

2021

Summary Plan Description

For Your Health and Welfare and Retirement Benefits

Caltech **JPL**

PRINTING INSTRUCTIONS

This Summary Plan Description handbook is organized into three main sections:

1. Health and Welfare Benefits
2. Retirement Benefits
3. Glossary & Contacts

The Glossary & Contacts apply to both sections. If you wish to print the health and welfare or the retirement portion only, follow these guidelines:

Health and Welfare Section:

Print pages 1 – 70 and 109 – 125

Retirement Section:

Print pages 1 – 4 and 71 – 125

2021 Benefits Summary Plan Description (SPD)

This SPD, together with plan documents/insurance contract and your Evidence of Coverage booklets (EOCs), describe the benefits provided under the Caltech Health and Welfare (H&W) and Retirement Benefit Plans effective January 1, 2021, is part of the H&W plan document under the Employee Retirement Income Security Act of 1974 (ERISA), and constitutes the Summary Plan Description (SPD) required by ERISA. This SPD also contains highlights of the Retirement Benefit Plans. This SPD describes the benefits available to you and is intended to help you use each benefit more effectively. Because certain sections relate to other sections, it is important you read this entire document carefully. Plan documents/insurance contracts and EOCs contain additional information. If there is a discrepancy between the information in this SPD and the Retirement Benefit Plan documents or H&W benefit (EOCs) and insurance contracts, the Retirement Benefit Plan documents, insurance contracts and health and EOCs, will govern. The sections of this SPD that relate to health and welfare benefits covered by ERISA are part of the applicable ERISA health and welfare Plan document(s). 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 applicable Benefits Office (see Contacts on page 122).

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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, in the Institute's sole discretion. Any such amendment, modification, suspension or termination shall be ratified, executed, or approved by the Executive Committee of the Board of Trustees of the Institute, the VP of Administration, the 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 or inactive employment or retirement, nor does it guarantee any specific level of benefits. Benefits provided are at the Institute's discretion. Neither the benefits, nor the documents describing them create a contract of employment. Any payment of benefits depends on your eligibility to receive them, as set forth in the governing documents and determined by the Institute in its sole discretion.

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Health and Welfare Benefits Summary Plan Description

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.
 - Reference page 4 of the Postdoctoral Scholar Handbook for Postdoctoral Scholars receiving a stipend from a Caltech fellowship program or who are funded directly from an outside funding source.
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.
 - Reference page 4 of the Postdoctoral Scholar Handbook for Postdoctoral Scholars receiving a stipend from a Caltech fellowship program or who are funded directly from an outside funding source.
4. Staff Employees, Temporary Staff Employees and Key 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 for Campus or Temporary Employee Special (TMS) at JPL 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.
 - Key Staff Employees are employees who are regularly scheduled to work 20 or more hours per week and meet additional minimum compensation requirements as described in the Retirement section on page 76.

Eligibility under the Affordable Care Act (ACA) and Nondiscrimination Rules

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 combined with the number of hours you have worked if the Institute determines under its sole discretion that coverage will be offered to you to allow the Institute to avoid penalties under the ACA or to satisfy certain nondiscrimination rules imposed by taxing authorities. Each year, the Institute will calculate how many hours of service you have worked and inform you if you are eligible for medical benefits under such special determination. Faculty working less than 20 hours per week who are considered highly compensated individuals under the self-funded health plan rules found in the Internal Revenue Code will be taxed on any self-funded medical benefits that they receive to the extent required by the Internal Revenue Code.

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
- Part-time employees regularly scheduled to work less than 20 hours per week
- The following JPL employee classifications
 - Summer (SUM)
 - Call Back Status (CBS)
 - Interim Employment Program (IEP)

Note: An “employee” does not include any of the following (as determined by the Institute in its sole discretion) except as required by law (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 (RDP). See Glossary of Terms on page 109,
- Your child(ren) up to age 26 (coverage ends the last day of the month in which child(ren) reach their 26th birthday),*
- Your child(ren) age 26 and over who are incapable of self-support because of a physical or mental disability. (Eligibility is subject to review and approval by the insurance carrier in accordance with the carrier's specific requirements for continued coverage for disabled children),*
- Any child(ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMSCO).

*This includes natural child, stepchildren, adopted children, children of a Registered Domestic Partner, and children for whom you are, and remain, a court appointed guardian while that guardianship remain in effect.

For the definition of eligible dependent for the Dependent Day Care Spending Account, see the Flexible Spending Account section on page 26.

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 as determined by the Institute, in its sole discretion.
- During annual open enrollment

Dependent Eligibility

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. You are responsible for reimbursing insurance premiums paid by the Institute for non-eligible covered dependents. 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.

New Employee Orientation

As a new Benefit-Based Employee, you may attend a new employee orientation meeting and have the opportunity to learn about your benefit options and how to enroll using the *MyBenefits* (for Caltech) or *Workday* (for JPL) website. Contact the Campus or JPL Benefits Office (see Contacts on page 109 for more information).

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 hire or becoming eligible for benefits.

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), if the Institute, in its sole discretion, determines that a QLE has occurred. See Enrolling or Making Changes to Your Benefit Elections During the Year on page 8 to learn more about Qualified Life Events (QLEs).

Qualified Life Events

Note: Your election must be made within the 31-day election period that includes the date of the QLE and the 30 days after. If you do not complete your enrollment within the 31-day election period, you will lose your right to enroll (or to make a change) until the next annual open enrollment or until you experience a Qualified Life Event. During this 31-day election period, you may revoke your initial election and make

During Annual Open Enrollment

You may enroll or dis-enroll 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.edu*.

- 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”

For **JPL**: Go to JPL Space and select the “*Workday*” icon

- If enrolling as a new Benefit-Based Employee, look for the “Benefit Change – New Hire” event in your Workday Inbox.
- If enrolling as a result of a QLE, from the Workday homepage, click on the Benefits shield, then select “Benefits” under the “Change” menu.

How to Enroll



Campus:
<https://MyBenefits.caltech.edu>.

JPL:
Access *Workday* through JPL Space by selecting the *Workday* icon.



Note: New faculty members should contact the Faculty Records Office regarding initial enrollment in benefit plans.

Enrolling or Making Changes to Your Benefit Elections During the Year

You can enroll in or change your Supplemental Life Insurance, Supplemental Long-term Disability, Personal Accident Insurance (PAI) and Health Savings Account (HSA) at any time, subject to satisfying any insurance company requirements, including Evidence of Insurability where applicable. However, if you are increasing your Supplemental Life Insurance election or adding Supplemental Long-term Disability coverage, you could be subject to an Evidence of Insurability (EOI) determination that may limit your coverage options, including ineligibility. For

more information, reference the Disability and Supplemental Life Insurance sections starting on page 30 for more information on EOI.

You may be able to change your Medical, Dental, Vision, and Health Flexible Spending Account or Dependent Day Care Flexible Spending Account elections during the plan year if you experience a Qualified Life Event as determined by the Institute, in its sole discretion. 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 the event 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 and Dependent Day 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;
- **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 on page 5);
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
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, adoption, or placement for adoption of a new child
- Marriage or loss of other health plan coverage.
- 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 request a change due to a special enrollment within the 31 day election period, coverage will be effective on the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. You may also switch between plans (for example, from HMO to PPO). However, you must request enrollment within 31 days of the Qualified Life Event.

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 Your Health Benefits Coverage Begins

Initial Benefit Eligibility and Qualified Life Events

| Benefit-Based Employees | All Employees |
|---|--|
| <p>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 (unless the law requires an earlier date):</p> <ul style="list-style-type: none"> • Medical • Dental • Vision • Health Savings Account (HSA) • Health Flexible Spending Account (HFSA) • Dependent Day Care Spending Account (DCFSA) • Life Insurance (Basic and Supplemental) • Personal Accident Insurance (PAI) • Disability Insurance (Basic LTD, Supplemental LTD and STD) <p>If you become benefit eligible on the first of the month then benefits will begin on that date.</p> <p>Medical, dental, and vision coverage will begin on the date of birth, adoption, or placement for adoption when adding dependents via a Qualified Life Event (QLE).</p> <p>Except for coverage under the Medical, Dental and Vision plans, to the extent permitted by law, you must be “Actively at Work” (as defined in the applicable insurance policy) 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.</p> | <p>For all employees, the following benefits begin on your date of hire :</p> <ul style="list-style-type: none"> • Business Travel Accident Insurance* • Extra-Hazardous Duty Insurance • Employee Assistance Program (EAP) • International SOS |

**Includes Medical Evacuation Repatriation (MER) Insurance; 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.*

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 other employees. Any changes to your Life, Personal Accident Insurance or Disability Plans (Basic and Supplemental LTD and Voluntary STD) will not take effect until you return to work for one full day and your coverage is 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.

What Coverage Costs for Your Health Benefits

The benefits you choose to enroll in will determine how much you will 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. Reference page 4 of the Postdoctoral Scholar Handbook for Postdoctoral Scholars receiving a stipend from a Caltech fellowship program or who are funded directly from an outside funding source.*

Costs

Log into *MyBenefits (for Caltech) or the AskHR Knowledge Base (for JPL)* for the costs of the plans. The following benefits are provided by the Institute at no cost:

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

Some Benefit-Based Employees will only be permitted to make contributions on an after-tax basis and/or they will be billed directly for the cost of health benefits coverage. This usually applies for postdoctoral scholars and visiting associates. Contact the Benefits staff at Campus or JPL if this applies to you.

You will pay 100% of the cost of

- Supplemental Life (Employee, Spouse, and Child)
- Supplemental LTD and Voluntary Short-term Disability (STD) benefits if you live in certain states
- Health Savings Account (HSA)
- Health Flexible Spending Account (HFSA) and Dependent Day Care Spending Account (DCFSA)
- Voluntary Benefits

Pre-tax or After-Tax Contributions

When you enroll in Medical, Dental or Vision coverage provided by Caltech, any contributions for these health benefits will automatically be deducted from your paycheck 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 an 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 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” for health benefit purposes as defined by the IRS (which is a special definition of “dependent”). Employees are responsible for reporting to the Institute if their domestic partner or child(ren) of a Domestic Partner are a tax-qualified dependent. Additionally, if your Domestic Partner or his or her children do not qualify as such tax dependents, the amount Caltech contributes for coverage on their behalf will be added to your taxable income. This will show as imputed earning on your paystubs and is subject to tax withholding.

When Your Health Benefits Coverage Ends

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

- The last day 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

Disability (Basic LTD, Supplemental LTD and Voluntary STD), Business Travel Accident Insurance and Extra-Hazardous Duty Insurance will end on your last day of work, unless an earlier date is specified in the applicable insurance policy.

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 coverage and Health Flexible Spending Account contributions through COBRA or, for life insurance coverages, by converting your coverage to an individual life insurance policy with the carrier within 31 days of when coverage ends.

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 employment with Caltech or retire from Caltech
- You are no longer eligible for Caltech group health benefits due to a reduction in hours
- 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

The cost for COBRA coverage is 100% of the full group rate plus an additional 2% administrative fee. Log into *MyBenefits (for Caltech)* or *the AskHR Knowledge Base (for JPL)* to see the current COBRA rates.

How to Continue Coverage

Contact the COBRA administrator, WageWorks, for information about your options and how to enroll. See Contacts on page 122 for contact information.

You must elect COBRA coverage within 60 days from the later of: the issue date of the COBRA notification OR the day coverage is lost due to the qualifying event.

If you or your dependents would like to convert or port 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 will continue 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:

- **Paid Leaves of Absence**
 - During an approved 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 are 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 benefits you decide to continue during this period, including supplemental life, supplemental LTD, Personal Accident Insurance (PAI), Health Care Flexible Spending Account (HFSA) and/or Health Savings Accounts (HSA), 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 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 DCFSA (if applicable) coverage will terminate at the beginning of the leave. You will become eligible for LTD and DCFSA (if applicable) coverage the first of the month following the date 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 your medical, dental, vision and/or Healthcare Spending Accounts (HFSA) 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 /or vision coverage than you paid before your leave.
 - If your USERRA leave extends beyond six months, you may be required to pay up to the entire amount (including both Institute and employee contributions plus an additional 2% administration fee) 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.

| Benefit | Plan Options |
|--|---|
| Medical | <ul style="list-style-type: none"> • Anthem Blue Cross High Deductible PPO (including a Health Savings Account) Plans (HDHP 1400 & HDHP 2800) • Anthem Blue Cross Advantage HMO • Kaiser Permanente (California) HMO • Medical Plans Outside of Southern CA |
| Dental | <ul style="list-style-type: none"> • Delta Dental PPO • MetLife (Safeguard) DHMO |
| Vision | <ul style="list-style-type: none"> • Vision Service Plan (VSP) |
| Flexible Spending Accounts (FSAs) | <ul style="list-style-type: none"> • Health FSA (HFSA) • Dependent Day Care FSA (DCFSA) |
| Disability | <ul style="list-style-type: none"> • Basic Short-term Disability (for CA and WA employees) • Voluntary Short-term Disability (for employees outside of CA) • Long-term Disability (basic and supplemental) |
| Life and Accident | <ul style="list-style-type: none"> • Life Insurance (basic and supplemental) • Personal Accident Insurance |
| Additional Benefits | <ul style="list-style-type: none"> • Business Travel Accident Insurance • Medical Evacuation Repatriation (MER) • Extra-Hazardous Duty Insurance • International SOS Medical Assistance • Employee Assistance Program (EAP) • The Hartford Life Essentials Program • Voluntary Benefits: <ul style="list-style-type: none"> • Long-term Care (LTC) Insurance • Non-medical insurance policies (auto, homeowner, renter's insurance, and more) |

Anthem Blue Cross High-Deductible PPO Plans

How the Plans Work

You can see any doctor or provider you want whose services are covered under the Plan, but you generally 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 Anthem and/or the Institute in its/their sole discretion. You can find Anthem Blue Cross PPO providers at www.anthem.com/ca/caltech.

Caltech offers 2 High-Deductible PPO Plans which have identical plan designs except for the deductible. The Anthem HDHP 1400 plan has a \$1,400 deductible if you cover only yourself. If you are covering one or more dependent(s) in the Anthem HDHP 1400 plan, the family deductible of \$2,800 must be met prior to the insurance paying claims for non-preventive visits. If you are enrolled in the Anthem HDHP 2800 plan, there is a per person deductible of \$2,800 and a family maximum of \$5,600

With either HDHP plan, 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. When you use services such as an emergency room visit, surgery, or pharmacy, you can use funds in your HSA for the deductible and coinsurance.

Health Savings Account (HSA)

You can enroll in the HSA if you are enrolled in either of the Anthem Blue Cross High Deductible PPO plans. 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 (for Caltech) or Workday (for JPL)*.

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

- Covered under another medical plan (such as a spouse’s group health or health flexible spending account) 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. Additional details are also available on *MyBenefits (for Caltech) or the AskHR Knowledge Base (for JPL)*.

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| Paying for Care | <p>Eligible in-network preventive care visits are covered at 100% and in-network preventive prescriptions have a copayment (except where the ACA requires no copayment), even before you meet the deductible. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> to learn about the co-insurance and copayments costs for all medical services (office visits, prescriptions, pregnancy, surgery, etc.) and to see the list of preventive prescriptions</p> <p>Below are the general steps on paying for medical services:</p> <ol style="list-style-type: none"> 1. You pay the full cost 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 percentage and Anthem pays a percentage. <p>After you reach 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.</p> |
| Additional Services | <ul style="list-style-type: none"> • Anthem Concierge – Your on-site Anthem personal health advocate can help you with claims, finding doctors or selecting the plan that is best for you. See Contacts on page 122 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 http://www.livehealthonline.com. |
| More Information | <p>For more detailed information about Anthem Blue Cross High-Deductible PPO, see the Evidence of Coverage document available at www.benefits.caltech.edu/SPD.</p> |

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 you should use. The only exceptions are emergency room visits OR urgent care visits when you are outside the HMO's service area. You can find Anthem Blue Cross HMO providers at www.anthem.com/ca/caltech (search in the Advantage HMO network).

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| Paying for Care | <p>The plan pays 100% for eligible preventive care services when you use Anthem HMO providers. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> 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:</p> <ol style="list-style-type: none"> 1. You do not pay a deductible. 2. You pay the applicable copayment and the plan pays for the rest. <p>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. Please note that infertility services do not apply to the out-of-pocket maximum.</p> <p>Treatment obtained without the authorization of your primary care physician is generally not covered.</p> |
| Additional Services | <ul style="list-style-type: none"> • Anthem Concierge – Your on-site Anthem personal health advocate can help you with claims, finding doctors or selecting the plan that is best for you. See Contacts on page 122 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 | <p>For more detailed information about Anthem Blue Cross HMO (including, but limited to, subrogation, lien, and right of reimbursement provisions), see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

Kaiser Permanente (California) HMO

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| How the Plan Works | <p>When you enroll in the Kaiser Permanente (California) HMO, you must receive all your care from doctors and hospitals affiliated with Kaiser Permanente. You must get a referral from your primary care physician (PCP) to specialists. The only exceptions are emergency room visits OR urgent care visits when you are outside Kaiser Permanente’s service area. To find Kaiser locations, visit my.kp.org/caltech.</p> |
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| Paying for Care | <p>The plan pays 100% for eligible preventive care services when you use Kaiser Permanente providers. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> 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:</p> <ol style="list-style-type: none"> 1. You do not pay a deductible. 2. You pay the applicable copayment and the plan pays for the rest. <p>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.</p> <p>Treatment obtained without the authorization of your primary care physician is generally not covered.</p> |
| More Information | <p>For more detailed information about Kaiser Permanente (California) HMO, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

Medical Plans Outside of Southern CA

Anthem Blue Card PPO

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| How Do I Qualify? | <p>If you are an Institute employee who is assigned to work at an Institute location outside of California at the request of the Institute, you and your Dependents may be able to enroll in coverage under the Blue Card PPO Plan with Anthem Blue Cross. Before you leave on your assignment, contact the Campus or JPL Benefits Office for further details.</p> |
| How the Plan Works | <p>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 Institute and/or Anthem in its/their discretion. You can find Anthem Blue Cross PPO providers at www.anthem.com/ca/caltech.</p> |

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| Paying for Care | <p>Eligible preventive care visits at in-network providers are covered at 100%. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> 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:</p> <ol style="list-style-type: none"> 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. <p>After you reach 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.</p> |
| More Information | <p>For more detailed information about Anthem Blue Card PPO, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

Anthem Owens Valley PPO

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| How Do I Qualify? | <p>You must be a Caltech employee working in the Owens Valley service area.</p> |
| How the Plan Works | <p>You can see any doctor or provider you want whose services are covered under the Plan, 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 Institute and/or Anthem in its/their sole discretion. You can find Anthem Blue Cross PPO providers at www.anthem.com/ca/caltech.</p> |
| Paying for Care | <p>Eligible preventive care visits at in-network providers are covered at 100%. Log into <i>MyBenefits (for Caltech)</i> 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:</p> <ol style="list-style-type: none"> 1. You do not pay a deductible. 2. You pay the applicable copayment and the plan pays for the rest. |
| More Information | <p>For more detailed information about Anthem Owens Valley, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

Kaiser Permanente (Washington) HMO

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| 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. You must get a referral from your primary care physician (PCP) to see a specialist. The only exceptions are emergency room visits OR urgent care visits when you are outside Kaiser's service area. To find Kaiser locations, visit my.kp.org/caltech . |
| Paying for Care | <p>The plan pays 100% for eligible preventive care services when you use Kaiser providers. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> 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:</p> <ol style="list-style-type: none">1. You do not pay a deductible.2. You pay the applicable copayment and the plan pays for the rest. <p>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.</p> |
| More Information | For more detailed information about Kaiser Permanente (Washington) HMO, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD . |

Kaiser Permanente (Mid-Atlantic) HMO

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| 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 do not 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. To find Kaiser locations, visit my.kp.org/caltech . |

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| Paying for Care | <p>The plan pays 100% for eligible preventive care services when you use Kaiser providers. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> 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:</p> <ol style="list-style-type: none"> 1. You do not pay a deductible. 2. You pay the applicable copayment and the plan pays for the rest. <p>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.</p> |
| More Information | <p>For more detailed information about Kaiser Permanente (Mid-Atlantic) HMO, see the plan documents available at www.benefits.caltech.edu/SPD.</p> |

Delta Dental PPO

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| How the Plan Works | <p>With the Delta Dental PPO plan, 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 will not get charged more than your expected share of the bill. If you cannot 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 will not get charged more than your expected share of the bill. To find a participating dentist, visit www.deltadentalins.com/caltech.</p> |
| Paying for Care | <p>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 <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> to learn about coinsurance costs for all dental services (fillings, root canal, crowns, etc.). Below are the general steps on paying for dental services:</p> <ol style="list-style-type: none"> 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 you pay a percentage and Delta Dental pays a percentage (up to the plan's maximum allowable benefit). |
| More Information | <p>For more detailed information about Delta Dental PPO, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

MetLife (Safeguard) DHMO (CA only)

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| How the Plan Works | <p>With the MetLife (Safeguard) DHMO, you must choose your dentist from the MetLife (Safeguard) DHMO directory by going to online.metlife.com/edge/web/public/benefits. 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 or orthodontia. Except for some emergency situations, you will not receive a benefit for out-of-network services.</p> |
| Paying for Care | <p>The plan provides 100% coverage for diagnostic and preventive care. Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> to learn about copayment costs for all dental services (fillings, root canal, crowns, etc.). Below are the general steps on paying for dental services:</p> <ol style="list-style-type: none"> 1. You do not pay a deductible. 2. You pay the applicable copayment and the plan pays for the rest. |
| More Information | <p>For more detailed information about MetLife (Safeguard) DHMO, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

Vision Service Plan (VSP)

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| How the Plan Works | <p>You can receive eye services and supplies from any vision care provider you choose, but you save money when you use a VSP Choice network provider. VSP provides coverage for eye exams and glasses (frames and lenses) or contact lenses. To search for a VSP <i>Choice network</i> provider, visit www.vsp.com.</p> |
| Paying for Care | <p>Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> to learn about copayment costs for all vision services (eye exam and vision care materials). Below are the general steps on paying for vision services:</p> <p>When you receive care from a VSP <i>Choice network</i> provider:</p> <ol style="list-style-type: none"> 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). <p>If you receive care from a non-VSP <i>Choice network</i> provider:</p> <ol style="list-style-type: none"> 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 | <p>For more detailed information about Vision Service Plan, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD.</p> |

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 pre-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, you can submit a claim to the flexible spending account for reimbursement for the expenses you paid. | | | | | |
|---|--|-------------------|--|---|---------------------|---|
| Health FSA (HFSA) | Set aside pre-tax money for you and your dependents to cover eligible health care expenses not covered under your medical, dental and/or vision plans. Below are some examples of what is covered and what is not covered under the HFSA. Visit www.healthequity.com for a full listing of reimbursement expenses. | | | | | |
| | <table border="1"> <thead> <tr> <th data-bbox="422 703 958 745">Eligible Expenses</th> </tr> </thead> <tbody> <tr> <td data-bbox="422 745 958 976"> <ul style="list-style-type: none"> • Medical, prescription drug, dental and vision deductibles and copays • Over-the-counter medications • Hearing aids and tests (if not covered under your medical plan) • Menstrual care products </td> </tr> </tbody> </table> | Eligible Expenses | <ul style="list-style-type: none"> • Medical, prescription drug, dental and vision deductibles and copays • Over-the-counter medications • Hearing aids and tests (if not covered under your medical plan) • Menstrual care products | <table border="1"> <thead> <tr> <th data-bbox="974 703 1477 745">Ineligible Expenses</th> </tr> </thead> <tbody> <tr> <td data-bbox="974 745 1477 976"> <ul style="list-style-type: none"> • Cosmetic surgery (unless medically necessary) • Expenses paid or reimbursed through any other policy, plan or program • Insurance premiums </td> </tr> </tbody> </table> | Ineligible Expenses | <ul style="list-style-type: none"> • Cosmetic surgery (unless medically necessary) • Expenses paid or reimbursed through any other policy, plan or program • Insurance premiums |
| Eligible Expenses | | | | | | |
| <ul style="list-style-type: none"> • Medical, prescription drug, dental and vision deductibles and copays • Over-the-counter medications • Hearing aids and tests (if not covered under your medical plan) • Menstrual care products | | | | | | |
| Ineligible Expenses | | | | | | |
| <ul style="list-style-type: none"> • Cosmetic surgery (unless medically necessary) • Expenses paid or reimbursed through any other policy, plan or program • Insurance premiums | | | | | | |
| Dependent Day Care FSA (DCFSA) | Set aside pre-tax money to pay for childcare for children under 13 years of age or day care expenses for an incapacitated dependent adult, while you and your spouse or domestic partner work or go to school. Below are some examples of what is covered and what is not covered under the DCFSA. | | | | | |
| | <table border="1"> <thead> <tr> <th data-bbox="422 1165 958 1207">Eligible Expenses</th> </tr> </thead> <tbody> <tr> <td data-bbox="422 1207 958 1470"> <ul style="list-style-type: none"> • A licensed day care center • Elder/dependent care facility • Nursery school or preschool • Day camp </td> </tr> </tbody> </table> | Eligible Expenses | <ul style="list-style-type: none"> • A licensed day care center • Elder/dependent care facility • Nursery school or preschool • Day camp | <table border="1"> <thead> <tr> <th data-bbox="974 1165 1477 1207">Ineligible Expenses</th> </tr> </thead> <tbody> <tr> <td data-bbox="974 1207 1477 1470"> <ul style="list-style-type: none"> • Child support payments • Expenses for care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled • Transportation to and from a dependent care location </td> </tr> </tbody> </table> | Ineligible Expenses | <ul style="list-style-type: none"> • Child support payments • Expenses for care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled • Transportation to and from a dependent care location |
| Eligible Expenses | | | | | | |
| <ul style="list-style-type: none"> • A licensed day care center • Elder/dependent care facility • Nursery school or preschool • Day camp | | | | | | |
| Ineligible Expenses | | | | | | |
| <ul style="list-style-type: none"> • Child support payments • Expenses for care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled • Transportation to and from a dependent care location | | | | | | |

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| Contribution Limits | <p>The IRS limits how much you can contribute to your flexible spending accounts each year:</p> <ul style="list-style-type: none"> • Health FSA: \$120 – \$2,750 per year • Dependent Day Care FSA: \$120 – \$5,000 per year (\$2,500 if married and filing separately). <ul style="list-style-type: none"> • Contribution amounts may be reduced for Highly Compensated Employees (HCEs) to comply with IRS nondiscrimination rules, in such reduction being made in such manner as the Institute, in its sole discretion, deems appropriate. <p>Per IRS regulations, there are rules on how money left in your account at the end of the plan year is handled:</p> <ul style="list-style-type: none"> • HFSA: you can carry over up to \$550 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 to a Health Savings Account for that calendar year. You forfeit any unused funds remaining above the \$550 carryover amount. • DCFSA: You forfeit any unused funds remaining in your account at the end of the calendar year. |
| Filing a Claim | <p>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 claims for eligible health care and dependent day care expenses incurred during the prior plan year.</p> <ul style="list-style-type: none"> • HFSA: 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 FSA at the time you submit your claim. • DCFSA: 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 Day Care FSA account, the excess expense will be carried over until you have sufficient funds in your account. |
| More Information | <p>For more detailed information about the FSAs, go to www.healthequity.com. The detailed materials at www.healthequity.com are considered EOC for purposes of this SPD.</p> |

Disability Benefits

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| Short-term Disability (STD) | <p>If you are an employee working 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 www.edd.ca.gov/Disability or contact State Disability Insurance at 1-800-480-3287 (English) or 1-866-658-8846 (Spanish).</p> <p>If you are an employee working in Washington, you may be eligible for Paid Family and Medical Leave (PFML) benefits through Washington State. For more information about PFML, visit www.paidleave.wa.gov or (833) 717-2273.</p> <p>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 The Hartford. You have 31 days from your hire date or the date you become eligible to purchase STD coverage without being subject to approval by the insurance carrier's Evidence of Insurability (EOI) process. If you enroll in the STD plan after the 31 days, you will be subject to EOI. Plan benefits are similar to the CA SDI benefits. STD coverage is voluntary and employee-paid. The upcoming EOI section has more information on the EOI process.</p> |
| Long-term Disability (LTD) | <p>Long-term disability (LTD) insurance protects you against the loss of income that can accompany a long-term leave due to illness or injury after six months of disability. The Institute offers both Basic and Supplemental LTD coverage through The Hartford. Certain offsets apply to both Basic and Supplemental LTD benefits (e.g., Social Security disability benefits). Check the Hartford Booklet and related materials for more information.</p> |
| Basic LTD | <p>Basic LTD provides you with 40% of your basic monthly earnings, minus other income benefits, to a maximum monthly benefit of \$10,000.</p> |
| Supplemental LTD | <p>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 or the date you become eligible to purchase Supplemental LTD coverage without being subject to approval by the insurance carrier's EOI process. The upcoming EOI section has more information on the EOI process.</p> |
| Paying for Coverage | <p>You are automatically enrolled in the Basic LTD plan, and the Institute pays for your coverage. Supplemental LTD coverage is voluntary and employee paid.</p> |

Filing a Claim

- **State Disability Insurance:** If you work in California, Washington, or another state with a mandatory state disability insurance program, you will contact the state to learn how to apply for benefits. For California and Washington, reference the above section for the contact information.
- **Voluntary STD:** If you are enrolled in the voluntary STD plan and will be disabled for longer than seven calendar days, please notify Human Resources. Caltech/JPL will contact the carrier to initiate your STD claim. The Hartford will contact you 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 STD or LTD, view the Evidence of Coverage available at www.benefits.caltech.edu/SPD or contact the Campus or JPL Benefits Office.

Life Insurance (Basic and Supplemental) and Personal Accident Insurance (PAI)

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| 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. |
| Basic Life Insurance | The Institute provides Basic Life Insurance to you at one times your annual salary, up to \$50,000, at no cost to you. The benefit will be paid to your beneficiary(ies) in the event of your death. |
| Supplemental Life Insurance | <p>You can elect to enroll yourself, your spouse/domestic partner, and/or child(ren) in optional Supplemental Life Insurance in the following levels of coverage:</p> <ul style="list-style-type: none"> • 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 employee's total (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 <p>In most cases, you must go through the insurance carrier's EOI process for Supplemental Life Insurance. The upcoming section of EOI has more information on the EOI process.</p> |
| Life Insurance Reductions 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 to 40% of the amount that was in effect immediately before the reduction at age 65 on January 1 following attainment of age 70. If you desire, at the time your coverage is reduced, you have 31 days to convert the difference to an individual plan. |
| Evidence of Insurability (EOI) | <p>Supplemental Life Insurance, Supplemental Long-term Insurance, and Voluntary Short-term Disability Insurance may require applicants to provide evidence of good health satisfactory to the insurance company before insurance coverage begins or the value is increased. In the insurance industry, evidence of good health is referred to as Evidence of Insurability (EOI).</p> <p>The insurance company will provide a health questionnaire to the applicant. Based on the information the applicant provides on the questionnaire, the coverage may be approved or 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 approved or denied based on the information provided during the EOI process.</p> <p>Log into <i>MyBenefits (for Caltech)</i> or the <i>AskHR Knowledge Base (for JPL)</i> to learn when EOI will apply.</p> |

| | |
|------------------------------------|--|
| Accelerated Death Benefit | The plan's Accelerated Death Benefit (ADB) feature allows you to receive a partial life insurance benefit if you, your spouse or your domestic partner meet certain conditions. Reference the Evidence of Coverage (EOC) for more information. |
| Personal Accident Insurance | <p>You can choose to enroll in Personal Accident Insurance (PAI) for yourself and/or your dependents. The PAI plan provides a benefit to you if you suffer a serious injury due to an accident (e.g., loss of a limb, eyesight, speech or hearing) or to your beneficiary if you die because of an accident.</p> <p>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.</p> |
| Naming Your Beneficiary | <p>You must name a beneficiary(ies) who will receive your Basic Life and/or Supplemental Life Insurance benefit should you die while you are covered. The beneficiary(ies) for PAI will be the same as the beneficiary(ies) for your Basic Life insurance. Go to the <i>MyBenefits (for Caltech) or Workday (for JPL)</i> website to designate a beneficiary(ies). You can change your beneficiary(ies) at any time.</p> <p>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.</p> <p>Reference the Evidence of Coverage (EOC) for payment distributions when you do not have a beneficiary on file.</p> |
| More Information | For more detailed information about Life and Accident Insurance, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD . |

Additional Benefits

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|---|--|
| Grand Rounds | <p>Grand Rounds provides all enrolled members in a Caltech medical plan and their enrolled dependent(s) a second medical opinion, and/or help selecting doctors and more, at no charge. Learn more by visiting www.grandrounds.com/caltech.</p> |
| Business Travel Accident Insurance | <p>Business Travel Accident Insurance provides a benefit as a result of an accidental injury, death, dismemberment, or loss of movement while traveling for Institute business. If you die, your beneficiary(ies) will receive a benefit of up to \$250,000. If you are injured, you will receive all, or a percentage, of the benefit if you suffer certain specific losses from an injury sustained in the accident.</p> <p>Your beneficiary(ies) will be the same beneficiary(ies) named for your Basic Life Insurance, unless otherwise specified.</p> |

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| Medical Evacuation and Repatriation coverage (MER) | Medical Evacuation and Repatriation coverage (MER) provides medically necessary transportation as a result of an injury or illness when you (and your dependents traveling with you) are 100+ miles from home. MER also covers repatriation if you (or your dependents traveling with you) die while traveling abroad. MER is not medical insurance. |
| Extra-Hazardous Duty Insurance | <p>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(ies) will receive a benefit of up to \$25,000. If you are injured, you will receive all, or a percentage, of the benefit if you suffer certain specific losses from an injury sustained in the accident.</p> <p>Your beneficiary(ies) will be the same beneficiary(ies) named for your Basic Life Insurance, unless otherwise specified.</p> |
| More Information | For more detailed information about Business Travel Accident Insurance, Medical Evacuation and Repatriation coverage, or Extra-Hazardous Duty Insurance, see the Evidence of Coverage available at www.benefits.caltech.edu/SPD or contact the Campus or JPL Benefits Office. |
| International SOS Medical Assistance | 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 www.internationalsos.com and enter your membership number (11BCMA000180) to learn more about your benefits. |
| Employee Assistance Program (EAP) | <ul style="list-style-type: none"> • Caltech – 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. • JPL – Access to LifeMatters/Empathia which 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 www.mylifematters.com (company password: jpl). |
| The Hartford Life Essentials Program | <p>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:</p> <ul style="list-style-type: none"> • Legal and Financial Services • Estate Planning • Grief Counseling • Funeral Planning Services • To learn more about the program visit www.thehartford.com/employee-benefits/value-added-services. |

Voluntary Benefits

- **Long-term Care (LTC) Insurance** — Covers certain costs for in-home care, nursing home care or residential facility care when you need care that is not covered by your health insurance. Coverage is available for you and certain family members, subject to the insurer's rules. Visit the below to learn about who is eligible, what it covers, how much it costs, and how to enroll:
 - Caltech employees: Visit www.Genworth.com/Caltech
 - JPL employees: Visit <http://www.Genworth.com/JPL>
- **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 a Caltech/JPL employee to receive the Caltech group rates.

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.

Reminder: You must enroll in or change your health benefits within 31 days of a qualified life event. If you experience a delay in receiving documentation of your life event, be sure to report your life event to the Benefits Office within 31 days.

Visit *MyBenefits (for Caltech)* or the *AskHR Knowledge Base (for JPL)* to view the full life events checklists and to take action on account of a Qualified Life Event.

| Qualified Life Events | |
|---------------------------------------|--|
| Family or Personal Events | <ul style="list-style-type: none">• Birth, Adoption or Legal Guardianship• Marriage or Registering a Domestic Partnership• Divorce, Legal Separation, or Termination of Domestic Partnership• Leaves of Absence• Death of an Employee, Spouse, or Child• Transferring Between Caltech Campus and JPL or Other Areas of the Institute• Leaving Caltech or JPL |
| Coverage or Eligibility Events | <ul style="list-style-type: none">• Child Turns 26• Employee and/or Dependent Gain or Loss of other Coverage• CHIP/Medicaid Eligibility or Loss of Eligibility• Significant Cost or Coverage Changes |

Qualified Life Events and What You Need to Do

You may make changes to your benefit elections—including adding or removing coverage or dependents—without a Qualified Life Event 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, as determined by the Institute in its sole discretion.

You must make the change in MyBenefits (for Caltech) or Workday (for JPL) 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, and consistent with, the Qualified Life Event. 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, Supplemental LTD Insurance and Personal Accident Insurance elections at any time during the year without a Qualified Life Event, subject to the insurance company's requirements, including satisfying Evidence of Insurability where applicable.

For more information about Qualified Life Events, including when your change in benefits will go into effect, see Enrolling in Your Health Benefits in the 2021 *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.edu*.

For JPL: Log in at JPL Space and select the “*Workday*” 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 and dependent day 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 to your coverage after a qualified life event.

Birth Adoption, or Legal Guardianship

1. Add Your New Dependent to Caltech Benefits

- Add your new dependent to your Caltech benefits through the *MyBenefits (for Caltech) or Workday (for JPL)* enrollment system.
- You must add your new dependent(s) to your coverage within 31 days of (30 days after) 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 (30 days after) birth.
- If you fail to enroll your new dependent within 31 days of (30 days after) the event, 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 you experience another qualified life event.

Marriage or Registering a Domestic Partnership

1. Add Your New Dependent Spouse or Domestic Partner to Caltech Benefits

- Add your new dependent to your Caltech benefits through the *MyBenefits (for Caltech) or Workday (for JPL)* enrollment system.
- You must add your new dependent to your coverage within 31 days of (30 days after) the event.
- If you fail to enroll your new dependent within 31 days of (30 days after), 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 you experience another qualified live event.

Dropping Dependent Coverage

Follow the steps below to remove a dependent from your coverage after a qualified life event. If your child is losing Caltech coverage due to turning age 26, see on page 37.

Divorce, Legal Separation, or Termination of Domestic Partnership

1. 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 (for Caltech)* or *Workday (for JPL)* enrollment system. Be sure to provide a new address, if applicable, for your former spouse or domestic partner so a COBRA offer can be sent to the correct address.
- You must make changes to your coverage within 31 days of (30 days after) the divorce, legal separation, or termination of domestic partnership.

Continuing Coverage and Divorce

It is your legal responsibility to inform Caltech within 31 days of (30 days after) the date of divorce or termination of domestic partnership. The qualified dependent's coverage will end on the last day of the month in which the divorce or termination of domestic partnership is final. When a spouse, partner, or child(ren) loses dependent status due to a divorce or termination of domestic partnership, they will also be eligible for COBRA benefits. You must supply Caltech with a current address for your former spouse or domestic partner and any children. Caltech will then notify you, your spouse, your domestic partner or your children of their rights under COBRA, including coverage, cost, and enrollment information.

Death of an Employee, Spouse, or Child

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 (for Caltech)* or *Workday (for JPL)* enrollment system.
- You must make changes to your coverage within 31 days of (30 days after) the date of death.
- Please call the Benefits Office for assistance with updating your benefits.

Leaves of Absence

You may be able to continue your benefits during a leave of absence to the extent permitted by the applicable insurance policy and plan document.

Leaves of Absence

Plan Your Leave

- Contact the Campus or JPL Benefits Office for more information on your rights to a leave of absence 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, 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.
- Ensure your address is up to date. If you are moving out of state, please contact Payroll in advance of changing your address.

2. Review Your Benefits

- Except for in the case of termination due to gross misconduct as determined by the Institute in its sole discretion, you and your *dependents* may be eligible to continue your medical, dental, vision and health flexible spending account coverage under *COBRA*. For more information about COBRA, contact the Campus or JPL Benefits Office. A COBRA offer will be mailed to your address of record via U.S mail.
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

Follow the checklist below if your child turns age 26 or gains coverage elsewhere.

Child Turns 26

Change Your Caltech Benefits

- If your child turns 26, their coverage will remain active until the end of the month in which they turn 26 and they will be offered COBRA coverage.
- Your child will be removed from your Caltech benefits through the *MyBenefits (for Caltech) or Workday (for JPL)* enrollment system. If your child is losing coverage because he or she is no longer eligible, you can elect to continue coverage for your child through COBRA.
- Also, review the enrollment system to determine if you need to adjust your Child Life and/or Personal Accident Insurance coverage.

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 Loss of Coverage

Change Your Caltech Benefits

- You must make changes to your coverage within 31 days of (30 days after) when you and/or your dependent gains or loses coverage. If you fail to make changes within 31 days of (30 days after) gaining or losing coverage, your next opportunity to make changes will be during annual open enrollment and 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 (for Caltech) or Workday (for JPL)* enrollment system.
- You must make changes to your coverage within 60 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 60 days of losing or gaining coverage under another plan, your next opportunity to make changes will be during *annual open enrollment* and 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.)

Significant Cost or Coverage Changes

Change Your Caltech Benefits

- You must make changes to your coverage within 31 days of (30 days after) 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 on the first of the month following the hire date or qualified life event date, see Enrolling or Making Changes to Your Benefit Elections During the Year on page 8 to learn more about when benefits start. To enroll in benefits in our benefit system, *MyBenefits (for Caltech)* or *Workday (for JPL)*, see Enrolling in Your Health Benefits on page 7 to learn how to access the system.

Can I change my benefits mid-year?

You can change your benefits if you experience certain qualified 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 is important to keep your benefits in mind and make updates as needed. If you want to make any changes or add/drop a dependent after a life event, you must do so within 31 days of (30 days after) the event. See Enrolling or Making Changes to Your Health Benefit Elections During the Year on page 8 to learn more.

My dependent child is turning 26 and will no longer be covered on my plan. What are my options?

Your child will be eligible for COBRA coverage for up to 36 months; see Continuing Your Health Benefits Coverage section 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/drop family members without a Qualified Life Event.

What happens to my benefits when I resign or retire?

Disability (Basic LTD, Supplemental LTD, and Voluntary STD), Business Travel Accident Insurance, ISOS, and Extra-Hazardous Duty Insurance end on your last day of work. All other benefits, for you and your Dependents, end on the last day of the month in which you resign/retire. See When Your Health Benefits Coverage Ends on page 14 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?

Per IRS guidelines, if you are enrolled in Medicare, you are not eligible to make contributions into a Health Savings Account.

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. Visit <http://benefits.caltech.edu/health/retirees> 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, your Caltech Retiree health benefits will end and 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 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 will continue to be covered under the Institute health plans offered to retirees.

What happens if my spouse, domestic partner, or parent is a Caltech retiree?

Refer to the Retiree Summary Plan Description for more information by visiting www.caltechretireebenefits.com/.

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 request one.

- **Medical and Dental** – An ID card will be sent mailed via USPS from the carrier about 2-3 weeks after enrolling in benefits
- **Health Savings Account (HSA)** – A debit card will be mailed via USPS from the carrier about 2-3 weeks after enrolling in benefits.
- **Flexible Spending Accounts (FSAs)** – A debit card is not provided but a welcome kit is sent.
- **Medical Evacuation & Repatriation and International SOS** – Visit www.internationalsos.com and enter your membership number (11BCMA000180) to learn more about your benefits, download an App, and to print 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 to verify your eligibility and benefits. If you are seeing an out of network provider, the provider can contact VSP's customer service 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 www.mylifematters.com).
- **Disability Insurance, Life Insurance, Personal Accident Insurance, Business Travel Accident Insurance, and JPL 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 or download their mobile app onto your smartphone to seek reimbursement for eligible expenses.

How do I submit a claim for reimbursement through HSA, DCFSA or HFSA?

- Go to www.healthequity.com and create an account.
- Download the HealthEquity mobile app once you have created an account on the HealthEquity website.
- The HSA has a debit card which you can use for reimbursement. A debit card is not provided for spending accounts.
- Download the HFSA and DCFSA Reimbursement Form from *MyBenefits* (Caltech) or *the AskHR Knowledge Base* (JPL).
- Contact HealthEquity at 1-877-582-4453 if you need assistance creating an account, seeking reimbursement, requesting forms, confirming what is eligible for reimbursement, and more.
- Note: You must seek reimbursement from your HFSA and DCFSA by March 31 of the following calendar year in order to be reimbursed. You must also add documentation that details your expenses. Visit https://answers.healthequity.com/app/answers/detail/a_id/1324/~/~substantiating-documents-for-requirements.

Health and Welfare Plan Disclosures and Administration

About This Summary Plan Description (SPD)

This health and welfare plan summary (which is part of the Institute health and welfare plan document) should be read carefully and 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.

If there is a discrepancy between the information in this SPD relating to H&W benefits and insurance contracts, the insurance contracts and health and welfare Evidence of Coverage booklets (EOCs), will govern.

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

Please see the EOCs for details of plan benefits.

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

Important Disclosures

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

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

Tax Consequences of Domestic Partner Coverage

Under federal tax law, if your domestic partner does not qualify as your tax dependent for health coverage purposes (as defined below), then you will pay for your domestic partner's coverage on an after-tax basis. The value of your domestic partner's coverage, less the amount you pay for the coverage on an after-tax basis, will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2. This includes any portion of the premiums that the Institute pays for your domestic partner's health coverage. (The value of coverage varies, depending on the coverage options you elect.) Effective as of September 16, 2013, your legally married same-sex spouse is not treated as a domestic partner but as a spouse.

Under the Plan, domestic partners (and/or the children of domestic partners) are not considered to be tax dependents unless you provide acceptable proof of tax dependency for the year. For before-tax treatment, you must complete and return a Certification of Dependent Status for Domestic Partners, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. You will be asked to complete a Certification each year at open enrollment.

Note: State tax treatment of health coverage for domestic partners and/or same sex spouses may differ. For example, some states including California exclude certain domestic partner coverage from gross income for state income tax purposes, even if the domestic partner is not a tax dependent for federal tax health coverage purposes.

Is Your Domestic Partner a Tax Dependent for Health Coverage Purposes?

The following conditions must be met in order for your domestic partner to qualify as your tax dependent for health coverage purposes under federal tax law:

- You and your domestic partner have the same principal place of abode for the entire calendar year.
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law).
- During the calendar year you provide more than half of your domestic partner's total support.
- Your domestic partner is not your (or anyone else's) "qualifying child" under Code Section 152(c).
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

Your domestic partner could be your federal tax dependent for health coverage purposes even if you do not claim an exemption for him or her on your Form 1040. If you believe you might provide more than half of your domestic partner's (and/or children of your domestic partner)

support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

The foregoing is a brief summary of general federal tax law and may not be applicable to your situation or your state. Tax laws change from time to time. You are encouraged to consult with your tax advisor at your own expense to determine the dependent and any other tax status of your domestic partner and/or domestic partner's children.

During California Pregnancy Disability Leave

If you are a California employee and cease active employment due to a leave of absence on account of pregnancy, childbirth or related medical conditions that qualifies as a pregnancy disability leave under the California Fair Employment and Housing Act (a "Pregnancy Leave"), coverage will be continued under the same terms and conditions which would have applied had you continued in active employment, provided you continue to pay your contribution share toward the cost of coverage, if any contribution is required. Contributions will remain at the same employer/ employee levels as were in effect on the date immediately prior to the leave of absence (unless contribution levels change for other employees in the same classification). Your contributions will be paid in the same manner as described above for FMLA Leave. If you do not return to active employment for other than FMLA Leave or other disability leave, Caltech can recover from you any contribution share you failed to pay during the Pregnancy Leave to the extent permitted by law.

For additional information on Pregnancy Leave, please contact your Human Resources Department.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), also referred to as a "military leave," you are entitled to continue coverage for up to 24 months as long as you give Caltech advance notice (with certain exceptions) of the leave.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full cost of coverage for you and your dependents, like the cost of COBRA. If you take military leave and your coverage under the Plan is terminated—for instance, because you do not elect the extended coverage—you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies upon your reinstatement into the Plan.

Under circumstances in which COBRA continuation coverage rights also apply (see the section entitled "COBRA"), an election to continue coverage during a military leave will be considered to be an election to take COBRA, and the two will run concurrently.

Subrogation and Reimbursement

Subrogation and Reimbursement applicable to fully-insured health benefits are described in the applicable insurer's EOC and related materials. For benefits under the Anthem HMO, Anthem PPO plans, the Delta Dental PPO, a Covered Person may incur medical or other charges related to injuries or illness caused, or allegedly caused, by the act or omission of another person; or a Third Party may be (or may be alleged or claimed to be) liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or Third Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or Third Party and the Plan will also be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole". In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement from a Recovery will not be reduced for any reason, including the Covered Person's attorneys' fees or costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

In no case will the amount subject to subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, out of any Recovery without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Covered Person" means anyone covered under the Plan, including minor Dependents.

"Third Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible (or who is alleged or claimed to be liable or legally responsible) to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

"Third Party" shall also include the party or parties who caused the injuries or illness (or are alleged or claimed to have caused the injuries or illness); the insurer, guarantor or other indemnifier of the party or parties who caused or allegedly caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible (or is alleged or claimed to be liable or legally responsible) for payment in connection with the injuries or illness.

"Recovery" shall mean the specific fund of any and all monies paid to the Covered Person by way of judgment, settlement, arbitration or otherwise (no matter how those monies may be characterized, designated, held, or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness covered under the Plan. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Reimbursement" shall mean repayment from the Recovery to the Plan for medical or other benefits it has paid toward the care and treatment of an illness or injury and for the expenses

incurred by the Plan in obtaining Reimbursement.

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person (including, but not limited to, recoupment from health care providers of any prior payments of those claims) and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the illness or injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are incurred related to an illness or injury for which a Recovery has been made. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

A Covered Person is required to:

- Include such expenses in any claim made against a Third Party for the injury or conditions
- Sign an agreement to Reimburse the Plan from any Recovery
- In the event of a Recovery, to reimburse the Plan from the Recovery
- Instruct your attorney, if one is retained, to Reimburse the Plan from any Recovery in a form satisfactory to the Plan
- Cooperate fully with the Plan in asserting its subrogation and Reimbursement rights from any Recovery and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose

Example of Subrogation from a Recovery

"Subrogation" is a legal term that means the substitution of one person for another with respect to a legal claim - this allows the Plan to assume the place of a Plan participant or beneficiary for the purpose of being reimbursed from any Recovery. For example, if you are injured in a car accident and the Plan pays the related medical expenses. If another driver was, or was claimed to be, responsible for the accident, the medical damages would typically be included in any claim by you against this driver. However, if you do not file a lawsuit or do not otherwise claim the medical expenses, the Plan will have paid expenses that should have been paid by the

driver at fault. The subrogation right allows the Plan to “step into your shoes” for the purposes of asserting claims for a Recovery against the driver who was, or was claimed to be, at fault.

Example of Reimbursement from a Recovery

The “reimbursement” right from a Recovery is similar to the subrogation right - however, the Plan does not “step into the shoes” of the participant or beneficiary by making claims against responsible parties.

Instead, the Plan seeks reimbursement from a Recovery. For example, if you are injured in a car accident and the Plan pays the related medical expenses. You bring a lawsuit or claim against the responsible driver and obtain a Recovery. The Reimbursement right allows the Plan to seek repayment from that Recovery. Note: Other cases under which the Plan may have a right of Reimbursement from a Recovery include a fall in store or parking lot, a fall or other injury sustained at someone’s home, medical malpractice, neighbor’s dog or cat bites you, assaults, motorcycle accidents, boating accidents and off-road vehicle accidents (this is not an exhaustive list).

The following provisions also apply:

- Recovery includes any amount received, whether by judgment, settlement, arbitration, compromise and release, or otherwise.
- All Reimbursement to the Plan must occur within 30 days of the receipt of any Recovery by you and/or your attorney(s).
- The Plan’s rights to subrogation and reimbursement from any Recovery shall take priority over your or your dependents’ right to be made whole. The “make whole” rule does not apply under the Plan.

COBRA Continuation Coverage

The Plan will offer COBRA continuation coverage to qualified beneficiaries after the Plan Administrator has been notified that a qualifying event has occurred. The EOCs describe available COBRA continuation coverage. For the plan’s COBRA notices, log into MyBenefits (for Caltech) or the AskHR Knowledge Base (for JPL). When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Sponsor must notify the Plan Administrator of the qualifying event. If your employment terminates (for reasons other than gross misconduct) or your hours are reduced, you will be sent an enrollment form for, and cost information on, continuing your benefits under COBRA.

If you or your dependents want the additional 11-month extension due to disability, you must notify the Claims Administrator within 60 days after the date the disabled qualified beneficiary receives his or her Social Security disability determination and before the end of the initial 18-month COBRA continuation coverage period. You also must notify the Claims Administrator within 30 days if Social Security determines you or your dependent is no longer disabled.

If you become divorced or legally separated, or your child no longer meets the eligibility requirements, you, your spouse, or your child is responsible for notifying the Claims Administrator within 60 days. COBRA rights will be forfeited if the Claims Administrator is not notified within 60 days of the qualifying event. The Claims Administrator will in turn notify you or your dependents of your COBRA continuation rights within 14 days of receiving your notice. You must elect COBRA coverage within 60 days of receiving the notice, or, if later, within 60 days of

the event causing the loss of coverage. COBRA rights will be forfeited if you or your dependent(s) do not elect COBRA coverage within this 60-day period.

Your Rights and Privileges Under ERISA

As a participant in the Caltech Health and Welfare Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Claims Administrator’s office and at other specified locations such as work sites, 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.
- Obtain copies of Plan documents (including component benefit program documents) and other Plan information upon written request to the Claims Administrator. The administrator may make a reasonable charge for the copies
- Receive a summary of the Plan’s annual financial report and Summary Annual Report (where required by law).
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Fiduciary Obligations under ERISA

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating the employee benefit plan:

- The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
- No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
- If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have your claim reviewed and reconsidered.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Claims Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Claims Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. If you file suit, the court may order the person you sued to pay your costs and fees. If you lose, the court may order you to pay the costs and fees of the person(s) you sued; for example, if it finds your claim is frivolous.
- If you have any questions about the Plan, you should contact the Plan Administrator.
- If you have any questions about this statement or about 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, or The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll free at 1-866-444-EBSA (3272).

Participants Contributions

Participants shall make contributions for coverage under the Plan during those periods and in such amounts as Caltech in its sole discretion may from time to time require. Caltech shall pay the remaining costs, if any, for such coverage from its general assets, but in no event, however, shall Caltech pay or otherwise be liable for any deductible, coinsurance or copayment amounts or other amounts which under the Plan are the responsibility of Covered Persons. To the fullest extent permitted by law, any dividends, settlements (including but not limited to class action settlements where the Plan is a member of the plaintiff class) premium refunds, rebates (including, but not limited to, pharmacy rebates) or like payments or adjustments payable under, or in connection with, the Plan shall be, and remain, solely the exclusive property of Caltech.

Plan Administrator's Discretion

The administration of the Plan is under the discretionary supervision of the Plan Administrator which is the Institute. The Claims Administrator(s) of the Institute's PPO and HMO plans and "delegates" of the Plan Administrator) has/have been designated to act on behalf of the Plan Administrator and the has been delegated the same discretionary authority as the Plan Administrator with respect to the services provided by those Claims Administrator(s). A principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, in its discretion, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing or denying benefit payments and gathering information necessary for administering the Plan. The Plan Administrator has delegated to its delegates (, including, but not limited to, Anthem, Kaiser and all other Claims Administrators)) full discretion in carrying out their respective duties under the Plan.

The Plan Administrator, has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in that discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is, or is not, entitled to receive any benefits under the Plan. If due to errors in drafting, any of the Plan's provisions do not accurately reflect the intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or is determined by the Plan Administrator, or its delegates been granted discretionary authority under the Plan, the Plan Administrator's or delegatee's prior exercise of such authority shall not obligated to exercise its authority in a like fashion thereafter. Kaiser, and Anthem have been delegated same discretionary authority as the Plan Administrator set forth above. The Plan Administrator may further delegate its duties under the Plan by a written instrument identifying the delegatee(s) and setting forth the nature and scope of such delegation. Any determination or

interpretation by the Plan Administrator and/or the delegate(s) shall be final, binding, and conclusive, in the absence of clear and convincing evidence that the determination or interpretation was arbitrary and capricious.

Benefit Modification

Under certain conditions, benefits payable under the Plan may be modified by the Plan Administrator to provide alternative treatment for a Covered Person's serious (or which, in the Plan Administrator's judgment, could become serious) sickness or injury. Benefit modification will be determined exclusively by the Plan Administrator in its sole discretion. The Plan Administrator shall have the right to review the patient's medical needs and determine which services, supplies and providers are available under the modification of benefits, taking into consideration such factors as the Plan Administrator deems appropriate, including, but not limited to, the cost-effectiveness of any benefit modification. The Plan Administrator shall determine the benefit coverage under which the alternative treatment shall be considered payable and the duration of the benefit modification. Alternative treatment does not include services and supplies which the Plan Administrator determines to be experimental or investigational or otherwise inappropriate (e.g., are unlikely to be successful)

Amendment or Termination of the Plan

Caltech, as Plan Sponsor, has the right to amend or terminate the Plan at any time. There are no vested rights or benefits under the Plan. The Plan may be amended or terminated by a written instrument signed or approved by a duly authorized officer of Caltech.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator, and any delegatee of the Plan Administrator including, without limitation, and officers or other employees of the Caltech, shall be indemnified for any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. Caltech may also obtain fiduciary liability insurance for the Committee and other fiduciaries of the Plan and the cost of such fiduciary liability shall be paid by Caltech and not the Plan.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor Caltech makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under this Plan will be excludable from the Covered Person's gross income for federal, state or local income tax purposes. It shall be the obligation of each Covered Person to determine whether each payment under this Plan is excludable from the Covered Person's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Covered Person has any reason to believe that such payment is not so excludable.

Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of California, to the extent not superseded by the Code, ERISA (which shall preempt all state laws, including those of California, relating to the Plan) or any other federal law.

HIPAA Privacy and Security Rules

This Summary Plan Description and Plan Document (collectively, the “Plan”) shall be interpreted in a manner that permits the Plan to comply with HIPAA and other applicable laws regarding protection of protected health information with respect to the Plan. In the event any provision of this Summary Plan Description and Plan Document fails to comply with HIPAA, such provision shall be automatically amended to so comply.

HIPAA Privacy Notice

Health coverage is subject to HIPAA privacy and security protections for certain protected health information. For the plan’s privacy notices, log into *MyBenefits (for Caltech)* or the *AskHR Knowledge Base (for JPL)*.

Code, HIPAA and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code, HIPAA and ERISA, and of all regulations issued thereunder. This Plan shall be construed operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, HIPAA and/or ERISA, the provisions of the Code, HIPAA and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict and automatically amended to no longer so conflict.

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 provided on page 68.

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 Caltech)* or the *AskHR Knowledge Base (for JPL)*.
- 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).

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 Flexible Spending Account and HRA claims are considered non-urgent "post-service" claims.

| | Medical, Dental, Vision, Employee Assistance Plan, HRA & Health Flexible Spending Account Plans | | | | Short-Term & Long-Term Disability | Life, PAI, Business Travel & Voluntary Benefits |
|---------------------------------|--|--|---|--|---|---|
| | Urgent Care Claims | Non-Urgent "Pre-Service" Claims | Non-Urgent "Post-Service" Claims | "Concurrent Care" Decision to Reduce Benefits | | |
| Time frame for Providing Notice | Notice of determination (<i>whether adverse or not</i>) 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. | Notice of determination (<i>whether adverse or not</i>) must be provided by the plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days. | Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days. | Notice of adverse determination must be provided by the plan enough in advance to give claimant an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated. | Notice of adverse determination must be provided by the plan within a reasonable period of time, but no later than 45 days. | Notice of adverse determination must be provided by the plan within a reasonable period of time, but no later than 90 days. |

| | Medical, Dental, Vision, Employee Assistance Plan, HRA & Health Flexible Spending Account Plans | | | | Short-Term & Long-Term Disability | Life, PAI, Business Travel & Voluntary Benefits |
|---------------------------------------|--|--|--|--|--|--|
| | Urgent Care Claims | Non-Urgent “Pre-Service” Claims | Non-Urgent “Post-Service” Claims | “Concurrent Care” Decision to Reduce Benefits | | |
| Extensions | If your claim is missing information, the plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the plan’s receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination. | The plan has up to 15 days, if necessary due to matters beyond the plan’s control, and must provide extension notice before initial 15-day period ends.* | The plan has up to 15 days, if necessary due to matters beyond the plan’s control, and must provide extension notice before the initial 30-day period ends.* | N/A | The plan has up to 30 days, if necessary due to matters beyond the plan’s control. A second 30-day extension may also be permitted. The plan must provide the extension notice before the period(s) ends.* | The plan has up to 90 days for special circumstances and must provide the extension notice before the period ends. |
| Period for Claimant to Complete Claim | Claimant has a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the plan that your claim is missing information). | Claimant has at least 45 days to provide any missing information. | Claimant has at least 45 days to provide any missing information. | N/A | Claimant has at least 45 days to provide any missing information. | No rule. |
| Other Related Notices | Notice that claim is improperly filed or that information is missing must be provided by the plan to the claimant as soon as possible (no later than 24 hours after receipt of the claim by the plan). | Notice that claim is improperly filed must be provided by the plan to the claimant as soon as possible (no later than five days after receipt of the claim by the plan). | N/A | N/A | N/A | |

| | | | | | | |
|--|--|--|---|--|--|--|
| | Medical, Dental, Vision, Employee Assistance Plan, HRA & Health Flexible Spending Account Plans | | | | Short-Term & Long-Term Disability | Life, PAI, Business Travel & Voluntary Benefits |
| | Urgent Care Claims | Non-Urgent "Pre-Service" Claims | Non-Urgent "Post-Service" Claims | "Concurrent Care" Decision to Reduce Benefits | | |

*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 do not 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 another appropriately 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 consider 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.

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.

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.

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.

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.

The rules below additionally apply to disability claims filed on or after April 1, 2018

- Benefit denial notices must contain a more complete discussion of why the Plan denied a claim and the standards used in making the decision. For example, the notices must include a discussion of the basis for disagreeing with a disability determination made by the Social Security Administration if presented by the claimant in support of his or her claim.
- Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Benefit denial notices also have to include the internal rules, guidelines, protocols, standards or other similar criteria of the Plan that were used in denying a claim, or a statement that none were used. The Plan is prohibited from denying benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

- The Plan must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.
- If the Plan does not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the Plan, unless the violation was the result of a minor error and other specified conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court. In this situation the Plan must treat a claim as re-filed on appeal upon the plan's receipt of a court's decision rejecting the claimant's request for review.
- Rescission of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g., errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.
- Benefit denial notices have to be provided in a culturally and linguistically appropriate manner in certain situations. If a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the required to provide a verbal customer assistance process in the non-English language and provide written notices in the non-English language upon request.
- Nothing in the above is any waiver of the Plan's or employer's attorney-client work product or other applicable legal privileges, and the Plan and employer fully reserve all such privileges.

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 appropriate Court with jurisdiction over the claim. To the extent there is concurrent state and federal court jurisdiction, the Plan serves the right to remove any state court action to federal court to the fullest extent permitted by law. Refer to the Plan Document for more information.

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.

| | Medical, Dental, Vision, Employee Assistance Plan, HRA & Health Flexible Spending Account Plans | | | Short-Term & Long-Term Disability | Life, PAI, Business Travel, Legal & Voluntary Benefits |
|--|--|--|---|--|--|
| | Urgent Care Claims* | Non-Urgent Care Pre-Service Claims* | Non-Urgent Care Post-Service Claims* | | |
| Period for Filing Appeal | Claimant has at least 180 days. | Claimant has at least 180 days. | Claimant has at least 180 days. | Claimant has at least 180 days. | Claimant has at least 60 days. |
| Time frame for Providing Notice of Benefit Determination on Review | As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review. | 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. | Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal. | Within a reasonable period of time, but not later than 45 days after receipt of request for review. | Within a reasonable period, but not later than 60 days from receipt of request for review. |
| Extensions | None. | None. | None. | Additional 45 days if special circumstances require extension (with period “tolled” until claimant responds to any information request from the plan). | Additional 60 days if special circumstances require extension. |

* 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 the claimant sufficient advance notice of the initial claims determination so the claimant may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the plan does not fully agree with the claimant’s claim, they 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 (for Caltech) or the AskHR Knowledge Base (for JPL) 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 Benefits
- 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.

| Plan Name | Plan Number |
|--|-------------|
| Caltech Base Retirement Plan (Base Plan) | 002 |
| Caltech Voluntary Retirement Plan (Voluntary Plan or formerly referred to as ERISA TDA Plan) | 005 |
| Caltech 457(b) Deferred Compensation Plan (457(b) Plan) | |
| Consolidated Welfare Plan of California Institute of Technology, which includes the following: <ul style="list-style-type: none"> • Kaiser Permanente HMO • Anthem Blue Cross Advantage HMO • Anthem Blue Cross HDHP 1400 • Anthem Blue Cross HDHP 2800 • Anthem BlueCard PPO • Delta Dental PPO • MetLife/Safeguard Dental • VSP • Employee Assistance Program (EAP) • Life Insurance (Basic and Supplemental) • Personal Accident Insurance (PAI) • Disability Insurance (Basic LTD, Supplemental LTD, Basic STD and Voluntary STD) • Business Travel Accident Plan • Extra-Hazardous Duty Insurance | 601 |
| California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HFSA not DCFSA) | |
| International SOS Medical Access/International Referral Service | |
| Caltech Non-ERISA Tax-Deferred Annuity Plan (closed to new enrollments) <ul style="list-style-type: none"> • TIAA accounts • Fidelity accounts • Prudential accounts | |

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 (Safeguard) DHMO, Hartford Life Insurance (Basic and Supplemental), Hartford Long Term Disability (Basic and Supplemental), Hartford Personal Accident Insurance, Zurich 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 flexible spending account (HFSA) 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 below.

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 Director of Benefits & Compensation, Total Rewards 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, except for benefits self-insured by the Institute.
- 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 Contacts on page 122 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.

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 upon 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.

| Plan | Claims Administrator Contact Information |
|---|---|
| Medical | |
| Anthem Blue Cross HDHP 1400 Anthem Blue Cross HDHP 2800 Anthem BlueCard Preferred Provider Organization (PPO) Plan Anthem Blue Cross Advantage HMO | 21555 Oxnard Street Woodland Hills, CA 91367 |
| Kaiser Foundation Health Plan, Inc. (Southern CA) | Claims Department 1-800-390-3510 P.O. Box 7004 Downey, CA 90242-7004 |
| Kaiser Permanente Health Plan of WA | Claims Department 1-888-901-4636 P.O. Box 30766 Salt Lake City, UT 84130-0766 |
| Optum Rx (for KPWA prescription claims) | Claims Department 1-888-901-4636 P.O. Box 29044 Hot Springs, AR 71903 |
| Kaiser Permanente Health Plan – Mid-Atlantic | Claim Address P.O. Box 371860 Denver, CO 80237-9998 Member Services 1-800-777-7902 |
| Employee Assistance Program (EAP) | Campus SFCC at 1-626-395-8360 or via e-mail: SFCC@caltech.edu JPL EAP is through 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 |
| Dental | |
| Delta Dental of California (PPO Dental) | P.O. Box 997330 Sacramento, CA 95899-7330 |
| MetLife (Safeguard) DHMO (Dental DHMO) | Claims Department P.O. Box 30930 Laguna Hills, CA 92654 |

| Plan | Claims Administrator Contact Information |
|---|--|
| Vision | |
| Vision Service Plan (VSP) | 1-800-877-7195 P.O. Box 385018 Birmingham, AL 35238-5018 |
| Spending Accounts | |
| Health Equity | 1-801-727-1590 15 W Scenic Pointe Dr, Ste 100 Draper, UT 84020 |
| Insurance | |
| Disability The Hartford Insurance Company | P.O. Box 14869 Lexington, KY 40512-4869 |
| Life Insurance and Accident Death & Personal Loss (PAI) The Hartford Life Insurance Service Center | P. O. Box 14299 Lexington, KY 40512-4299 |
| Medical Access/International Referral Service International SOS | 1-800-523-6586 International SOS accepts collect calls from members overseas |
| Business Travel Accident Insurance And Medical Evacuation and Repatriation (MER) coverage | Zurich American Insurance Company P.O. BOX 968041 Schaumburg, IL 60196-8041 |
| 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 |

Agent of Legal Process

Any legal correspondence regarding the plans should be sent to:

Office of the General Counsel
California Institute of Technology
1200 E. California Blvd., Mail Code 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.

2021 Retirement Plan Summary Plan Description

About Your Retirement Benefits

Caltech Base Retirement Plan

| | |
|--------------------------------|--|
| How the Base Plan Works | <p>The Caltech Base Retirement Plan (Base 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 1st and ends on December 31st.</p> |
| Base Plan Eligibility | <p>Effective January 1, 2019 you are eligible to participate in the Base Retirement Plan if you are a Benefit Based employee in one of the following categories:</p> <p>Tenure/Tenure-Track Faculty:</p> <ul style="list-style-type: none">○ Professor, Associate Professor, Assistant Professor, Director of Athletics, University Librarian, President and Vice President <p>Non-Professorial Faculty:</p> <ul style="list-style-type: none">○ Faculty Associate, Instructor, Long Term Lecturer, Research Assistant Professor, Research Professor, Senior Faculty Associate, Visiting Professor, Moore Distinguished Scholar or any other non-professorial faculty not excluded from the retirement plan. <p>Staff Employees and Temporary Staff Employees:</p> <ul style="list-style-type: none">○ Staff Employees 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 at Campus and Temporary Employee Special TMS employees at JPL 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. <p>Postdoctoral Scholars and Senior Postdoctoral Scholars:</p> <ul style="list-style-type: none">○ Postdoctoral Scholars and Senior Postdoctoral Scholars paid by Caltech are eligible to participate in the Base Plan. |

Employees not Eligible to Participate in the Base Plan:

- Lecturers
- Visiting Associates
- Visitors
- Leased employees
- Independent contractors
- Occasional employees
- Part-time employees working less than 20 hours per week
- 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

How Employment Service Is Used

- Under the Base Plan, your years of Benefit Based service with the Institute is used in two different ways. First, it is used to determine when you are eligible to participate in the Base Plan based on Eligibility Service (defined below). Second, it is used to determine the Institute's contribution percentage under the Staff Contribution Formula based on Years of Service (defined below).
- **Eligibility Service** - used to determine initial eligibility to participate in the Base Plan. This includes periods of service with the Institute during which you complete one hour of service beginning with date of employment (see Glossary of Terms "Eligibility Service").
- **Years of Service** - used to determine Institute contributions to the Base Plan under the Staff contribution formula. This excludes periods of time during which you are employed in a non-eligible category (see Glossary of Terms "Years of Service").

When Base Plan Participation Begins

Base Plan Participation - New hires:

Staff Employees & Non-Professorial Faculty:

- **Key Staff Formula** - Mandatory participation begins on the first of the month following or coinciding with your date of hire.
- **Staff Formula** - Mandatory participation begins on the first of the month following or coinciding with the date you earn six months of Eligibility Service, or the required Years of Service.

Tenure & Tenure-Track Faculty:

- **Key Staff Formula** - Mandatory participation begins on the first of the month following or coinciding with your date of hire.

Postdoctoral Scholars:

- **Staff Formula** - Mandatory participation begins on the first of the month following or coinciding with the date you earn two years of Eligibility Service or the required Years of Service.

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 to the Plan Administrator (see Contacts on page 122 for information) 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.

Additional Participation Rules

Optional Participation for Visiting Professorial Faculty

A non-highly compensated faculty member who is neither a citizen of the United States nor a permanent resident alien or a Visiting Professorial Faculty may participate on an optional basis. Any election to participate on an optional basis is irrevocable. Participation on an optional basis begins on the first of the month following or coinciding with your date of hire.

JPL Grandfathered Employees

If you were an Eligible Employee at JPL, and were considered a Key Staff Employee on March 16, 1997, according to the plan's terms in effect at that time, you are a Key Staff Employee (even though in 1997 and later years your Regular Salary is less than the Minimum Compensation Level).

Status Changes

If you gain eligibility while you are employed or qualify for a different contribution formula due to a change in employment status, then your participation and/or contribution formula will begin on the first of the month following the date of your status change. For example:

- Move from Part-time/Occasional NON-Benefit Based to Part-time (20 hours per week) or Full-Time Benefit Based – You will participate in the Base Plan on the first of the month following the date of your status change.
- Move from the Staff contribution formula to Key Staff contribution formula – When your salary changes to at or above the MCL, the Staff contribution formula changes to the Key Staff contribution formula as of the first of the month following the date of your salary change.

If You Lose Eligibility for the Key Staff Contribution Formula

If any employee (other than a Grandfathered Employee as described above) receives Regular Salary that falls below the applicable Minimum Compensation Level for the year, and no longer meets the definition of Key Staff you will participate in the plan as follows:

- **Less than 10 years of Benefit Based service** - The Base Plan provides a bridging period to minimize the impact to your contribution amount. You will be “bridged” and remain in the Key Staff contribution formula until you reach 10 Years of Service. If your compensation level remains below the MCL after you reach 10 Years of Service, you will move to the Staff contribution formula on the first of the month following your 10 year service anniversary date. If you terminate employment during your bridging period and are later rehired with compensation below the MCL, you will not continue with the bridging period.
- **10 or more years of Benefit Based service** - Your contribution will be changed to the Staff contribution formula on the first of the month following the month in which your compensation falls below the MCL.

What Happens If You Terminate Employment and Are Subsequently Rehired:

- 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 receiving payments from the Base Plan prior to reemployment, you may be required to discontinue those payments.

What Happens If You Go on an Approved Leave of Absence:

- Special rules apply if you go on a 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. **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 Taxable 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 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. When you return from a qualified military leave, contact the Benefits Office to verify the dates your leave began and ended.
- **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.

Base Plan Contributions

Under the Base Plan you will receive either the Staff contribution formula or the Key Staff contribution formula based on the eligibility criteria outlined above:

- **Staff Contribution Formula (Staff Formula)** - Staff employees and Non-Professorial Faculty whose salary is below the Minimum Compensation Level (MCL, \$124,000 in 2021) and Postdoctoral Scholars are eligible to receive the Staff formula.
- **Key Staff Contribution Formula (Key Staff Formula)** - Tenure/Tenure-Track Faculty regardless of salary, Staff employees and Non-Professorial Faculty whose Annual Base Compensation is equal to or greater than the Minimum Compensation Level (MCL) are eligible to receive the Key Staff formula. The MCL is \$124,000 in 2021.

Contributions are generally made at least monthly. If you participate in the Base 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 Contribution Formula:

Your contributions are based on your pay, job classification, age and Years of Service with the Institute. The Staff contribution formula for Staff Employees, Non-Professorial Faculty and Postdoctoral Scholars is detailed below:

| Completed Years of Service | Plan Contribution Percentage* |
|---|-------------------------------|
| Six months (two years for Postdoctoral Scholars) but less than 10 years | 5.0% of gross pay** |
| Ten or more years and under age 50 | 8.0% of gross pay** |
| Ten or more years and age 50 or older | 12.0% of gross pay** |

* 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 compensation eligible for retirement contributions.

Staff Contribution Formula Retirement Plan Earnings

Under the Staff contribution formula, the Base Plan provides contributions based on your Retirement Plan Earnings. Retirement Plan Earnings under the Staff formula means gross pay, which includes W-2 wages plus pre-tax contributions made to an eligible plan (such as pre-tax contributions for medical/dental benefits, 403(b) contributions, etc.). In the event a participant is receiving Short Term or Long Term Disability benefits, Institute contributions are based on the Participant’s rate of pay in effect at the time of Disability. During a period of qualified military service, Institute contributions are based on the Participant’s rate of pay in effect on the last day worked. Retirement Plan Earnings excludes all compensation paid after severance of employment, except as permitted under Code Section 415.

Key Staff Contribution Formula

The Key Staff contribution formula is applicable to Tenure and Tenure Track Faculty regardless of salary and Staff Employees and Non-Professorial Faculty whose full-time equivalent salary is at or above the MCL.

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% times your annual regular salary above the Social Security Taxable Wage Base, which is \$142,800 for 2021.
- **After age 55:** Beginning with the first of the month coincident with or following your 55th birthday, the Institute will contribute 12.3% times your annual regular salary up to the Social Security Taxable Wage Base, plus 18% times your salary above the Social Security Taxable Wage Base, which is \$142,800 for 2021.

Participant Contributions

You pay 5.7% times 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 executives and senior management).

For 2021, the Social Security Taxable Wage Base is \$142,800.

Adjustment to Contribution Rates If Social Security Old Age Tax Rates Increase:

In the unlikely event that the percentage of the Social Security tax rate that is applied to old age benefits increases above 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 higher Social Security old age 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 higher Social Security old age tax rate.
- Employee contribution percentages will equal this higher percentage of the Social Security tax rate that is applied to old age benefits which is greater than 5.7%.

Key Staff Retirement Plan Earnings - Regular Salary

Under the Base Retirement Plan Key Staff Formula, the plan provides contributions based on your Regular Salary. For Professorial 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 Professorial Faculty member, 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.

Fellowship stipends distributed by Caltech are not considered compensation eligible for Institute contributions.

In no event will the Regular Salary taken into account under the Base Plan exceed the limits of Internal Revenue Code Section 401(a)(17). (The limit for 2021 is \$290,000. 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.

The Institute will continue making Institute Contributions for an eligible participant during a period of a qualifying military leave based on the participant's rate of pay in effect on the last day worked and taking into account the Minimum Compensation Level on that date. Contact the Benefits Office for more information and to let them know when you begin and end military leave.

Election to Remain Under the Staff Contribution Formula

A Staff Employee or Non-Professorial Faculty 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, may elect to remain under the Staff contribution formula for purposes of the Base Plan. The election to remain under the Staff contribution formula 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 Base Plan under the Key Staff contribution formula, provided he/she still satisfies the definition of Key Staff Employee or is still at or above the Minimum Compensation Level.

The contributions made on your behalf to this plan 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)* or the *AskHR Knowledge Base (JPL)*.

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 Base Plan's Qualified Default Investment Alternative (QDIA) which is a TIAA 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 birthday for information about the fund). For more information about the TIAA Lifecycle Funds, visit

<https://www.tiaa.org/public/tcm/caltech/view-all-investments>.

You may change your investment elections or transfer existing account balances between funds by contacting TIAA or logging in to your online account, 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 fund changes. Visit

<https://www.tiaa.org/public/tcm/caltech/view-all-investments> 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 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.

**Base Plan
Withdrawals
and
Distributions**

Withdrawals

You may elect an In-service withdrawal if you are at least age 59½, provided it is permitted under the provisions of the relevant funding vehicle. Otherwise, you must wait until you terminate employment to begin distributions. Special distribution rules may apply if you reach Required Minimum Distribution (RMD) age, or become deceased.

Regardless of age, you may elect an in-service withdrawal of any previously deposited rollover contributions at any time, provided it is permitted under the provisions of the relevant funding vehicle.

You are encouraged to review your situation with your tax advisor. You should carefully consider the tax consequences of any withdrawal. Contact TIAA for more information on the potential tax implications.

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.

Automatic Distributions - Former Employee Accounts Under \$1,000

If the account of a former employee does not exceed \$1,000 at the time of review, the value of the participant's account will be distributed in a single sum and applicable taxes withheld including any applicable early withdrawal penalties. Communications will be provided to the address of record in advance of the distributions allowing the participant to elect a direct rollover of rollover eligible assets.

Distributions

Some retirement distributions are eligible to be rolled over to an IRA or another qualified 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 in addition to any other applicable taxes. 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.

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.

Special Distribution Rules

Required Minimum Distributions (RMD)

Generally, you can wait until you terminate employment with the Institute to start required minimum distribution payments from the Caltech Base and Voluntary Retirement Plans. You are encouraged to review your individual circumstances with your tax advisor.

Federal law requires that non-employed participants begin their retirement benefits no later than April 1 following the year in which you reach:

- Age 70½ or the year in which you leave the Institute if you reached age 70½ before January 1, 2020; OR
- Age 72 or the year in which you leave the Institute

Some examples:

- Maria reached age 70½ in 2019 and her employment with the Institute ends in 2021. She must begin minimum distributions no later than December 31, 2021.
- John's employment with the Institute ended in 2020, and he reached age 72 in 2021. He must begin minimum distributions no later than April 1, 2022.
- Dora is a benefit eligible employee of the Institute and is age 72. Under the rules for the Base and Voluntary Retirement Plans, she is not required to take required minimum distributions while she is still employed by the Institute.
- Charles is a non-benefit eligible employee of the Institute and is age 72. Under the rules for the Base and Voluntary Retirement Plans, he is not required to take required minimum distributions while he is still employed by the institute.

TIAA will automatically contact any participant who meets the age requirement for required distributions several months before the date they are required to begin receiving your distribution whether they are currently employed by the Institute or not. 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. You are encouraged to review your individual circumstances with your tax advisor.

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.

Base Plan Beneficiaries

It is 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:

- Campus employees: Log in to *MyBenefits* through www.access.caltech.edu
- JPL employees: Access *Workday* through the JPL Space Intranet
 - Select the Benefits shield icon
 - Select Manage TIAA Beneficiaries under External Links

Base 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. Hardship withdrawals taken before age 59½ are subject to a 10% federal excise tax in addition to any other applicable taxes.

IRS regulations limit the funds contributed by an employer that are eligible for hardship withdrawal. Funds in the Base Plan not eligible for hardship withdrawal are those in custodial accounts like mutual funds and any funds transferred from a custodial account. This rule does not apply to funds within the Caltech Voluntary Plan. Call TIAA at 800-842-2252 for a listing of funds available to you for a hardship withdrawal from the Base Plan.

A financial hardship is an immediate and heavy financial need that cannot 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.

Base Plan Loans

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

- Maximum number of outstanding loans:
 - Loan(s) issued after January 1, 2019 are subject to the rules of one loan each from the Caltech's plans. Only one outstanding loan from the Voluntary Plan and one outstanding loan from the Base Plan are permitted at a time.
 - Loan(s) issued prior January 1, 2019 will remain under the same terms and conditions on the agreement when initiated.
- Loan term: Up to 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
- There is a \$75 origination fee for each loan
- Loan repayments must be made through automatic electronic payments (ACH) from your bank checking or savings account.

You will be required to make regular repayments on your loan until it is paid off. 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 Base 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.

Loan Payments While on Military Leave

During a period of qualifying military leave, your loan payments may be suspended if you are unable to make regular scheduled payments during your military leave. Contact TIAA to find out more details on plan loans, including how much you are able to borrow, to request a loan, or to request a loan suspension while on military leave.

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|-------------------------|--|
| Base 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 Base Plan. Please refer to the fee disclosure statement you receive annually from TIAA, or go to https://www.tiaa.org/public/investment-performance and enter plan number 403497 for current fund performance and fees/expenses information. Contact TIAA for questions. |
| More Information | The Caltech Base Retirement Plan document is available upon request from the Plan Administrator. See page 122 for contact information. |

Caltech Voluntary Retirement Plan

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|-------------------------------------|---|
| How the Voluntary Plan Works | <p>The Caltech Voluntary Retirement Plan (Voluntary Plan) allows you to defer a portion of your current eligible 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 can also make a Roth after-tax contribution, whereby your contribution is taken out of your paycheck after taxes, and your withdrawals at retirement are generally tax-free. You determine how your account is invested among the options offered by the Voluntary Plan. The Plan Year begins on January 1st and ends on December 31st.</p> <p>This Voluntary Plan was formerly referred to as the ERISA TDA Plan.</p> |
| 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 or Roth after-tax basis, or a combination of both, 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 your account through *MyBenefits (for Caltech)* or the *AskHR Knowledge Base (for JPL)*.

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

If you return from a qualified military leave of absence, 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 may 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 the 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 a previous employer’s retirement plan. Certain after-tax accounts are not eligible for rollover. Contact TIAA for more information, on which retirement plan accounts are eligible for rollover. Contact TIAA to initiate a rollover contribution.

**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 Voluntary 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). For more information about the TIAA Lifecycle Funds, visit <https://www.tiaa.org/public/tcm/caltech/view-all-investments>.

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. Visit <https://www.tiaa.org/public/tcm/caltech/view-all-investments> 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.

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|---|--|
| Vesting of Voluntary Plan Contributions | You are fully and immediately vested in your Voluntary Plan accounts. Such amounts are non-forfeitable. |
| Voluntary Plan Withdrawals and Distributions | <p>Withdrawals</p> <p>In general, you may begin receiving your benefits following termination of employment, becoming disabled, as defined by the Voluntary Plan, or an In-Service withdrawal after reaching age 59½. Special distribution rules apply if you reach age Required Minimum Distribution (RMD) age, pass away or are on qualifying military leave.</p> <p>Regardless of age, you may elect an in-service withdrawal of any previously deposited rollover contributions at any time.</p> <p>You are encouraged to review your situation with your tax advisor. You should carefully consider the tax consequences of any withdrawal. Contact TIAA for more information on the potential tax implications.</p> <p>In general, you are required to pay applicable taxes upon withdrawal/distribution of assets. Earnings associated with Roth after-tax contributions in the Voluntary Plan may be non-taxable income if it is under a qualified withdrawal. A qualified withdrawal of Roth after-tax contributions occurs if at the time of the withdrawal/distribution the participant is at least age 59½ and the initial Roth after-tax contribution in the Voluntary Plan was made at least five whole years prior.</p> <p>Withdrawals While on Military Leave</p> <p>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 Plan accounts, even though you may be considered still actively employed. In that event, your voluntary pre-tax deferrals</p> |

to the Voluntary 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.

You are encouraged to review your situation with your tax advisor. You should carefully consider the tax consequences of any withdrawal. Contact TIAA for more information on the potential tax implications.

Automatic Distributions - Former Employee Accounts Under \$1,000

If the account of a former employee does not exceed \$1,000 at the time of review, the value of the participant's account will be distributed in a single sum and applicable taxes withheld including any applicable early withdrawal penalties. Communications will be provided to the address of record in advance of the distributions allowing the participant to elect a direct rollover of rollover eligible assets.

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.

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.

Special Distribution Rules

Required Minimum Distributions

Generally, you can wait until you terminate employment with the Institute to start payments. You are encouraged to review your individual circumstances with your tax advisor.

Federal law requires that non-employed participants retirement benefits must begin no later than April 1 following the year in which you reach:

- Age 70½ or the year in which you leave the Institute if you reached age 70 ½ before January 1, 2020; OR
- Age 72 or the year in which you leave the Institute Some examples:
- Maria reached age 70½ in 2019 and her employment with the Institute ended in 2021. She must begin receiving minimum distributions no later than December 31, 2021.
- John's employment with the Institute ended in 2020, and reached age 72 in 2021. He must begin receiving minimum distributions no later than April 1, 2022.
- Dora is a benefit eligible employee of the Institute and is age 72. Under the rules for the Base and Voluntary Plans, she is not required to take required minimum distributions while she is still employed by the Institute.
- Charles is a non-benefit eligible employee of the Institute and is age 72. Under the rules for the Base and Voluntary Plans, he is not required to take required minimum distributions while he is still employed by the institute.

**Voluntary
Plan
Beneficiaries**

TIAA will automatically contact participants who meet the age requirement for required distributions several months before the date they are required to begin receiving your distribution regardless of their employment status at the Institute. 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. You are encouraged to review your individual circumstances with your tax advisor.

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.

It is 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. Active employees can also access their accounts online through:

- Campus employees: Log in to *MyBenefits* through www.access.caltech.
- JPL employees: Access *Workday* through the JPL Space Intranet
 - Select the Benefits shield icon
 - Select Manage TIAA Beneficiaries under External Links

**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. Hardship withdrawals taken before age 59½ are subject to a 10% federal excise tax in addition to any other applicable taxes. You may voluntarily stop your deferral election to the Voluntary Plan by calling TIAA or logging into your online account. Please refer to the deferral election schedule for timing of the change to go into effect.

A financial hardship is an immediate and heavy financial need that cannot 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.

Voluntary Plan Loans

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

- Maximum number of outstanding loans:
 - Loans issued after January 1, 2019 are subject to the rules of one loan each from the Caltech plans. Only one outstanding loan from the Voluntary Plan and one outstanding loan from the Base Plan are permitted at a time.
 - Loans issued prior to January 1, 2019 will remain under the same terms and conditions in the agreement when initiated.
- 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
- \$75 origination fee for each loan
- Loan repayments must be made through automatic electronic payments (ACH) from your bank checking or savings account.

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 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

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| | <p>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.</p> <p>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.</p> <p>Contact TIAA to find out more about plan loans, including how much you are able to borrow, or to request a loan.</p> |
| Voluntary Plan Fees | <p>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 and enter plan number 403498, or contact TIAA. See page 109 for contact information.</p> |
| More Information | <p>The Caltech Voluntary Retirement Plan document is available upon request from the Plan Administrator. See page 122 for contact information.</p> |

California Institute of Technology 457(b) Deferred Compensation Plan

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| How the 457(b) Plan Works | <p>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-deferred 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 <i>MyBenefits (Caltech)</i> or the <i>AskHR Knowledge Base (JPL)</i>.</p> <p>The plan year begins on January 1 and ends on December 31.</p> |
| 457(b) Plan Eligibility | <p>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.</p> <p>Newly hired employees whose annual rate of salary (including regular increases paid as a lump sum) meet the salary threshold become eligible upon hire. For faculty, eligible compensation means the salary stated in the academic year contract and administrative supplements.</p> <p>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, 2020 salary threshold of \$247,860 would determine your eligibility to participate in the 457(b) Plan for the plan year</p> |

beginning January 1, 2021. The Plan Administrator determines the new salary rate threshold as of each November 1 for determining who is eligible for the 457(b) 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 (\$130,000- for 2020) 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 457(b) Plan effective the following January 1. You may become eligible for the 457(b) 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.

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| 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 457(b) Plan or change your deferral amount. Check with TIAA for the deferral election schedule. See page 122 for contact information. |
| 457(b) Plan Contributions | You can contribute up to the IRS limit \$19,500 in 2021. You choose how to invest your contributions among the available investment options. You may change your investment elections at any time by contacting TIAA or logging onto your online account. |
| 457(b) 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 TIAA Traditional Fund. For additional details about the investment options, visit https://www.tiaa.org/public/tcm/caltech/view-all-investments . 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 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 www.tiaa.org/public/tcm/caltech/view-all-investments 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. |

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| Vesting of 457(b) Plan Contributions | You are fully and immediately vested in your 457(b) Plan accounts. Such amounts are non-forfeitable, but are subject to general creditors of the Institute. |
| 457(b) Plan Distributions | <p>In general, you may begin receiving your benefits following termination of employment. You should carefully consider the tax consequences of any withdrawal.</p> <p>Your benefit may generally be paid in the following forms:</p> <ul style="list-style-type: none"> • 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 <p>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 payment option as described in the above list. You cannot defer the start of distribution later than April 1 following the calendar year you reach age 72 unless you remain an employee past age 72. If you were age 70½ prior to January 2020, you cannot defer the start of distribution later than age 70½ or separation from the Institute. 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.</p> <p>If you provide your written election and subsequently return to the Institute as a benefit based or non-benefit based employee, the benefit will be distributed according to your election even if you are employed by the Institute at that time.</p> <p>Contact TIAA for additional information, and to initiate your distribution. See page 122 for contact information.</p> |
| 457(b) Plan Beneficiaries | <p>It is 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:</p> <ul style="list-style-type: none"> • Campus employees: Log in to <i>MyBenefits</i> through www.access.caltech • JPL employees: Access <i>Workday</i> through the JPL Space Intranet <ul style="list-style-type: none"> • Select the Benefits shield icon • Select Manage TIAA Beneficiaries under External Links |
| More Information | The Caltech 457(b) Deferred Compensation Plan document is available upon request from the Plan Administrator. See page 122 for contact information. |

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 800-842-2252, Fidelity at 800-343-0860 or Prudential at 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. See **What Happens If...** on page 34 to view the checklists.

Plan Enrollment

Enrollment for the Base Plan is mandatory, unless you make a one-time irrevocable election not to participate in the plan. For more information on Base Plan participation, see page 71 or contact TIAA.

Enrollment for the Voluntary Plan and 457(b) Plan is voluntary. For more information on enrollment, see the Voluntary Plan section of this guide on page 84 or the 457(b) Plan section of this guide on page 91, or contact TIAA.

Changing Deferral Elections

For the Voluntary 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:

- Campus employees: Log in to *MyBenefits* through www.access.caltech.
- JPL employees: Access *Workday* through the JPL Space Intranet
 - Select the Benefits shield icon
 - Select Manage TIAA Contributions under External Links.

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 at www.tiaa.org or contact TIAA.
- Log onto <https://www.tiaa.org/public/tcm/caltech/view-all-investments> for the latest fund information for each of the plans below:
 - Base Plan
 - Voluntary Plan
 - 457(b) Plan

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 beginning page 71. For information on borrowing from the Voluntary Plan, see the Voluntary Plan section of this guide beginning page 84.

Financial Hardship Reasons

A hardship withdrawal can be made when an immediate and heavy financial need cannot 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 Base and Voluntary Plans while still employed if you reach age 59½ or you have an immediate financial need (see financial hardship reasons listed above). See the respective Base Retirement Plan section beginning on page 71 and Voluntary Plan section beginning page 84 for more information on requesting a hardship withdrawal and for more information on requesting an age 59½ in-service withdrawal.

In-service withdrawals are available regardless of age for any previously deposited rollover contributions at any time.

Termination

Upon termination of employment, you will 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 Base or Voluntary Plans

Any outstanding loans will be defaulted if you do not make a full repayment within a certain time frame. For more information on loan default, see “Base Plan Loans” on page 83 and “Voluntary Plan Loans” on page 90.

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, above.

For additional information on receiving a distribution, review each retirement plan’s section, beginning on page 71.

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 (see instructions below) or contact TIAA.

- Campus employees: Log in to *MyBenefits* through www.access.caltech.
- JPL employees: Log in to *Workday* through the JPL Space Intranet
 - Select the Benefits shield icon
 - Select Manage TIAA Beneficiaries under External Links

Divorce

You may obtain a copy of the Qualified Domestic Relations Order (QDRO) Guidelines for the retirement plans in *MyBenefits (Caltech)* or *the AskHR Knowledge Base (JPL)*, or by contacting 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 employees become eligible the first of the month following meeting the Minimum Compensation Level (this threshold can change each year).

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

How do I determine if I am eligible for the Key Staff contribution formula?

To be eligible for the Key Staff contribution formula, you must be a tenure or tenure track faculty member or your annual compensation as defined by the Base Retirement Plan must be equal to or greater than the Minimum Compensation Level (MCL).

What is the bridging period?

Employees who have been eligible for the Key Staff contribution formula and have less than 10 Years of Service and no longer meet the MCL are bridged. The bridging period is designed to minimize the impact to the retirement contribution after 10 years of service. You will continue to receive the Key Staff contribution formula until you reach 10 Years of Service.

What if my compensation is below the MCL once I reach 10 Years of Service?

The bridging period will only apply until you reach 10 Years of Service. When you reach 10 Years of Service, you will receive the Staff contribution formula if your compensation falls below the MCL.

If I terminate employment during the bridging period and am later rehired, will the bridging period be reinstated?

No, if you terminate employment for any reason during your bridging period and are rehired with compensation below the MCL, you will not continue to be bridged.

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?

Access your accounts online through:

- Campus employees: Log in to *MyBenefits* through www.access.caltech .
- JPL employees: Access *Workday* through the JPL Space Intranet
 - Select the Benefits shield icon
 - Select Manage TIAA Contributions under External Links

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

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

Contact TIAA at 800-842-2252 and also review the QDRO Guidelines for the Caltech Retirement Plans in *MyBenefits (Caltech)* or the *AskHR Knowledge Base (JPL)*.

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 does not 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.

This Summary Plan Description (SPD) contains only highlights of Caltech's benefit plans.

Plan documents contain full provisions.

If there is a discrepancy between the information in this SPD and in plan documents, the plan documents will govern.

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* (Caltech) or the *AskHR Knowledge Base* (JPL) 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 & Compensation, 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.

| Plan Name | Plan Number |
|--|-------------|
| Caltech Base Retirement Plan (Base Plan) | 002 |
| Caltech Voluntary Retirement Plan (Voluntary Plan, formerly -known as the ERISA TDA Plan) | 005 |
| Caltech 457(b) Deferred Compensation Plan (457(b) Plan) | |
| Consolidated Welfare Plan of California Institute of Technology, which includes the following: <ul style="list-style-type: none"> • Kaiser Permanente HMO • Anthem Blue Cross Advantage HMO • Anthem Blue Cross HDHP 1400 • Anthem Blue Cross HDHP 2800 • Anthem BlueCard PPO • Delta Dental PPO • MetLife/Safeguard Dental • VSP PPO • Employee Assistance Program (EAP) • Life Insurance (Basic and Supplemental) • Personal Accident Insurance (PAI) • Disability Insurance (Basic LTD, Supplemental LTD, Basic STD and Voluntary STD) • Business Travel Accident Plan • Extra-Hazardous Duty Insurance | 601 |
| California Institute of Technology Tax Savings and Spending Accounts Plans (Applies to HFSA not DCFSA) | |
| International SOS Medical Access/International Referral Service | |
| Caltech Non-ERISA Tax-Deferred Annuity Plan (closed to new enrollments) <ul style="list-style-type: none"> • TIAA accounts • Fidelity accounts • Prudential accounts | |

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 on page 106.

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 Director of Benefits & Compensation, Total Rewards 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 on page 122 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.

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.

| Plan | Claims Administrator Contact Information |
|---|---|
| Medical | |
| Anthem Blue Cross HDHP 1400 Anthem HDHP 2800 Anthem BlueCard Preferred Provider Organization (PPO) Plan Anthem Blue Cross Health Savings Plan Anthem Blue Cross Advantage HMO | 21555 Oxnard Street Woodland Hills, CA 91367 |
| Kaiser Foundation Health Plan, Inc. (Southern CA) | Claims Department 1-800-390-3510 P.O. Box 7004 Downey, CA 90242-7004 |
| Kaiser Permanente Health Plan of WA | Claims Department 1-888-901-4636 P.O. Box 30766 Salt Lake City, UT 84130-0766 |
| Optum Rx (for KPWA prescription claims) | Claims Department 1-888-901-4636 P.O. Box 29044 Hot Springs, AR 71903 |
| Kaiser Permanente Health Plan – Mid-Atlantic | Claim Address P.O. Box 371860 Denver, CO 80237-9998 Member Services 1-800-777-7902 |
| Employee Assistance Program (EAP) | Campus SFCC at 1-626-395-8360 or via e-mail: SFCC@caltech.edu JPL EAP is through 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 |
| Dental | |
| Delta Dental of California (PPO Dental) | P. O. Box 997330 Sacramento, CA 95899-7330 |
| MetLife (DHMO) Safeguard (Dental DHMO) | Claims Department P.O. Box 30930 Laguna Hills, CA 92654 |

| Plan | Claims Administrator Contact Information |
|--|--|
| Vision | |
| Vision Service Plan (VSP) | 1-800-877-7195 P.O. Box 385018 Birmingham, AL 35238-5018 |
| Spending Accounts | |
| Health Equity | 1-801-727-1590 15 W Scenic Pointe Dr, Ste 100 Draper, UT 84020 |
| Insurance | |
| Disability Aetna Insurance Company | P.O. Box 14560 Lexington, KY 40512-4560 |
| Life Insurance and Accident Death & Personal Loss (PAI) Aetna Life Insurance Service Center | 51 Farmington Avenue Hartford, CT 06156 |
| Medical Access/International Referral Service International SOS | 1-800-523-6586 International SOS accepts collect calls from members overseas |
| Business Travel Accident Insurance | Zurich American Insurance Company P. O. BOX 968041 Schaumburg, IL 60196-8041 |
| Retirement Claims | |

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

Agent of Legal Process

Any legal correspondence regarding the plans should be sent to:

Office of the General Counsel
California Institute of Technology
1200 E. California Blvd., Mail Code 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.

Glossary & Contacts

Glossary of Terms

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

IMPORTANT!

These terms refer to Caltech's health and welfare and retirement plans. Your providers and other organizations may define these terms differently. Please refer to the material provided by the carriers that describes these types of plans.

A

Actively at Work

Refer to the Evidence of Coverage (EOC) documents for each benefit plan's definition of Actively at Work. Generally, Actively at Work means any day that you are performing your duties as a Benefit-Based Employee.

For all benefits under the Caltech benefits program except for your medical, dental and vision coverage, you must be Actively at Work on the day your coverage under the Caltech benefits program or any election changes you have made to your benefits is to begin. Otherwise, coverage or election changes begin on the day you return to work as a Benefit-Based Employee.

Medical, dental and vision coverage or benefit election changes made during annual open enrollment while you are on an unpaid leave of absence will not become effective until you return to work as a Benefit-Based Employee. However, if you are on an approved FMLA leave and your medical, dental and vision coverage is in effect and has not lapsed, any election changes made during annual open enrollment will become effective while you are on your FMLA leave.

Adopted or Adoption

Refers to legal adoption or placement for adoption.

Annual Open Enrollment

A period during which a Benefit-Based Employee may add or drop certain benefits and add or drop dependents without restriction, subject to each specific benefit plan's limitations.

Annual Salary

Your base wage or compensation for your regular hours of employment. Annual Salary includes any salary reduction amounts under IRC Section 125 (pre-tax and spending account contributions), but excludes bonuses, commissions, overtime, extended work week compensation, per diems, shift differentials, field rate bonuses, flight bonuses, off-site service pay and similar payments.

B

Beneficiary

The person(s) you designate to receive death benefits provided under the Caltech benefits program in the event of your death.

Benefit-Based Employees

Refer to the Eligibility provisions in the Summary Plan Description's Health Benefits Eligibility section or Retirement Eligibility section for the definition of Benefit-Based Employees.

Bridging

Effective January 1, 2019, if you are eligible for the Key Staff contribution formula and your compensation falls below the Minimum Compensation Level (MCL) and you have less than 10 Years of Service (benefit-based service), the Base Plan provides a bridging period to minimize the impact to your contribution amount. You will be bridged and remain in the Key Staff contribution formula until you reach 10 Years of Service. If your compensation level remains below the MCL after you reach 10 Years of Service, you will move to the Staff contribution formula.

If you terminate employment for any reason during your bridging period and are rehired with compensation below the MCL, you will not continue to be bridged.

C

Caltech

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

Campus or JPL Benefits Office

The Benefits Office on campus is a component of the Human Resources Department of the California Institute of Technology and is responsible for the administration of the Caltech benefits program. The Benefits Office at the Jet Propulsion Laboratory (JPL) is responsible for the day-to-day administration of the Caltech benefits plans at JPL.

Child (ren)

Your eligible child(ren), as described in this document, include an eligible employee's:

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

Claimant

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

COBRA

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

Coinsurance

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

Coordination of Benefits (COB)

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

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

Copay

A “copay” is the charge you are required to pay for certain covered medical, dental, and vision care services when you receive them.

D

Deductible

The amount of covered expenses that must be paid each year before a certain benefit plan will pay its portion of eligible expenses. Refer to each benefit plan’s Evidence of Coverage (EOC), if applicable, for a description of the deductible amount.

Dental Health Maintenance Organization (DHMO)

A dental plan that provides, offers, or arranges for coverage of designated dental services needed by plan members for a fixed, prepaid premium. Services are provided by a participating dentist.

Dependents

Certain plans provide coverage for eligible dependents. Unless otherwise noted, for all plans except the spending account(s), your eligible dependents include your:

- Legal spouse.
- Registered Domestic Partner

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

For the dependent day care spending account(s) dependent eligibility, refer to the carrier for details.

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

Disability or Total Disability

Please refer to the medical Evidence of Coverage (EOC), and the group life and long-term disability plan documents for plan-specific definitions of total disability or disability. For EOCs, go to www.benefits.caltech.edu/SPD.

Domestic Partners

Means any of the following:

Registered Domestic Partner (RDP)

- Registered Domestic Partners are two adults who have registered with the California Secretary of State, or other applicable state agencies. Registered Domestic Partners may be same-sex or opposite-sex RDPs and their dependents may be enrolled as dependents in a Benefit-Based Employee's medical, dental, vision, group life and personal accident insurance (PAI) plans, provided the general terms and conditions of coverage for the respective plans are met. The pre-tax and spending accounts are available only for domestic partners who are tax-qualified dependents under the Internal Revenue Code. Employer-provided coverage for a Registered Domestic Partner who is not a tax-qualified dependent, will be subject to imputed income. Registration with a state agency is not required for those enrolled prior to January 1, 2011.
- Registered Domestic Partners may be same sex or opposite sex of any age, as of January 1, 2020. Contact the Campus or JPL Benefits Office regarding registered domestic partner certification, termination and rates.
- Registered domestic partners and their covered dependents are eligible for continuation of medical, dental and vision insurance benefits similar to COBRA and have similar conversion rights under group life and PAI coverage.

E

Employee Assistance Program (EAP)

The Institute offers an Employee Assistance Program (EAP) to assist employees and eligible dependents in handling personal or work-related matters. EAP services include counseling and referrals to appropriate resources.

ERISA

ERISA refers to the Employee Retirement Income Security Act of 1974. This law mandates, among other items, certain reporting and disclosure requirements for group life, health, and retirement plans. Your ERISA rights are summarized in Section 8, Plan Information. Non-ERISA plans are not subject to the same requirements and mandates.

Evidence of Coverage (EOC)

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

To download a plan's EOC, visit the carrier's website, which is provided in the Contacts of this SPD.

Evidence of Insurability (EOI)

Evidence of Insurability is proof presented through a written statement and/or a medical examination that an individual meets the minimum requirements of good health as defined by the individual plan. It is usually only required for late enrollments, certain increases in life coverage, or for coverage over certain limits, but will not apply to Medical plan enrollment. Also known as Evidence of Good Health or a Statement of Good Health. Refer to the specific plan for a description of the plan's EOI requirements, if applicable.

F G H

Health Maintenance Organization (HMO)

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

Health Savings Account (HSA)

If you enroll in the High Deductible PPO, and you are not enrolled in any part of Medicare you can open a Health Savings Account (HSA), which you can fund using employee pre-tax

contributions. You can use money in your HSA to pay for your qualified health care expenses that are not otherwise covered. Your unused HSA balance rolls over to the next year and earns interest, so you can build tax-free savings over time.

High Deductible PPO

With the Anthem Blue Cross High Deductible PPO, you receive PPO-type coverage, including the option to seek care with any licensed provider. By using a participating (or in-network) PPO provider, the PPO provider have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this plan will be different for non-participating providers than for participating providers. When using a non-participating provider (or out-of-network), the services will cost you more because you pay a higher percentage of covered charges than you would if you used participating providers, since their fees may be greater than those negotiated with participating providers. Non-participating providers have not agreed to the reimbursement rates and other provisions.

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

Highly Compensated Employee (HCE)

An employee with compensation in the prior plan year at or above a certain threshold, as defined by the Internal Revenue Code. For 2021, employees with 2020 compensation of at least \$130,000 are HCEs.

HIPAA

The Health Insurance Portability and Accountability Act of 1996. To protect your privacy, federal law sets rules about the proper use and disclosure of your personal health information and gives you certain rights. HIPAA also provides plan participants with special enrollment rights and other benefits-related protections that are applicable to the Caltech benefits program. Refer to the Qualified Life Events section for rules on changing your benefits under HIPAA special enrollment rights.

I

Ineligible Expense

An “ineligible expense” is an expense the plan determines to be ineligible for coverage under the plan provisions, and therefore no benefits will be paid from the plan for the expense.

Initial Enrollment

The initial enrollment period is the first 31 days after you become eligible to enroll for coverage under the Caltech benefits program. If you wait until after 31 days, you may not enroll coverage until the next annual open enrollment or if you experience a HIPAA Special Enrollment Event or Change in Status Event (see Qualified Life Events section for more information).

Institute

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

Interim Employee Program

An employee hired under the Interim Employee Program works an irregular work schedule, works at intervals according to the demands of the job and may not work more than 990 hours in a calendar year. Employees working in these employment statuses are not eligible for Institute benefits or holiday pay and the Institute may end their employment at its discretion.

J

Jet Propulsion Laboratory (JPL)

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

K

L

Lump-Sum Payment

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

M

Minimum Compensation Level

The compensation threshold used to determine if an employee receives the Key Staff contribution formula under the Base Retirement Plan. The Minimum Compensation Level (MCL) for Caltech is \$124,000 annualized salary for Caltech and \$59.60 per hour for JPL as of January 1, 2021.

Effective January 1, 2020, and each year thereafter, the MCL will be 90% of the previous year SSWB, rounded up to the nearest \$500. The MCL will not exceed an \$8,000 increase in any one year.

N

Non-Benefit-Based Employees

The following employees are considered Non-Benefit-Based Employees:

- Occasional employees - works an irregular work schedule, works at intervals according to the demands of the job and may not work more than 990 hours in a calendar year.
- Part-time employees regularly scheduled to work less than 20 hours per week
- Employee hired under the Interim Employee Program

Refer to the Eligibility provisions in the Summary Plan Description's Health Benefits Eligibility section or Retirement Eligibility section for the definition of Benefit-Based Employees.

O

Occasional Employee

An occasional employee is an employee who works an irregular work schedule, works at intervals according to the demands of the job, and may not work more than 990 hours in a calendar year, and whose employment the Institute may end at any time at its discretion. An occasional employee is not eligible for Institute benefits or holiday pay. Refer to Human Resources Personnel Memoranda 9 "Employment" for more information.

Out-of-Network Provider

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

P

Plan Administrator

The plan administrator is Caltech or its designee in charge of administering the plan.

Plan Year

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

Postdoctoral Scholar or Senior Postdoctoral Scholar

Caltech or JPL research appointees sponsored by professorial faculty for contractual terms reviewed annually.

Preferred Provider Plan (PPO)

This type of plan allows you to use a participating PPO provider or any non-participating provider each time you need care. By using a PPO provider, the PPO provider have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this plan will be different for non-participating providers than for participating providers. When using a non-participating provider (or out-of-network), the services will cost you more because you pay a higher percentage of covered charges than you would if you used participating providers, since their fees may be greater than those negotiated with participating providers. Non-participating providers have not agreed to the reimbursement rates and other provisions

Q

Qualified Default Investment Alternative (QDIA)

A Qualified Default Investment Alternative (QDIA) is defined by the Department of Labor (DOL) as an investment fund or model portfolio that seeks both long-term appreciation and capital preservation through a mix of equity and fixed income investments. Management of the fund's or portfolio's investments must be based on an employee's age or target retirement date or on the overall age of the plan's employees. Investments that qualify as a QDIA include lifecycle or target date retirement funds, balanced funds or managed accounts. The QDIA adopted by both the Caltech Base Retirement Plan and Caltech Voluntary Retirement Plan is a TIAA-CREF Lifecycle Fund with the targeted retirement date that is closest to the participant's 65th birthday.

Qualified Domestic Relations Order (QDRO)

An order, decree, judgment, or administrative notice (including a settlement agreement) which establishes the rights of another person (the "alternate payee") to your pension benefits, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law that which has the force and effect of law in that state and which meets the requirements of ERISA.

Qualified Life Event

A change in your situation that can make you eligible for a special enrollment period, allowing you to enroll in health insurance outside the annual open enrollment period. For more information about Qualified Life Events, please refer to Enrolling or Making Changes to Your Benefit Elections During the Year on page 8.

Qualified Medical Child Support Order (QMCSO)

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

R

Reasonable and Customary Charge Limits

Most plans pay benefits only up to "reasonable and customary charge" limits. If your provider is charging fees for treatment and services that fall within a range that is similar to those of providers with similar training and experience in your geographic area, the fees are considered reasonable and customary. You are responsible for any charges in excess of reasonable and customary charge limits.

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

Regular Salary

Regular salary is:

- For Faculty: the salary stated in your academic year contract.
- For Key Staff Employees: salary (including a regular salary increase which is paid in a lump sum) exclusive of benefits, overtime, bonuses, commissions, extended work week compensation, per diems, 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, but excludes all compensation paid after severance of employment, except as permitted under 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.

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 Base Retirement Plan exceed the limits of Code Section 401(a)(17). (The limit for 2021 is \$290,000. This amount is indexed annually 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 to 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.

Retiree

A retiree is an Institute employee who retires from active employment at the Institute and who has attained the required age and years of service in a benefits-based position in order to be eligible to participate in the Caltech Retiree Health and Life Benefits Program.

S

Spouse

Your husband or wife under a legally valid marriage. Spouses and their dependents may be enrolled as dependents in a Benefit-Based Employee's medical, dental, vision, group life and personal accident insurance (PAI) plans, provided the general terms and conditions of coverage

for the respective plans are met. Pre-tax benefits and spending accounts are available only to spouses who are tax-qualified dependents.

Summary Plan Description (SPD)

A description of a benefits plan or program available to persons covered by those plans as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD consists of this document and the Evidence of Coverage certificates issued by the insurance carrier. See also “Evidence of Coverage (EOC).”

T

Tax-Qualified Dependent

A dependent, registered domestic partner or child of a registered domestic partner, as applicable, who meets the requirements of Section 152 of the Internal Revenue Code.

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

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

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

Contact the Campus or JPL Benefits Office if you have any questions or for more information.

Temporary Staff Employees

Temporary staff employees are employees who are regularly scheduled to work 20 or more hours per week in an assignment that is expected to last at least 90 days (for Campus employees), and they qualify as benefit-based. The date the temporary staff employee is first scheduled to work 20 or more hours per week will be used in determining the benefit coverage effective date.

Total Disability or Disability

Please refer to the medical Evidence of Coverage (EOC), and the group life and LTD sections in the SPD document for plan-specific definitions of Total Disability or Disability. To download a plan’s EOC, visit the carrier’s website, which is provided in the Contacts section of the SPD.

U, V, W, X Y

Years of Service

Years of Service are used to determine Institute contributions to the retirement plan for Staff employees and bridging for Key Staff employees. Years of Service include the following periods of service as an eligible employee:

- Up to six months of eligibility service completed before the staff employee became a participant. However, if a staff employee becomes eligible for the plan and had previous service as a postdoctoral scholar, service as a postdoctoral scholar will be included, up to a maximum of two years.
- Up to two years of eligibility service completed before a postdoctoral scholar became a participant. Years of Service shall be defined by the plan without regard to the two-year limitation.
- The period beginning with the date the staff employee or postdoctoral scholar becomes a participant in the plan and ending on the severance from service date. Years of Service also includes all periods after the eligible employee's initial date of employment during which he/she worked in a postdoctoral scholar position whether or not wages were subject to FICA taxes.
- Any subsequent period beginning on a reemployment date and ending on a severance from service date.

Years of Service for the purpose of determining Institute contributions to the retirement plan and Key Staff bridging shall not include time periods during which the employee is employed in a non-eligible employee classification.

Your eligibility service is a period of service with the Institute during which you complete one hour of service with the institute and for which the employee has receive remuneration that is subject to FICA taxes. All time periods are combined, beginning with your date of employment and ending on your severance from service date (and beginning on any following date of reemployment and ending on your next "severance from service date"). A year of service is credited for each 12-month period of service described above. Fractional periods of a year are expressed in terms of days. Thirty days are considered to be one month in the case of aggregation of fractional months.

The "severance from service date" for this purpose is:

- The date the staff employee retires, quits, dies or is discharged; or
- The first 12-month anniversary of the date he or she is first absent from service for any other reason (other than a paid leave or a disability leave), or the date within such 12-month period that he or she quits, is discharged, dies or retires.

In determining Years of Service, paid leaves or disability leaves lasting longer than 12 months are treated as service.

You / Your

In this document, “you” and “your” refer to employees who meet the eligibility requirements for the Caltech benefits program.

Z

Contacts

Campus and JPL Contacts

| Benefits Office | |
|--|---|
| Campus | JPL |
| 1-626-395-6443 HRBenefits@caltech.edu | 1-818-354-4447 Click on AskHR portal on the Human Resources webpage |
| Anthem Concierge | |
| Campus | JPL |
| Keita Heckard 1-626-395-6628 Keita.Heckard2@anthem.com | Vida Techachaiponpoj 1-818-354-7790 Vida.Techachaiponpoj@anthem.com |

Plan Contacts

| Plan | Phone Numbers and Websites | Contract Numbers* | |
|---------------------------------|---|--|------------|
| Medical Plans | | | |
| Anthem Blue Cross Advantage HMO | 1-866-820-0765 www.anthem.com/ca/caltech h | Campus | JPL |
| Anthem Blue Cross HDHP 1400 | | 175104H200 | 175104H220 |
| Anthem Blue Cross HDHP 2800 | | 175104M279 | 175104M283 |
| | | 175104M277 | 175104M281 |
| Kaiser Permanente | California 1-800-464-4000 1-800-788-0616 (Spanish) Mid-Atlantic 1-800-777-7902 Washington 1-888-901-4636 my.kp.org/Caltech | California 101829 Mid-Atlantic 12639 Washington-Campus 4918800 Washington-JPL 4918801 | |
| Grand Rounds | 1-800-929-0926 grandrounds.com/caltech | 49188800 | |

| Plan | Phone Numbers and Websites | Contract Numbers* | |
|--|--|--------------------------------|-----------------------------|
| Dental Plans | | | |
| Delta Dental PPO | 1-800-765-6003 www.deltadentalins.com/ca/itech | Campus 3608-2001 | JPL 3608-2002 |
| MetLife (Safeguard) DHMO | 1-800-880-1800 online.metlife.com/edge/web/public/benefits | Campus 136384-0001 | JPL 136384-0004 |
| Vision Plans | | | |
| Vision Service Plan (VSP) | 1-800-877-7195 www.vsp.com | Campus 12250422-0100 | JPL 12250422-0200 |
| Flexible Spending Accounts (Health and Dependent Day Care) | | | |
| Health Equity | 1-877-582-4453 www.healthequity.com | 92394 | |
| Health Savings Account (for High Deductible PPO plan members) | | | |
| Health Equity | 1-877-582-4453 www.healthequity.com | 92394 | |
| Disability | | | |
| The Hartford (administered by Aetna) Short-term Disability (STD) (outside of CA) Long-term Disability (LTD) | Specific Claim Information: 1-888-807-0657 For general inquiries call the Campus or JPL Benefits Office | 866280 | |
| CA State Disability Insurance (SDI) | 1-800-480-3287 (English) or 1-866-658-8846 (Spanish) | N/A | |
| Life and Accident Insurance | | | |
| The Hartford (administered by Aetna) Life Insurance (Basic and Supplemental) Personal Accident Insurance | Call the Campus or JPL Benefits Office | 866280 | |

| Plan | Phone Numbers and Websites | Contract Numbers* |
|---|---|---|
| Additional Benefits | | |
| Zurich Business Travel Accident Insurance Plan Medical Evacuation and Repatriation (MER) coverage | Call the Campus or JPL Benefits Office | GTU 3031879-00 |
| The Hartford Extra-Hazardous Duty Plan | Call the Campus or JPL Benefits Office | ETB 201241 |
| Access/International Referral Service International SOS Medical Assistance | For referrals and assistance: 1-800-523-6586 (within U.S.) For general inquiries call the Campus or JPL Benefits Office www.internationalsos.com | 11BCMA000180 |
| Employee Assistance Program (EAP) | Campus Staff and Faculty Consultation Center 1-626-395-8360 JPL www.MyLifeMatters.com 1-800-367-7474 | Campus 03608-2001 JPL 03608-2002 |
| Genworth Long-Term Care (LTC) Insurance | 1-800-266-4938 Campus www.genworth.com/caltech JPL www.genworth.com/JPL | N/A |
| COBRA Administrator | | |
| WageWorks | 1-877-924-3967 www.wageworks.com | N/A |
| Retirement Plans | | |
| Caltech Base Retirement Plan | 1-800-842-2252 | 403497 |

| Plan | Phone Numbers and Websites | Contract Numbers* |
|--|--|------------------------------------|
| Caltech Voluntary Retirement Plan | 1-800-842-2252 | 403498 |
| California Institute of Technology 457(b) Deferred Compensation Plan TIAA Fidelity (closed to new enrollments) | 1-800-842-2252 1-800-343-0860 | 101207/403499 71061 |
| Non-ERISA TDA (closed to new enrollments) TIAA Accounts Fidelity Accounts Caltech JPL Prudential Medley Program Sun America (formerly Mutual Benefit Life) | 1-800-842-2252 1-800-343-0860 1-800-421-1056 1-877-999-9205 | 101206 85675 85680 030021 |
| TIAA 1-on-1 Consultations | 1-800-732-8353 (option 1) Caltech http://www.tiaa.org/schedule-now-caltech JPL www.tiaa.org/schedule-now-jpl | |

**Not all contract numbers are listed. Please contact Campus or JPL Benefits Office for the full list of contract numbers.*