td>
</tr>
</tbody>
</table>

* An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.
Claim-Related Definitions

Claim
“Claim” is 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:

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.

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).

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

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.
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;
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical benefit 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 benefits, 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 time frames 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; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
Other Rules Impacting Health and Welfare Benefits

Log into MyBenefits to review the following Health and Welfare notices, rules, and limits:

- HIPAA Privacy Notice
- Coordination of Benefits Rules
- Acts of Third Parties
- Recovery of Overpayment
- Non-assignment
- Misstatements and Misrepresentations
- Nondiscrimination
ERISA Rights and Plan Administration

Plan Administration Information

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

Plan Names/Numbers
The employer identification number assigned to the plan sponsor by the IRS is **95-1643307**. The official names of the plans and their plan numbers are shown below. Plans that do not have numbers are not subject to ERISA.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caltech Base Retirement Plan (Base Plan)</td>
<td>002</td>
</tr>
<tr>
<td>Caltech Voluntary Retirement Plan (Voluntary Plan or formerly referred to as ERISA TDA Plan)</td>
<td>005</td>
</tr>
<tr>
<td>Caltech 457(b) Deferred Compensation Plan (457(b) Plan)</td>
<td></td>
</tr>
<tr>
<td>Consolidated Welfare Plan of California Institute of Technology, which includes the following:</td>
<td></td>
</tr>
<tr>
<td>• Kaiser Permanente HMO</td>
<td></td>
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<tr>
<td>• Anthem Blue Cross Advantage HMO</td>
<td></td>
</tr>
<tr>
<td>• Anthem Blue Cross High Deductible PPO</td>
<td></td>
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<tr>
<td>• Delta Dental PPO</td>
<td></td>
</tr>
<tr>
<td>• MetLife/Safeguard Dental</td>
<td></td>
</tr>
<tr>
<td>• VSP PPO</td>
<td></td>
</tr>
<tr>
<td>• Employee Assistance Program (EAP)</td>
<td></td>
</tr>
<tr>
<td>• Life Insurance (Basic and Supplemental)</td>
<td></td>
</tr>
<tr>
<td>• Personal Accident Insurance (PAI)</td>
<td></td>
</tr>
<tr>
<td>• Disability Insurance (Basic LTD, Supplemental LTD and STD)</td>
<td>601</td>
</tr>
<tr>
<td>• Business Travel Accident Plan</td>
<td></td>
</tr>
<tr>
<td>• Extra-Hazardous Duty Insurance</td>
<td></td>
</tr>
<tr>
<td>California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HCSA not DCSA)</td>
<td></td>
</tr>
<tr>
<td>International SOS Medical Access/International Referral Service</td>
<td></td>
</tr>
<tr>
<td>Caltech Non-ERISA Tax-Deferred Annuity Plan (closed to new enrollments)</td>
<td></td>
</tr>
<tr>
<td>• TIAA accounts</td>
<td></td>
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<tr>
<td>• Fidelity accounts</td>
<td></td>
</tr>
<tr>
<td>• Prudential accounts</td>
<td></td>
</tr>
</tbody>
</table>
Plan Sponsor
The plan sponsor for all plans is the California Institute of Technology. You may contact the plan sponsor at the following addresses:

**Mailing Address for Caltech Employees:**
California Institute of Technology
1200 E. California Blvd
Mail Code 161-84
Pasadena, CA 91125

**Mailing Address for JPL Employees:**
JPL
4800 Oak Grove Dr.
Mail Code T1720-B
Pasadena, CA 91109

**Physical Address:**
California Institute of Technology
399 S. Holliston Ave
Mail Code 161-84
Pasadena, CA 91125

Plan Funding and Type of Administration
The Kaiser HMO, Vision Service Plan (VSP), MetLife DHMO (Safeguard), Aetna Life Insurance (Basic and Supplemental), Aetna Long Term Disability (Basic and Supplemental), Aetna Personal Accident Insurance, Hartford Business Travel Accident Insurance Plan, and Hartford Extra-Hazardous Insurance Plan benefits are fully insured and benefits are guaranteed under insurance contracts.

The Anthem HMO, Anthem PPO plans, the Delta Dental PPO, and the HealthEquity health care spending account (HCSA) are self-funded and benefits are paid out of general assets. Claims are administered by a third-party administrator. The Claims Administrator for the self-funded plans is responsible for determining whether you are entitled to benefits and authorizing payment.

The name and address of the Claims Administrator for the fully insured and self-funded plans are listed under the Claims Administrator section.
Source of Contributions
Employees who participate in the plan are required to make contributions for certain coverage. The California Institute of Technology, in its sole and absolute discretion, shall determine the amount of any required employee contributions under the plan and may increase or decrease the amount of the required contribution at any time. The California Institute of Technology may require different contribution levels for different classes of employees and will notify employees annually as to what the employee contribution rates will be.

The California Institute of Technology shall contribute the difference between the amount employees contribute and the premiums for the group insurance coverage. Any experience credits or refunds under a group insurance contract shall be applied first to reimburse The California Institute of Technology for its contributions, unless otherwise provided in that group insurance contract or required by applicable law. Voluntary coverages are paid entirely by employees.

Plan Administrator
The Plan Administrator for all plans is the Institute. Caltech has named the Sr. Director of Total Rewards, Human Resources to be responsible for enrolling participants and for performing other duties required for the operation of the plans.
Your ERISA Rights
As a participant in the Caltech 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.

Prudent Action by Plan Fiduciaries
In addition to creating rights for you, ERISA imposes duties on the people responsible for the operation of employee benefit plans. The people who operate your plan, called fiduciaries, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

If you have a claim for benefits denied or ignored in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the plan’s claims and appeals procedures, as described in your plan’s Evidence of Coverage (EOC). See the SPD’s Contacts and Resources section for detailed contact information.

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

Spouse’s Rights Under the ERISA Plans: Joint and Survivor Benefits Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan

Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan, benefits must be paid to married participants in the plan only as described below, unless a written waiver of the benefits by the participant and a written consent to the waiver by the spouse is filed with TIAA. This provision applies to both retirement benefits and pre-retirement death benefits.

If benefits began before your death, your surviving spouse at your death will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, the full current value of your annuity accumulation becomes payable (pre-retirement death benefit). Federal law requires that at least 50% of such benefit be paid to your spouse (with the remaining 50% paid to your designated beneficiary) unless your spouse has waived, and consented in writing to an alternate beneficiary for, such benefit. Pre-retirement death benefits are payable in a single sum or under one of the income options offered by TIAA.

Married participants and their spouses may waive the spouse’s right to a joint and survivor annuity or his or her pre-retirement death benefit only if a written waiver of the benefit signed by the participant and the spouse (and notarized) is filed with TIAA. The necessary forms will be provided to the participant by TIAA.

For post-retirement survivor benefits (joint and survivor annuity), the waiver may be made only during the 180-day period before benefits begin. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.
Spouse's Rights Under the ERISA Plans: Joint and Survivor Benefits Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan (continued)

The period during which you and your spouse may elect to waive the pre-retirement survivor death benefit begins on the first day of the plan year in which you reach age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before reaching age 35 — that is, before you have had the option to make a waiver — 50% of the current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by TIAA; the remaining 50% is payable to your designated beneficiary. If you terminate employment before age 35, the period for waiving the spousal pre-retirement death benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

If a judgment, decree, or order made following a state domestic relations law establishes the rights of another person (the "alternate payee") to your benefits under this plan, and if such an order (called a "qualified domestic relations order") is for providing child support, alimony, or other marital property payments, then payments will be made according to that order, provided the order does not conflict with the provisions of the plan or the terms of a previous qualified domestic relations order. If a court issues a qualified domestic relations order, the order overrides the usual requirements that your spouse be considered your primary beneficiary for a portion of the accumulation. Copies of the plan’s procedures relating to qualified domestic relations orders are available on written request to the Plan Administrator.

Since the Caltech Base Retirement Plan is a defined contribution plan, it is not insured by the Pension Benefit Guaranty Corporation (PBGC). The PBGC is the government agency that guarantees certain types of benefits under covered plans.

Contact the Plan Administrator

You may contact the Plan Administrator at the following addresses:

**Mailing Address for Caltech Employees:**
California Institute of Technology
1200 E. California Blvd
Mail Code 161-84
Pasadena, CA 91125

**Mailing Address for JPL Employees:**
JPL
4800 Oak Grove Dr.
Mail Code T1720-B
Pasadena, CA 91109

**Physical Address:**
California Institute of Technology
399 S. Holliston Ave
Mail Code 161-84
Pasadena, CA 91125
# Contact the Claims Administrator

Use the chart below to contact the Claims Administrator for each plan.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Claims Administrator Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
</tr>
<tr>
<td>Anthem Blue Cross High Deductible PPO</td>
<td>21555 Oxnard Street Woodland Hills, CA 91367</td>
</tr>
<tr>
<td>Anthem Blue Cross Health Savings Plan</td>
<td></td>
</tr>
<tr>
<td>Anthem Blue Cross Advantage HMO</td>
<td></td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc. (Southern CA)</td>
<td>Claims Department 1-800-390-3510 P.O. Box 7004 Downey, CA 90242-7004</td>
</tr>
<tr>
<td><strong>Group Health Cooperative</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td>Campus SFCC at 1-626-395-8360 or via e-mail: <a href="mailto:SFCC@caltech.edu">SFCC@caltech.edu</a> JPL EAP is through our vendor Empathia and is known as LifeMatters. Go to MyLifeMatters.com, company password is JPL, or call a counselor at any time at 1-800-367-7474</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
</tr>
<tr>
<td>Delta Dental of California (PPO Dental)</td>
<td>P. O. Box 997330 Sacramento, CA 95899-7330</td>
</tr>
<tr>
<td>MetLife (DHMO) Safeguard (Dental DHMO)</td>
<td>Claims Department P.O. Box 30930 Laguna Hills, CA 92654</td>
</tr>
</tbody>
</table>
## 2018 Summary Plan Description – For Your Health and Welfare Benefits

### Eligibility and Enrolling

### About Your Health Benefits

### What Happens If...

### Frequently Asked Questions

### Contacts

### Glossary

### Health and Welfare Plan Disclosures and Administration

### ERISA Rights and Plan Administration

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### ERISA Rights and Plan Administration

#### Plan Administration Information

#### Your ERISA Rights

#### Contact the Claims Administrator

#### Agent of Legal Process

#### Contract of Employment

#### Disclaimer

For more information on your Retirement benefits, go to the Retirement Benefits Homepage >

Download a Printable Version of this SPD >

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## Plan

<table>
<thead>
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<th>Plan</th>
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<tr>
<td>Vision</td>
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<tr>
<td>Vision Service Plan (VSP)</td>
<td>1-800-877-7195</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 385018</td>
</tr>
<tr>
<td></td>
<td>Birmingham, AL 35238-5018</td>
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<td>Health Equity</td>
<td>1-801-727-1590</td>
</tr>
<tr>
<td></td>
<td>15 W Scenic Pointe Dr, Ste 100</td>
</tr>
<tr>
<td></td>
<td>Draper, UT 84020</td>
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</tbody>
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<tr>
<td>Disability</td>
<td>P.O. Box 14560</td>
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<tr>
<td>Aetna Insurance Company</td>
<td>Lexington, KY 40512-4560</td>
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<th></th>
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<tr>
<td>Life Insurance and Accident Death &amp; Personal Loss (PAI)</td>
<td>51 Farmington Avenue</td>
</tr>
<tr>
<td>Aetna Life Insurance Service Center</td>
<td>Hartford, CT 06156</td>
</tr>
</tbody>
</table>

| Medical Access/International Referral Service | 1-800-523-6586 |
| International SOS | International SOS accepts collect calls from members overseas |

### Retirement Claims

#### Plan Administrator: Caltech

#### For Caltech employees:

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

#### For JPL employees:

- JPL
- 4800 Oak Grove Dr.
- Mail Code T1720-B
- Pasadena, CA 91109

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Agent of Legal Process
Any legal correspondence regarding the plans should be sent to:

General Counsel
California Institute of Technology
1200 E. California Blvd., 108-31
Pasadena, CA  91125

Contract of Employment Disclaimer
This SPD provides information about the benefit plans and does not constitute an implied or expressed contract or guarantee of employment.

Refer to the Health and Welfare Benefits and Retirement Plan sections for important notices and other specific plan administration including the rules on claims and appeals.
2018 Benefits Summary Plan Description

This SPD describes the benefits available to you and is intended to help you use each benefit more effectively. This SPD contains highlights of the benefit plans. Plan documents/insurance contracts contain supplemental information. If there is a discrepancy between the information in this SPD and in plan documents/insurance contracts, the plan documents/insurance contracts, including Evidence of Coverage (EOC) booklets, will govern. This SPD together with your evidence of coverage certificates, describes the benefits provided under the Caltech benefits program effective January 1, 2018, and constitutes the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA). The plans included in this document that are not subject to ERISA are so indicated.

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 Benefits office (see Contacts).

How Can We Help You?

Click the links below, on the left, or across the top to get to the information you need about your Retirement Plans.

- Caltech Base Retirement Plan
- Caltech Voluntary Retirement Plan
- 457(B)Deferred Compensation Plan

The Institute expects and intends to continue the Caltech benefits program but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time and for any reason. Any such amendment, modification, suspension or termination shall be executed by the Executive Committee of the Board of Trustees of the Institute, the VP of Administration and Chief Financial Officer and/or Associate VP of 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. Any payment of benefits depends on your eligibility to receive them.
About Your Retirement Benefits

Caltech Base Retirement Plan

How the Base Plan Works

The Caltech Base Retirement Plan (Base Plan or the plan) consists of employer contributions, and in some cases, employee contributions that are invested for your future financial security. As a defined contribution plan under Section 403(b) of the Internal Revenue Code, the Base Plan allows you to defer taxation on contributions and investment earnings until you withdraw your account from the Base Plan. Once you satisfy the eligibility requirements, you determine how your account is invested among the options offered by the Base Plan. The plan year begins on January 1 and ends on December 31.

Base Plan Eligibility

You are eligible to participate in the Base Plan if you are in one of the following employee categories:

- Faculty – A faculty member other than a lecturer, visiting associate or visitor.
- Key Staff – For a complete definition, see the Glossary.
- Benefit-Based Staff Employee – An employee or temporary staff employee on a regular schedule of 20 hours or more per week who is not covered by any other Institute-funded retirement plan. A temporary staff employee must also work for six consecutive months on a regular schedule of at least 20 hours per week to become eligible.

Eligible employees exclude:

- Leased employees
- Independent contractors
- Interim Employee Program (IEP) employees
- Institute employees who permanently reside and work outside of the United States
- Student employees such as, among others, summer hires, interns and academic part time
**Caltech Base Retirement Plan (Continued)**

**Base Plan Participation**

Once you become eligible, your participation begins as follows:

- **Staff Employees:** Mandatory participation begins on the first of the month following or coinciding with the date you earn six months of Eligibility Service, or years of service, (or, if later, the first of the month following or coinciding with the date you become an eligible Staff Employee).

- **Faculty:** Mandatory participation begins on the first of the month following or coinciding with your date of hire (or, if later, the first of the month following or coinciding with meeting eligibility requirements). However, participation is optional provided you are not a Highly Compensated Employee under the Internal Revenue Code, and you are a Visiting Professorial Faculty, or you are neither a citizen of the United States nor a permanent resident alien – in those cases, participation begins the first of the month after you complete an enrollment application. An election to participate on an optional basis is irrevocable.

- **Key Staff:** Mandatory participation begins on the first of the month following or coinciding with your date of hire as a Key Staff Employee (or, if later, the first of the month following or coinciding with the date you qualified as a Key Staff Employee). For grandfathered key staff employees, please refer to ‘Key Staff Employee’ in the Glossary.

- **Postdoctoral Scholars:** Mandatory participation begins on the first of the month following or coinciding with the date you earn two years of Eligibility Service (or, if later, the first of the month following or coinciding with the date you become a Postdoctoral Scholar).

Eligibility Service is used to determine a Staff Employee’s and Postdoctoral Scholar’s initial eligibility to participate in the Base Plan and Years of Service are used to determine Institute contributions to the Base Plan.

TIAA, the record keeper for the Caltech Retirement Plans, will notify you when you have completed the requirements for participation in the Base Plan. If you do not want to participate, you may make a written election not to participate within 30 days of first becoming eligible. However, once made, your election cannot be revoked and applies to your entire service with the Institute.
Caltech Base Retirement Plan (Continued)

About Your Retirement Benefits
Caltech Base Retirement Plan
Caltech Voluntary Retirement Plan
California Institute of Technology 457(b) Deferred Compensation Plan
Non-ERISA TDA

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Caltech Base Retirement Plan (Continued)

Your participation in the Base Plan may be impacted by the following special situations:

- Rehire: If you previously met the eligibility requirements of the Base Plan, you will participate immediately upon rehire as an Eligible Employee, unless you had previously elected not to participate. If you began payments from the Base Plan prior to reemployment, you may be required to discontinue those payments.
- Leave of absence: Special rules apply to paid or unpaid leave of absence, disability leave and military leave that falls under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994—see below for details.

Participation During an Approved Leave of Absence (Other Than Military or Disability)
During a paid leave of absence, both the Institute’s and your own contributions (if any) will continue, based on your rate of pay and the Social Security Wage Base in effect at the time your leave begins.

During an unpaid leave of absence granted for any reason other than qualified military service or disability, both the Institute’s and your own contributions (if any) will stop.

Participation in the Event of Military Leave
The Institute (Caltech/JPL) supports calls to military training and active duty and complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. During a period of qualified military leave, the Institute’s contributions will continue, based on your rate of pay in effect on the last day worked and taking into account the Minimum Compensation Level and the Social Security Taxable Wage Base. You may also continue to make mandatory and/or voluntary contributions (if applicable) during an unpaid military leave. Please contact the Benefits Office for a complete description of the Institute’s policies for military leaves.

Participation in the Event of Disability
If you become disabled (as defined by the Institute), the Institute’s contributions will continue during your period of disability until the end of your sixth month of leave or when your paid leave status ends, whichever is later.

Contributions for Faculty and Key Staff Employees will be based on the regular salary you were receiving and the Social Security Taxable Wage Base. Contributions for Staff Employees will be based on the rate of pay you were receiving at the time you became disabled.
Caltech Base Retirement Plan (Continued)

Base Plan Contributions

Contributions are generally made at least monthly. If you participate in the plan for only a part of a year, your contribution will be based on the portion of salary applicable to the period in which you participate.

Staff Employees and Postdoctoral Scholars - Institute Contributions

Your contributions are based on your pay, your job classification and your age or years of service with Caltech. For the contribution schedule applicable to Staff Employees and Postdoctoral Scholars, see the below:

<table>
<thead>
<tr>
<th>Completed Years of Service</th>
<th>Plan Contribution Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six months (two years for Postdoctoral Scholars) but less than 10 years</td>
<td>5.0% of gross pay**</td>
</tr>
<tr>
<td>Ten or more years and under age 50</td>
<td>8.0% of gross pay</td>
</tr>
<tr>
<td>Ten or more years and age 50 or older</td>
<td>12.0% of gross pay</td>
</tr>
</tbody>
</table>

If you return from qualifying military leave, you may be eligible for contributions covering the time you missed while on leave. Contact the Benefits Office for more information, and to let them know when you begin and end military leave.

* Contribution percentages become effective the first of the month after completion of the age and service requirements.

** Fellowship stipends distributed by Caltech are not considered “salary” eligible for retirement contributions.

Faculty and Key Staff Employee Contributions

For the contribution schedule applicable to Faculty and Key Staff Employees, including employee mandatory contributions, see the below:

Institute Contributions

- **Before age 55:** The Institute will contribute 8.3% times your annual regular salary up to the Social Security taxable wage base, plus 14% of your annual regular salary above the Social Security taxable wage base, which is $128,400 for 2018.
- **After age 55:** Beginning with the first of the month coincident with or following your 55th birthday, the Institute will contribute 12.3% of your annual regular salary up to the Social Security taxable wage base, plus 18% of your salary above the Social Security taxable wage base, which is $128,400 for 2018.
Caltech Base Retirement Plan (Continued)

**Participant Contributions**
You pay 5.7% of your annual regular salary, which is in excess of the Social Security taxable wage base. Participant contributions will be divided evenly over the year and will not be limited to the period you are not paying Social Security taxes. However, participant contributions will not be required for the following amounts:

- A regular salary increase that is paid in a lump sum instead of being paid throughout the year, if before the increase your regular salary was not in excess of the Social Security taxable wage base and you were not already making participant contributions; and
- Lump sum payments made under the Institute’s Early Retirement Option (effective January 1, 2005, the ERO benefit is discontinued for executive and senior management).

For 2018, the Social Security taxable wage base is $128,400.

**Adjustment to contribution rates if Social Security tax rates increase:** In the unlikely event that the Social Security tax rate for old age benefits increases above the current 5.7%, the contribution rates described above will be adjusted as follows:

- Before age 55, the 8.3% Institute contribution rate on annual regular salary up to the Social Security taxable wage base will equal 14% minus the new Social Security tax rate.
- After age 55, the 12.3% Institute contribution rate on annual regular salary up to the Social Security taxable wage base will equal 18% minus the new Social Security tax rate.
- Employee contribution percentages will equal the new Social Security tax rate.

**Regular Salary**
For Faculty, regular salary means the salary stated in the academic year contract. For Key Staff Employees, regular salary means salary (including a regular salary increase that is paid in a lump sum) exclusive of benefits, overtime, bonuses, commissions, extended workweek compensation, per diem, shift differential, field rate bonuses, flight bonuses, offset service pay and similar pay. Regular salary includes any differential wage payments made during a period of qualified military service. Regular salary excludes all compensation paid after severance of employment, except as permitted under Internal Revenue Code Section 415.

Regular salary includes, in the case of a Faculty member or Key Staff Eligible Employee, the lump sum payment, if any, paid under the Institute’s Early Retirement Option. In addition, for terminating or retiring Key Staff Employees, regular salary shall include any amounts paid under a separation and/or severance program (to the extent such amounts are paid on or before the employee’s date of termination) and any unused vacation pay.

Continued
Caltech Base Retirement Plan (Continued)

Base Plan Contributions (continued)

Fellowship stipends distributed by Caltech are not considered “salary” eligible for Institute contributions. In no event will the regular salary taken into account under the plan exceed the limits of Internal Revenue Code Section 401(a)(17). (The limit for 2018 is $275,000. This amount is adjusted under the Code to reflect cost of living increases.)

For the purposes of determining whether or not regular salary exceeds the Minimum Compensation Level, a participant’s hourly rate of pay (a regular salary increase which is paid in a lump sum is excluded when determining a participant’s hourly rate) is compared with the equivalent Minimum Compensation Level hourly rate. The equivalent Minimum Compensation Level hourly rate is determined as follows:

- The annual Minimum Compensation Level is converted to a full-time weekly salary rate and truncated to whole dollars, and
- This weekly salary rate is converted to an hourly rate assuming a full-time workweek.

If you return from qualifying military leave, you may be eligible for contributions covering the time you missed while on leave. Contact the Benefits Office for more information, and to let them know when you begin and end military leave.

Election to Remain a Staff Employee

A Staff Employee under age 55 who is promoted to a Key Staff classification or reaches the Minimum Compensation Level, and who is considered a “non-highly compensated employee” under the Internal Revenue Code (for 2018, defined as having current annualized gross pay less than $120,000) may elect to remain a Staff Employee for purposes of the plan. The election to remain a Staff Employee must be made within 15 business days of being notified of the change. Such an election remains in effect, even if the employee becomes a “highly compensated employee” under the Internal Revenue Code, until the first of the month coincident with or the next following the employee’s 55th birthday, at which point the employee will participate in the plan as a Key Staff Employee, provided he/she still satisfies the definition of Key Staff Employee.

The contributions made on your behalf for any year will not exceed the limits imposed by the Internal Revenue Code. For more information on these limits, contact TIAA or log into MyBenefits.
Caltech Base Retirement Plan (Continued)

Base Plan Investments

A wide range of investment options are available to help you achieve your retirement savings goals. You choose how to invest your contributions among the available investment options. If you don’t make an affirmative investment election, your contributions will be invested in the plan’s QDIA which is a TIAA-CREF Lifecycle Fund with the targeted retirement date that is closest to your 65th birthday (click on the applicable TIAA-CREF Lifecycle Fund year nearest to your age 65 for information about the fund). You may change your investment elections or transfer existing account balances between funds by contacting TIAA, consistent with applicable restrictions. Elections made by 4:00 pm ET will take effect the next business day on which the stock market is open.

The Base Plan is intended to qualify as a participant-directed account plan under ERISA Section 404(c). This means you bear responsibility for selecting the investment options that best meet your situation. ERISA Section 404(c) is a Department of Labor regulation relating to investment options made available by plan sponsors for employer tax-qualified savings plans. Under these regulations, plan sponsors are not liable for investment losses incurred by plan participants, provided the plan sponsor makes available appropriate, reasonably priced investment options that provide participants an appropriate opportunity to diversify their investments. Plan sponsors must also meet disclosure requirements related to the fund’s objectives, policies and fees, and must provide sufficient opportunity for participants to make changes in their investment selections.

In the event that a participant does not make an investment selection, plan sponsors may invest the participant’s account in a default fund, provided the default fund meets certain requirements under this regulation.

Caltech’s Retirement Plan Investment Oversight Committee (RPIOC) will periodically review the investment options to ensure the funds continue to meet plan objectives. You will be notified of any investment changes. Visit the TIAA website for the latest investment options, or click here.

TIAA offers a number of services, including personalized investment advice, to help you evaluate your investment options. Individual appointments are available with TIAA consultants. Call 1-800-732-8353, option 1 or log into www.tiaa.org/schedulenow-caltech or www.tiaa.org/schedulenow-jpl to schedule an appointment.

Vesting of Base Plan Contributions

You are fully and immediately vested in your plan accounts. Such amounts are non-forfeitable.
Caltech Base Retirement Plan (Continued)

**Base Plan Withdrawals and Distributions**

**Withdrawals**
You may elect an in-service withdrawal if you are at least age 59½ and you are no longer a Benefit-Based Employee, provided it is permitted under the provisions of the relevant funding vehicle. Otherwise, generally, you must wait until you terminate employment to begin distributions. Special distribution rules apply if you reach age 70½, or become deceased. You are encouraged to review your situation with your tax advisor.

**Distributions**
Some retirement distributions are eligible to be rolled over to an IRA or another retirement plan. Rolling over your account may allow you to preserve the tax-favored treatment of your account until you are ready to begin receiving distributions. Please contact TIAA for information on your rollover options.

You should carefully consider the tax consequences of any distribution. Most distributions received before age 59½ are subject to a 10% federal excise tax. Contact TIAA for more information on the potential tax implications. You are also encouraged to review your situation with your tax advisor.

Your benefit may generally be paid in the following forms:

- **Lump sum** – A single payment of the entire balance of your account
- **Rollover** – All or a portion of your account balance transferred to another retirement plan or IRA
- **Installment** – Systematic payments (monthly, quarterly or annually) of a set amount or over a set period of years
- **Annuity** – Guaranteed payments spread out over your lifetime (or the joint lifetimes of you and your beneficiary), or over a fixed period of time

If you are married, you will need to obtain spousal consent to elect a benefit or a survival benefit for your spouse, as required by law. This requirement does not apply to distributions from the 457(b) Plan.

Contact TIAA to determine which distribution options are available to you, and to schedule your distribution. You should schedule your distribution at least two months in advance of when the distribution is desired to allow for the application and processing of your request.

Some retirement distributions are eligible to be rolled over to an IRA or another retirement plan. If you have a balance in the 457(b) Plan, you may roll your account over only to another tax-exempt employer’s 457(b) plan. Rolling over your account may allow you to preserve the tax-favored treatment of your account until you are ready to begin receiving distributions. Please contact TIAA for information on your rollover options.
Caltech Base Retirement Plan (Continued)

Base Plan Withdrawals and Distributions (continued)

**Special Distribution Rules**

**Required Distributions Starting at Age 70½**

Generally, you can wait until you terminate employment with Caltech to start payments. Federal law requires that retirement benefits must begin:

- If you reached age 70½ before January 1, 2000 – No later than the April 1 following the year in which you reach age 70½; or
- If you reach age 70½ after December 31, 1999 – No later than the April 1 following the later of the year in which you reach age 70½ or the year in which you retire.

Some examples:

- Maria reached age 70½ in 2017 and will retire in 2018. She must begin receiving benefits no later than April 1, 2019.

TIAA will automatically contact you several months before the date you are required to begin receiving your distribution. It is important that you begin receiving benefits as required. Federal law imposes a 50% excise tax on the portion of the benefit that was not paid when due.

**Death Benefits**

If you die before beginning to receive benefits, your entire balance is payable as a lump sum to your beneficiary or beneficiaries. If you die after beginning to receive benefits, your remaining benefit will be paid at least as rapidly as under the distribution option you selected.

If you have not selected a beneficiary, your account will be paid 50% to your spouse and 50% to your estate, or 100% to your estate if you are not married.

Federal rules place limits on the timing of death benefits. Please contact TIAA to determine how those rules apply to your situation, as well as the distribution options that are available, including any beneficiary rights to roll over a distribution to an inherited IRA or to another retirement plan.
### Caltech Base Retirement Plan (Continued)

#### Base Plan Withdrawals and Distributions (continued)

**Withdrawals While on Military Leave**

If you are called to active military duty for more than 30 days, you are eligible to withdraw part or all of your Caltech Voluntary Retirement Plan accounts, even though you may be considered still actively employed. In that event, your voluntary pre-tax deferrals to the plan will be suspended for six months. If you are ordered to active duty for at least 180 days, you may be eligible to receive a qualified reservist distribution, which does not require a suspension of deferrals. Contact the Benefits Office for additional information.

#### Base Plan Beneficiaries

It’s very important that you keep your beneficiary designations up to date for all retirement plans to avoid an unnecessary burden for your beneficiaries. To update your beneficiaries, call TIAA or log in to your account at www.tiaa.org. Active employees can also access their accounts online through MyBenefits:

- Campus employees: Log in to MyBenefits through access.caltech.
- JPL employees: Log in to MyBenefits through JPL Space Intranet and select the MyBenefits heart icon, or go to the HR website and select Benefits and Life Events, then MyBenefits

#### Base Plan Loans

If you are actively employed, you may be able to borrow against your plan account.

- Maximum number of outstanding loans: 4 at a time
- Loan term: 5 years, or 10 years for purchase of primary residence
- Minimum amount: $1,000
- Maximum amount: Lesser of 50% of vested account or $50,000 (may be reduced by loans taken in previous years and loans in other Caltech Retirement Plans)
- Interest rate: Contact TIAA for current rate
- Spousal consent required if you are married

You will be required to make regular repayments on your loan until it is paid off. During a period of qualifying military leave, your loan payments may be suspended. If you default on your loan repayments, the outstanding balance of your loan will become taxable income, and you may also be subject to an additional 10% excise tax. You may want to consult with a financial planner or tax advisor before requesting a loan from the Base Plan.

The IRS requires that plan loans be repaid through regularly scheduled repayments sufficient to pay off the loan by the established term of the loan. In the event that a loan repayment is missed, the IRS requires that the missed payment be made up by the end of the following calendar quarter.

Example: Jill makes monthly payments of $100 on her Voluntary Retirement Plan loan. Jill missed her February payment. She has until June 30 of that year to make up the missed payment.
Caltech Base Retirement Plan (Continued)

**Base Plan Loans**

| If you do not repay a missed payment by the end of the following calendar quarter, the loan is considered in default, and the balance of the loan becomes taxable income. You will receive an IRS Form 1099-R for the year of the missed payment. In addition, if you are under age 59½, you may owe an additional 10% penalty tax for early withdrawal of the loan amount. Note that if your account is not available for a distributable event (e.g., employment termination), the outstanding loan amount plus accrued interest will remain as part of your account until such time as it can be deemed a distribution from your account. During this time, the loan will count against the $50,000 IRS limit on plan loans, and may reduce the amount available to you for future loans.

If you have a distributable event and you do not pay off the outstanding balance before the end of the following quarter, the loan will be defaulted and deemed a distribution of the account, and the loan will no longer be attributed to your account.

Contact TIAA to find out more details on plan loans, including how much you are able to borrow, or to request a loan.

<table>
<thead>
<tr>
<th><strong>Base Plan Fees</strong></th>
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</thead>
<tbody>
<tr>
<td>In addition to investment fees that are described in the investment fund prospectus, your account may be charged for certain transactions that you initiate, for example when you initiate a loan from the Base Plan. Please refer to the fee disclosure statement you receive annually from TIAA, or go to <a href="https://www.tiaa.org/public/investment-performance">https://www.tiaa.org/public/investment-performance</a> and enter plan number 403497 for current fund performance and fees/expenses information. Contact TIAA for questions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>More Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Caltech Base Retirement Plan document is available upon request from the Plan Administrator.</td>
</tr>
</tbody>
</table>
**Caltech Voluntary Retirement Plan**

**How the Voluntary Plan Works**

The Caltech Voluntary Retirement Plan (Voluntary Plan or the plan) allows you to defer a portion of your current pay to be invested for your future financial security. As a defined contribution plan under Section 403(b) of the Internal Revenue Code, the Voluntary Plan allows you to defer taxation on your contributions and investment earnings until you withdraw your funds from the Voluntary Plan. You determine how your account is invested among the options offered by the Voluntary Plan. The plan year begins on January 1 and ends on December 31.

This Voluntary Plan was formerly referred to as the ERISA TDA Plan.

**Voluntary Plan Eligibility**

All individuals who are classified as an employee on the Caltech or JPL payrolls may participate in the Voluntary Plan. Visiting professors who are considered employees of another organization and those receiving non-taxable pay under a tax treaty are not eligible to participate.

**Voluntary Plan Enrollment**

You may enroll in the Voluntary Plan at any time. Your salary deferrals will start with the first pay period following receipt of your deferral election, provided it is received by the pay period cutoff date. A calendar of the pay period cutoff dates for Caltech and JPL is available when you log in to your account at www.tiaa.org or if you call TIAA.

**Voluntary Plan Contributions**

Contributions are deducted from your paycheck on a pre-tax basis and are forwarded to TIAA for investment. Total contributions made for any year will not exceed the limits imposed by the Internal Revenue Code. For more information on these limits, contact TIAA or log into MyBenefits.

You may start, change, or stop your plan contributions at any time by contacting TIAA.

If you return from qualifying military leave, you may be able to “catch up” on contributions you missed while on leave. Contact the Benefits Office for more information, and to let them know when you begin and end military leave.

Upon retirement, you might be eligible to contribute a portion of your unused sick leave credit to the voluntary plan.

If you have an account balance in the Caltech Non-ERISA TDA Plan (frozen as of December 31, 2009), you may be able to elect to transfer funds from the Non-ERISA TDA Plan to this Voluntary Plan. Contact TIAA, Fidelity or Prudential as appropriate to see if this applies to you.

You may be able to roll over your balance from your prior employer’s retirement plan. You may not roll after-tax or Roth contribution accounts. Contact TIAA for more information, or to initiate a rollover contribution.
Caltech Voluntary Retirement Plan (Continued)

Voluntary Plan Investments

A wide range of investment options are available to help you achieve your retirement savings goals. You choose how to invest your contributions among the available investment options. If you don’t make an affirmative investment election, your contributions will be invested in the Plan’s QDIA which is a TIAA-CREF Lifecycle Fund, with the targeted retirement date that is closest to your 65th birthday (click on the applicable TIAA-CREF Lifecycle Fund year nearest to when you are age 65 for information about the fund). You may change your investment elections or transfer existing account balances between funds at any time by contacting TIAA. Elections made by 4:00 pm ET will take effect the next business day on which the stock market is open.

The Voluntary Plan is intended to qualify as a participant directed account plan under ERISA Section 404(c). This means you bear responsibility for selecting the investment options that best meet your situation. ERISA Section 404(c) is a Department of Labor regulation relating to investment options made available by plan sponsors for employer tax-qualified savings plans. Under these regulations, plan sponsors are not liable for investment losses incurred by plan participants, provided the plan sponsor makes available appropriate, reasonably priced investment options that provide participants an appropriate opportunity to diversify their investments. Plan sponsors must also meet disclosure requirements related to the fund’s objectives, policies and fees, and must provide sufficient opportunity for participants to make changes in their investment selections.

In the event that a participant does not make an investment selection, plan sponsors may invest the participant’s account in a default fund, provided the default fund meets certain requirements under this regulation.

Caltech’s Retirement Plan Investment Oversight Committee (RPIOC) will periodically review the investment options to ensure the funds continue to meet plan objectives. You will be notified if there are any changes to investments. Click here for the latest investment options.

TIAA offers a number of services, including personalized investment advice, to help you evaluate your investment options. Individual appointments are available with TIAA consultants. Call 1-800-732-8353, option 1 or log in to www.tiaa.org/schedulenow-caltech or www.tiaa.org/schedulenow-jpl to schedule an appointment.

Vesting of Voluntary Plan Contributions

You are fully and immediately vested in your plan accounts. Such amounts are non-forfeitable.
### Caltech Voluntary Retirement Plan (Continued)

<table>
<thead>
<tr>
<th>Voluntary Plan Withdrawals and Distributions</th>
<th>Withdrawals</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, you may begin receiving your benefits following termination of employment, becoming disabled, as defined by the Voluntary Plan, or after reaching age 59½. Special distribution rules apply if you reach age 70½, pass away or are on qualifying military leave. You are encouraged to review your situation with your tax advisor.</td>
<td></td>
</tr>
</tbody>
</table>

#### Distributions

Some retirement distributions are eligible to be rolled over to an IRA or another retirement plan. Rolling over your account may allow you to preserve the tax-favored treatment of your account until you are ready to begin receiving distributions. Please contact TIAA for information on your rollover options.

You should carefully consider the tax consequences of any distribution. Most distributions received before age 59½ are subject to a 10% federal excise tax. Contact TIAA for more information on the potential tax implications.

You are also encouraged to review your situation with your tax advisor.

Your benefit may generally be paid in the following forms:

- **Lump sum** – A single payment of the entire balance of your account
- **Rollover** – All or a portion of your account balance transferred to another retirement plan or IRA
- **Installment** – Systematic payments (monthly, quarterly or annually) of a set amount or over a set period of years
- **Annuity** – Guaranteed payments spread out over your lifetime (or the joint lifetimes of you and your beneficiary), or over a fixed period of time

If you are married, you will need to obtain spousal consent to elect a benefit or a survival benefit for your spouse, as required by law. This requirement does not apply to distributions from the 457(b) Plan.

Contact TIAA to determine which distribution options are available to you, and to schedule your distribution. You should schedule your distribution at least two months in advance of when the distribution is desired to allow for the application and processing of your request.

Some retirement distributions are eligible to be rolled over to an IRA or another retirement plan. If you have a balance in the 457(b) Plan, you may roll your account over only to another tax-exempt employer’s 457(b) plan. Rolling over your account may allow you to preserve the tax-favored treatment of your account until you are ready to begin receiving distributions. Please contact TIAA for information on your rollover options.
### Voluntary Plan Withdrawals and Distributions (continued)

<table>
<thead>
<tr>
<th><strong>Special Distribution Rules</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Distributions Starting at Age 70½</strong></td>
</tr>
<tr>
<td>Generally, you can wait until you terminate employment with Caltech to start payments. Federal law requires that retirement benefits must begin:</td>
</tr>
</tbody>
</table>

- If you reached age 70½ before January 1, 2000 – No later than the April 1 following the year in which you reach age 70½; or
- If you reach age 70½ after December 31, 1999 – No later than the April 1 following the later of the year in which you reach age 70½ or the year in which you retire.

Some examples:

- Maria reached age 70½ in 2017 and will retire in 2018. She must begin receiving benefits no later than April 1, 2019.

TIAA will automatically contact you several months before the date you are required to begin receiving your distribution. It is important that you begin receiving benefits as required. Federal law imposes a 50% excise tax on the portion of the benefit that was not paid when due.

### Death Benefits

If you die before beginning to receive benefits, your entire balance is payable as a lump sum to your beneficiary or beneficiaries. If you die after beginning to receive benefits, your remaining benefit will be paid at least as rapidly as under the distribution option you selected.

If you have not selected a beneficiary, your account will be paid 50% to your spouse and 50% to your estate, or 100% to your estate if you are not married.

Federal rules place limits on the timing of death benefits. Please contact TIAA to determine how those rules apply to your situation, as well as the distribution options that are available, including any beneficiary rights to roll over a distribution to an inherited IRA or to another retirement plan.
## Caltech Voluntary Retirement Plan (Continued)

### Voluntary Plan Withdrawals and Distributions (continued)

#### Withdrawals While on Military Leave

If you are called to active military duty for more than 30 days, you are eligible to withdraw part or all of your Caltech Voluntary Retirement Plan accounts, even though you may be considered still actively employed. In that event, your voluntary pre-tax deferrals to the plan will be suspended for six months. If you are ordered to active duty for at least 180 days, you may be eligible to receive a qualified reservist distribution, which does not require a suspension of deferrals. Contact the Benefits Office for additional information.

### Voluntary Plan Beneficiaries

It’s very important that you keep your beneficiary designations up to date, to avoid any unnecessary burdens for your beneficiaries. To update your beneficiaries, call TIAA or log into your account at [www.tiaa.org](http://www.tiaa.org). Active employees can also access their accounts online through MyBenefits:

- Campus employees: Log in to MyBenefits through access.caltech.JPL employees: Log in to MyBenefits through JPL Space Intranet and select the MyBenefits heart icon, or go to the HR website and select Benefits and Life Events, then MyBenefits

### Voluntary Plan Hardship Withdrawals

You may be permitted to withdraw a portion of your contributions in the case of a Financial Hardship, as defined by the IRS. If you take a hardship withdrawal, any voluntary pre-tax deferrals to Caltech-sponsored plans will be suspended for six months. Hardship withdrawals taken before age 59½ are subject to a 10% federal excise tax. After the six-month suspension is over, you must make a new deferral election if you wish to continue making future contributions to the Voluntary Plan.

A financial hardship is an immediate and heavy financial need that can’t be met from any other reasonably available source and is needed to:

- Purchase your principal residence (not including mortgage payments) or repair casualty damage to your principal residence.
- Prevent eviction from or foreclosure on your principal residence.
- Pay tuition and related expenses over the next 12 months for post-high school education for yourself, your spouse or an eligible dependent.
- Pay medical expenses for yourself, your spouse or eligible dependents.
- Pay burial or funeral expenses for your deceased parent, spouse, child or dependent.

Contact TIAA for information about hardship withdrawals and making or changing your deferral elections.
Caltech Voluntary Retirement Plan (Continued)

Voluntary Plan Loans

If you are actively employed, you may be able to borrow against your plan account.

- Minimum amount: $1,000
- Maximum amount: Lesser of 50% of vested account or $50,000 (may be reduced by loans taken in previous years and loans in other Caltech Retirement Plans)
- Loan term: 5 years, or 10 years for purchase of primary residence
- Interest rate: Contact TIAA for current rate
- Spousal consent required if you are married
- The number of loans available depends on the amount of your account balance and whether you have had any other loans from any of Caltech’s plans within the past year
- You will be required to make regular repayments on your loan until it is paid off. During a period of qualifying military leave, your loan payments may be suspended. If you default on your loan repayments, the outstanding balance of your loan will become taxable income, and you may be subject to an additional 10% excise tax. You may want to consult with a financial planner or tax advisor before requesting a loan from the Voluntary Plan.

The IRS requires that plan loans be repaid through regularly scheduled repayments sufficient to pay off the loan by the established term of the loan. In the event that a loan repayment is missed, the IRS requires that the missed payment be made up by the end of the following calendar quarter.

Example: Jill makes monthly payments of $100 on her Voluntary Retirement Plan loan. Jill missed her February payment. She has until June 30 of that year to make up the missed payment.

If you do not repay a missed payment by the end of the following calendar quarter, the loan is considered in default, and the balance of the loan becomes taxable income. You will receive an IRS Form 1099-R for the year of the missed payment. In addition, if you are under age 59½, you may owe an additional 10% penalty tax for early withdrawal of the loan amount. Note that if your account is not available for a distributable event (e.g., employment termination), the outstanding loan amount plus accrued interest will remain as part of your account until such time as it can be deemed a distribution from your account. During this time, the loan will count against the $50,000 IRS limit on plan loans, and may reduce the amount available to you for future loans.

If you have a distributable event and you do not pay off the outstanding balance before the end of the following quarter, the loan will be defaulted and deemed a distribution of the account, and the loan will no longer be attributed to your account.

Contact TIAA to find out more about plan loans, including how much you are able to borrow, or to request a loan.
Caltech Voluntary Retirement Plan (Continued)

Voluntary Plan Fees  
In addition to investment fees that are described in the investment fund prospectus, your account may be charged for certain transactions that you initiate, for example when you initiate a loan from the Voluntary Plan. For detailed information on plan fees, please refer to the fee disclosure notice you receive annually from TIAA, or go to [www.tiaa.org/public/investment-performance](http://www.tiaa.org/public/investment-performance) and enter plan number 403498, or contact TIAA.

More Information  
The Caltech Voluntary Retirement Plan document is available upon request from the [Plan Administrator](mailto:plan_administrator@caltech.edu).
# California Institute of Technology 457(b) Deferred Compensation Plan

## How the 457(b) Plan Works

The Caltech 457(b) Deferred Compensation Plan (the 457(b) Plan) is a tax-deferred compensation plan. You make pre-tax contributions to the 457(b) Plan, reducing your current taxable income, so you pay less in taxes now. Your earnings also remain tax-free until you begin making withdrawals. If eligible, you can participate in this plan in addition to participating in the Caltech Base Retirement Plan and the Caltech Voluntary Retirement Plan. For a comparison of the Voluntary Plan and the 457(b) Plan, log into [MyBenefits](#).

The plan year begins on January 1 and ends on December 31.

## 457(b) Plan Eligibility

The 457(b) Plan is available to active faculty and staff who are scheduled to work at least 20 hours per week and who meet the salary threshold for eligibility. Professors Emeriti, Lecturers, Visitors and Postdoctoral Scholars are not eligible.

Newly hired employees whose annual rate of salary (excluding regular increases paid as a lump sum) meets the salary threshold become eligible upon hire. Employees who do not initially meet the salary threshold but who subsequently meet the salary threshold as of November 1 of each year become eligible on January 1 of the following year. For example, the November 1, 2017, salary threshold of $228,960 would determine your eligibility to participate in the plan for the plan year beginning January 1, 2018. The Plan Administrator determines the new salary rate threshold as of each November 1 for determining who is eligible for the Plan the following January 1.

Starting in 2017, the salary rate threshold for eligibility was amended to align with 180% of the Social Security Taxable Wage Base in a given year. Employees already eligible for the 457(b) Plan whose annual rate of salary remains at or above the IRS Highly Compensated Employee (HCE) pay threshold ($120,000 for 2018) as of November 1 of each year will continue to be eligible for the 457(b) Plan the following plan year.

However, if your annual rate of salary falls below the HCE threshold, you will not be able to make contributions to the plan effective the following January 1. You may become eligible for the plan in a future year if your annual rate of salary equals or exceeds the indexed salary rate threshold in effect on a subsequent November 1.

## 457(b) Plan Enrollment

You can enroll or change your deferral amount at any time throughout the year. However, you must make your election in the month prior to when you wish to participate in the plan or change your deferral amount. Check with TIAA for the deferral election schedule.
### California Institute of Technology 457(b) Deferred Compensation Plan (Continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>457(b) Plan Contributions</strong></td>
<td>You can contribute up to the IRS limit ($18,500 in 2018). You choose how to invest your contributions among the available investment options. You may change your investment elections at any time by contacting TIAA.</td>
</tr>
<tr>
<td><strong>457(b) Plan Investments</strong></td>
<td>A wide range of investment options are available to help you achieve your retirement savings goals. You choose how to invest your contributions among the available investment options. If you don’t make an affirmative investment election, your contributions will be invested in the TIAA Traditional Fund and click on TIAA Traditional Fund for more information about the fund. You may change your investment elections or transfer existing account balances between funds at any time by contacting TIAA. Elections made by 4:00 pm ET will take effect the next business day on which the stock market is open. Caltech’s Retirement Plan Investment Oversight Committee (RPIOC) will periodically review the investment options to ensure that the funds continue to meet plan objectives. You will be notified if any investment changes occur. Visit <a href="http://www.tiaa.org/public/tcm/caltech/view-all-investments">www.tiaa.org/public/tcm/caltech/view-all-investments</a> for the latest investment options. TIAA offers a number of services, including personalized investment advice, to help you evaluate your investment options. Individual appointments are available with TIAA consultants.</td>
</tr>
<tr>
<td><strong>Vesting of 457(b) Plan Contributions</strong></td>
<td>You are fully and immediately vested in your plan accounts. Such amounts are non-forfeitable, but are subject to general creditors of Caltech.</td>
</tr>
</tbody>
</table>
California Institute of Technology 457(b) Deferred Compensation Plan (Continued)

457(b) Plan Distributions

In general, you may begin receiving your benefits following termination of employment. You should carefully consider the tax consequences of any withdrawal.

You benefit may generally be paid in the following forms:

- Lump sum – Single payment of the entire balance of your account
- Installment – Systematic payments (monthly, quarterly or annually) of a set amount or over a set period of years
- Annuity – Guaranteed payments spread out over your lifetime (or the joint lifetimes of you and your beneficiary), or over a fixed period of time

You have the option of completing a written election within 120 days after your employment ends to choose the start date for the distribution of your benefits and the form of distribution as described in the above list. You cannot defer the start of distribution later than April 1 following the calendar year you reach age 70½ unless you remain an employee past age 70½. If your written election is not received within the 120 days after your employment ends, your benefit will be paid in a lump sum as soon as administratively feasible and the distribution will be subject to applicable income taxes.

Contact TIAA for additional information, and to initiate your distribution.

457(b) Plan Beneficiaries

It’s very important that you keep your beneficiary designations up to date, to avoid any unnecessary burdens for your beneficiaries. To update your beneficiaries, call TIAA or log onto your account at www.tiaa.org. Active employees can also access their accounts online through MyBenefits.

- Campus employees: Log in to MyBenefits through access.caltech.
- JPL employees: Log in to MyBenefits through JPL Space Intranet and select the MyBenefits heart icon, or go to the HR website and select Benefits and Life Events, then MyBenefits.

More Information

The Caltech 457(b) Deferred Compensation Plan document is available upon request from the Plan Administrator.
Non-ERISA TDA

Former savings plan closed to new contributions
The California Institute of Technology Tax- Deferred Account Plan (also referred to as the Non-ERISA TDA Plan) no longer accepts new participants or new contributions, and is not covered by this document.

If you have an account in this plan with Fidelity, Prudential or TIAA, contact TIAA at 1-800-842-2252, Fidelity at 1-800-343-0860 or Prudential at 1-800-621-1089 to find more information on this plan.
What Happens If...

You can reference checklists on how to take action in the case of a qualified life event or plan change.

Plan Enrollment

Enrollment for the Base Retirement Plan is mandatory, unless you make a one-time irrevocable election not to participate in the plan. For more information on Base Retirement Plan participation click here, or contact TIAA.

Enrollment for the Voluntary Retirement Plan and 457(b) Plan is voluntary. For more information on enrollment, see the Voluntary Plan section of this guide or the 457(b) Plan section of this guide, or contact TIAA.

Changing Deferral Elections

For the Voluntary Retirement Plan and 457(b) Plan, you can change or stop your deferral election at any time by logging in to your account at www.tiaa.org. Active employees can also access their accounts online through MyBenefits:

- Campus employees: Log in to MyBenefits through access.caltech.
- JPL employees: Log in to MyBenefits through JPL Space Intranet and select the MyBenefits heart icon, or go to the HR website and select Benefits and Life Events, then MyBenefits.

Changing Investment Elections

You can change your investment elections for future contributions as well as investment allocations of your current account balances. You can make these changes on the TIAA website or contact TIAA. Below are the links to the investment section of each plan:

- Base Retirement Plan: https://www.tiaa.org/public/tcm/caltech/view-all-investments
- Voluntary Retirement Plan: https://www.tiaa.org/public/tcm/caltech/view-all-investments
- 457(b) Plan: https://www.tiaa.org/public/tcm/caltech/view-all-investments
Loans

You may be able to borrow against your account in the Base Plan or the Voluntary Plan. You are not able to borrow from the 457(b) Plan. It is important to pay back your loan on time to avoid taxation of your loan and potential tax penalties.

The IRS limits the amount you can borrow. To find out the amount you may borrow from your accounts, contact TIAA.

For information on borrowing from the Base Plan, see the Base Retirement Plan section of this guide. For information on borrowing from the Voluntary Plan, see the Voluntary Plan section of this guide.

Financial Hardship Reasons

A hardship withdrawal can be made when an immediate and heavy financial need can’t be met from any other reasonably available source and is needed to:

- Purchase your principal residence (not including mortgage payments) or repair casualty damage to your principal residence.
- Prevent eviction from or foreclosure on your principal residence.
- Pay tuition and related expenses over the next 12 months for post-high school education for yourself, your spouse or an eligible dependent.
- Pay medical expenses for yourself, your spouse or eligible dependents.
- Pay burial or funeral expenses for your deceased parent, spouse, child or dependent.

In-service or Hardship Withdrawals While Still Employed

You may withdraw from the Voluntary Plan while still employed if you reach age 59½ or you have an immediate financial need (financial reasons listed above). Click here for more information on requesting a hardship withdrawal. Click here for more information on requesting an age 59½ in-service withdrawal.

If you are still employed by Caltech or JPL but are no longer eligible for the Base Plan, you may request a withdrawal of your Base Plan accounts for any reason upon reaching age 59½. Click here for additional information on taking an in-service withdrawal from the Base Plan.
Termination
Upon termination of employment, you’ll be able to receive benefits from the retirement plans. However, you will no longer be eligible to:

- Make deferrals to the Voluntary Plan and 457(b) Plan (if applicable)
- Receive employer contributions in the Base Plan
- Request a new loan or in-service/hardship withdrawal from the Voluntary Plan
- Request a new loan from the Base Plan

Any outstanding loans will be defaulted if you do not make a full repayment within a certain timeframe. For more information on loan default, click here for base plan loans or click here for voluntary base plan loans.

Receiving a Distribution
In general, you must terminate employment to begin receiving benefits from the retirement plans. For withdrawal options available while still employed, see In-service or Hardship Withdrawals While Still Employed.

For additional information on receiving a distribution, follow the link to each plan:

- Base Plan
- Voluntary Plan
- 457(b) Plan

Establish/Update Beneficiary Designation
A beneficiary designation should be completed for each plan. It is also critical for you to regularly review all beneficiary designations and update them as needed. Active employees can access their accounts online through MyBenefits or contact TIAA.

- Campus employees: Log in to MyBenefits through access.caltech.
- JPL employees: Log in to MyBenefits through JPL Space Intranet and select the MyBenefits heart icon, or go to the HR website and select Benefits and Life Events, then MyBenefits

Divorce
You may obtain a copy of the Qualified Domestic Relations Order (QDRO) guidelines for the retirement plans by clicking here, or contact TIAA for any additional questions.
Frequently Asked Questions

What are the differences between the Caltech Base Retirement Plan (Base Plan) and the Caltech Voluntary Retirement Plan (Voluntary Plan)?

Both the Base Plan and the Voluntary Plan are defined contribution plans under Section 403(b) of the Internal Revenue Code. The Base Plan is for contributions made by the Institute. In some cases, key staff employees are required to make mandatory contributions to the base plan. Staff-level employees become eligible the first of the month following six months of service. Key Staff level become eligible the first of the month following meeting the hourly rate threshold (this threshold can change each year).

The Voluntary Plan is for your pre-tax deferred contributions that you make through JPL/Caltech payroll up to the annual IRS limits.

When will I receive my first contribution to the Caltech Base Retirement Plan (Base Plan) after I meet the eligibility criteria?

Your participation date is typically the first of the month after meeting the eligibility criteria, and your first contribution will typically occur the first pay period including your participation date. To see the contribution amount, log into your TIAA account the following Monday of the respective pay date and look at the transaction history for the Base Plan.

How do I change my Voluntary Plan deduction from my paycheck?

Log on to your account at TIAA (www.tiaa.org) and select “Change My Contributions” under the My Account tab or call TIAA at 1-800-842-2252.

Do I need to change my Voluntary Plan deduction amount at the end of the year so I do not exceed the IRS contribution limits?

No. TIAA and Caltech/JPL payroll systems are programmed so you do not exceed the IRS contribution limits for the Voluntary Plan. If you have participated in similar retirement plans at other employers during the same calendar year, it is your responsibility to ensure that you do not exceed the IRS contribution limit in the aggregate between all plans that you participated in for that year. Please note that if you have participated in another employer’s plan in the calendar year that you are also contributing to the Caltech Voluntary Plan, TIAA has a tool to help you manage the contribution limits in the aggregate. You can contact TIAA at 1-800-842-2252 for more information.

Who do I contact about splitting my retirement plan accounts as part of a divorce?

Contact TIAA at 1-800-842-2252 and also review the QDRO Guidelines for the Caltech Retirement Plans in MyBenefits.
Retirement Plan Disclosures and Administration

About This Summary Plan Description (SPD)
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 Benefits Program. However, this SPD provides only a summary of these benefits and doesn’t cover all the details. Additional plan details are provided in the official plan documents, which can be provided by contacting the Campus or JPL Benefits Office.

Required Retirement Participant Notices
- Participant Fee Disclosure
- Summary Annual Report
- Qualified Default Investment Alternative (QDIA) notice

Qualified Domestic Relations Order (QDRO)
A qualified domestic relation order (QDRO) is a domestic relations order (DRO) that creates, or recognizes the existence of the right of an "alternate payee" (former spouse, child(ren) or other dependent(s)) to receive all or a part of your vested account balance under the plan.

A DRO is a judgment (generally issued by the court to be recognized as a DRO under ERISA), decree, or order that relates to the provision of child support, alimony payments, or marital property rights for the benefit of a spouse, former spouse, child, or other dependent.

The plan has to honor any DRO relating to your plan benefit as long as it complies with the QDRO Guidelines of the plan and applicable legal requirements. You may obtain a copy of the QDRO Guidelines from the Plan Administrator or log into MyBenefits for the Retirement Plan QDRO guidelines.
Claims and Appeals for Retirement

The following rules describe the claim procedures under the Caltech Base Retirement Plan and the Caltech Voluntary Retirement Plan.

- **Filing a claim for benefits** – A claim or request for plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to the Director of Benefits, Human Resources.

- **Processing the claim** – The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the plan expects to make its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

- **Denial of claim** – If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent Plan provisions on which the denial is based, a description of any additional material or information necessary for claim approval, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not given to you within the 90-/180-day period, the claim is considered denied and you must be permitted to proceed to the review stage.

- **Review procedure** – You or your authorized representative have at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to see all plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.

- **Decision on review** – The plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the plan procedures provide for such a hearing), you must be furnished with written notice of the extension. Such notice must be provided no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. If appeal is denied, in whole or in part, you have a right to file suit in a state or federal court.
ERISA Rights and Plan Administration

Plan Administration Information

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

Plan Names/Numbers
The employer identification number assigned to the plan sponsor by the IRS is 95-1643307. The official names of the plans and their plan numbers are shown below. Plans that do not have numbers are not subject to ERISA.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caltech Base Retirement Plan (Base Plan)</td>
<td>002</td>
</tr>
<tr>
<td>Caltech Voluntary Retirement Plan (Voluntary Plan or formerly referred to as ERISA TDA Plan)</td>
<td>005</td>
</tr>
<tr>
<td>Caltech 457(b) Deferred Compensation Plan (457(b) Plan)</td>
<td></td>
</tr>
<tr>
<td>Consolidated Welfare Plan of California Institute of Technology, which includes the following:</td>
<td>601</td>
</tr>
<tr>
<td>- Kaiser Permanente HMO</td>
<td></td>
</tr>
<tr>
<td>- Anthem Blue Cross Advantage HMO</td>
<td></td>
</tr>
<tr>
<td>- Anthem Blue Cross High Deductible PPO</td>
<td></td>
</tr>
<tr>
<td>- Delta Dental PPO</td>
<td></td>
</tr>
<tr>
<td>- MetLife/Safeguard Dental</td>
<td></td>
</tr>
<tr>
<td>- VSP PPO</td>
<td></td>
</tr>
<tr>
<td>- Employee Assistance Program (EAP)</td>
<td></td>
</tr>
<tr>
<td>- Life Insurance (Basic and Supplemental)</td>
<td></td>
</tr>
<tr>
<td>- Personal Accident Insurance (PAI)</td>
<td></td>
</tr>
<tr>
<td>- Disability Insurance (Basic LTD, Supplemental LTD and STD)</td>
<td></td>
</tr>
<tr>
<td>- Business Travel Accident Plan</td>
<td></td>
</tr>
<tr>
<td>- Extra-Hazardous Duty Insurance</td>
<td></td>
</tr>
<tr>
<td>California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HCSA not DCSA)</td>
<td></td>
</tr>
<tr>
<td>International SOS Medical Access/International Referral Service</td>
<td></td>
</tr>
<tr>
<td>Caltech Non-ERISA Tax-Deferred Annuity Plan (closed to new enrollments)</td>
<td></td>
</tr>
<tr>
<td>- TIAA accounts</td>
<td></td>
</tr>
<tr>
<td>- Fidelity accounts</td>
<td></td>
</tr>
<tr>
<td>- Prudential accounts</td>
<td></td>
</tr>
</tbody>
</table>
Plan Sponsor
The plan sponsor for all plans is the California Institute of Technology. You may contact the plan sponsor at the following addresses:

**Mailing Address for Caltech Employees:**
California Institute of Technology  
1200 E. California Blvd  
Mail Code 161-84  
Pasadena, CA 91125

**Mailing Address for JPL Employees:**
JPL  
4800 Oak Grove Dr.  
Mail Code T1720-B  
Pasadena, CA 91109

**Physical Address:**
California Institute of Technology  
399 S. Holliston Ave  
Mail Code 161-84  
Pasadena, CA 91125

Plan Funding and Type of Administration
The Kaiser HMO, Vision Service Plan (VSP), MetLife DHMO (Safeguard), Aetna Life Insurance (Basic and Supplemental), Aetna Long Term Disability (Basic and Supplemental), Aetna Personal Accident Insurance, Hartford Business Travel Accident Insurance Plan, and Hartford Extra-Hazardous Insurance Plan benefits are fully insured and benefits are guaranteed under insurance contracts.

The Anthem HMO, Anthem PPO plans, the Delta Dental PPO, and the HealthEquity health care spending account (HCSA) are self-funded and benefits are paid out of general assets. Claims are administered by a third-party administrator. The Claims Administrator for the self-funded plans is responsible for determining whether you are entitled to benefits and authorizing payment.

The name and address of the Claims Administrator for the fully insured and self-funded plans are listed under the **Claims Administrator** section.
Source of Contributions
Employees who participate in the plans are required to make contributions for certain coverage. The California Institute of Technology, in its sole and absolute discretion, shall determine the amount of any required employee contributions under the plan and may increase or decrease the amount of the required contribution at any time. The California Institute of Technology may require different contribution levels for different classes of employee and will notify employees annually as to what the employee contribution rates will be.

The California Institute of Technology shall contribute the difference between the amount employees contribute and the premiums for the group insurance coverage. Any experience credits or refunds under a group insurance contract shall be applied first to reimburse the California Institute of Technology for its contributions, unless otherwise provided in that group insurance contract or required by applicable law. Voluntary coverages are entirely paid by employees.

Plan Administrator
The plan administrator for all plans is the Institute. Caltech has named the Senior Director of Total Rewards, Human Resources to be responsible for enrolling participants and for performing other duties required for the operation of the plans.
Your ERISA Rights

As a participant in the Caltech 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.

Prudent Action by Plan Fiduciaries

In addition to creating rights for you, ERISA imposes duties on the people responsible for the operation of employee benefit plans. The people who operate your plan, called fiduciaries, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

If you have a claim for benefits denied or ignored in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the plan’s claims and appeals procedures, as described in your plan’s Evidence of Coverage (EOC). See the SPD’s Contacts and Resources section for detailed contact information.

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

Spouse’s Rights Under the ERISA Plans: Joint and Survivor Benefits Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan

Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan, benefits must be paid to married participants in the plan only as described below, unless a written waiver of the benefits by the participant and a written consent to the waiver by the spouse is filed with TIAA. This provision applies to both retirement benefits and pre-retirement death benefits.

If benefits began before your death, your surviving spouse at your death will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, the full current value of your annuity accumulation becomes payable (pre-retirement death benefit). Federal law requires that at least 50% of such benefit be paid to your spouse (with the remaining 50% paid to your designated beneficiary) unless your spouse has waived, and consented in writing to an alternate beneficiary for, such benefit. Pre-retirement death benefits are payable in a single sum or under one of the income options offered by TIAA.

Married participants and their spouses may waive the spouse’s right to a joint and survivor annuity or his or her pre-retirement death benefit only if a written waiver of the benefit signed by the participant and the spouse (and notarized) is filed with TIAA. The necessary forms will be provided to the participant by TIAA.

For post-retirement survivor benefits (joint and survivor annuity), the waiver may be made only during the 180-day period before benefits begin. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.
Spouse’s Rights Under the ERISA Plans: Joint and Survivor Benefits Under the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan (continued)

The period during which you and your spouse may elect to waive the pre-retirement survivor death benefit begins on the first day of the plan year in which you reach age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before reaching age 35 — that is, before you have had the option to make a waiver — 50% of the current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by TIAA; the remaining 50% is payable to your designated beneficiary. If you terminate employment before age 35, the period for waiving the spousal pre-retirement death benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

If a judgment, decree, or order made following a state domestic relations law establishes the rights of another person (the “alternate payee”) to your benefits under this plan, and if such an order (called a “qualified domestic relations order”) is for providing child support, alimony, or other marital property payments, then payments will be made according to that order, provided the order does not conflict with the provisions of the plan or the terms of a previous qualified domestic relations order. If a court issues a qualified domestic relations order, the order overrides the usual requirements that your spouse be considered your primary beneficiary for a portion of the accumulation. Copies of the plan’s procedures relating to qualified domestic relations orders are available on written request to the Plan Administrator.

Since the Caltech Base Retirement Plan is a defined contribution plan, it is not insured by the Pension Benefit Guaranty Corporation (PBGC). The PBGC is the government agency that guarantees certain types of benefits under covered plans.
Contact the Plan Administrator

You may contact the plan administrator at the following addresses:

**Mailing Address for Caltech Employees:**
California Institute of Technology  
1200 E. California Blvd  
Mail Code 161-84  
Pasadena, CA 91125

**Mailing Address for JPL Employees:**
JPL  
4800 Oak Grove Dr.  
Mail Code T1720-B  
Pasadena, CA 91109

**Physical Address:**
California Institute of Technology  
399 S. Holliston Ave  
Mail Code 161-84  
Pasadena, CA 91125
Contact the Claims Administrator

Use the chart below to contact the Claims Administrator for each plan.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Claims Administrator Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
</tr>
<tr>
<td>Anthem Blue Cross High Deductible PPO</td>
<td>21555 Oxnard Street</td>
</tr>
<tr>
<td>Anthem Blue Cross Health Savings Plan</td>
<td>Woodland Hills, CA 91367</td>
</tr>
<tr>
<td>Anthem Blue Cross Advantage HMO</td>
<td></td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc.</td>
<td>393 East Walnut Street</td>
</tr>
<tr>
<td></td>
<td>Pasadena, CA 91188-8110</td>
</tr>
<tr>
<td><strong>Group Health Cooperative</strong></td>
<td>Claims Department</td>
</tr>
<tr>
<td></td>
<td>1-888-901-4636</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 34585</td>
</tr>
<tr>
<td></td>
<td>Seattle, WA 98124</td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td>Campus SFCC at 1-626-395-8360 or via e-mail: <a href="mailto:SFCC@caltech.edu">SFCC@caltech.edu</a></td>
</tr>
<tr>
<td></td>
<td>JPL EAP is through our vendor Empathia and is known as LifeMatters. Go to <a href="http://MyLifeMatters.com">MyLifeMatters.com</a>, company password is JPL, or call a counselor at any time at 1-800-367-7474</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
</tr>
<tr>
<td>Delta Dental of California (PPO Dental)</td>
<td>P. O. Box 997330</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA 95899-7330</td>
</tr>
<tr>
<td>MetLife (DHMO) Safeguard (Dental DHMO)</td>
<td>Claims Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 30930</td>
</tr>
<tr>
<td></td>
<td>Laguna Hills, CA 92654</td>
</tr>
</tbody>
</table>
### Plan Claims Administrator Contact Information

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision</strong></td>
<td></td>
</tr>
<tr>
<td>Vision Service Plan (VSP)</td>
<td>1-800-877-7195</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 997105</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA 95899-7105</td>
</tr>
<tr>
<td><strong>Spending Accounts</strong></td>
<td></td>
</tr>
<tr>
<td>Health Equity</td>
<td>1-801-727-1590</td>
</tr>
<tr>
<td></td>
<td>15 W Scenic Pointe Dr, Ste 100</td>
</tr>
<tr>
<td></td>
<td>Draper, UT 84020</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>51 Farmington Avenue</td>
</tr>
<tr>
<td>Aetna Insurance Company</td>
<td>Hartford, CT 06156</td>
</tr>
<tr>
<td>Life Insurance and Accident Death &amp; Personal Loss (PAI)</td>
<td>1-800-523-6586</td>
</tr>
<tr>
<td>Aetna Life Insurance Service Center</td>
<td>International SOS</td>
</tr>
<tr>
<td>Medical Access/International Referral Service</td>
<td></td>
</tr>
<tr>
<td>International SOS</td>
<td>International SOS accepts collect calls from members overseas</td>
</tr>
</tbody>
</table>

For more information on your Health and Welfare benefits, go to the Health and Welfare Benefits Homepage >

Download a Printable Version of This SPD >

Continued
# 2018 Summary Plan Description – For Your Retirement Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Claims Administrator Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement Claims</td>
<td></td>
</tr>
<tr>
<td>Plan Administrator:</td>
<td>For Caltech employees:</td>
</tr>
<tr>
<td>Caltech</td>
<td>California Institute of Technology</td>
</tr>
<tr>
<td></td>
<td>1200 E. California Boulevard</td>
</tr>
<tr>
<td></td>
<td>Mail Code 161-84</td>
</tr>
<tr>
<td></td>
<td>Pasadena, CA 91125</td>
</tr>
<tr>
<td></td>
<td>For JPL employees:</td>
</tr>
<tr>
<td></td>
<td>JPL</td>
</tr>
<tr>
<td></td>
<td>4800 Oak Grove Dr.</td>
</tr>
<tr>
<td></td>
<td>Mail Code T1720-B</td>
</tr>
<tr>
<td></td>
<td>Pasadena, CA 91109</td>
</tr>
</tbody>
</table>

**Agent of Legal Process**

Any legal correspondence regarding the plans should be sent to:

General Counsel  
California Institute of Technology  
1200 E. California Blvd., 108-31  
Pasadena, CA 91125

**Contract of Employment Disclaimer**

This SPD provides information about the benefit plans and does not constitute an implied or expressed contract or guarantee of employment.

Refer to the Health and Welfare Benefits and Retirement Plan sections for important notices and other specific plan administration including the rules on claims and appeals.