REQUIRED LEGAL BENEFIT NOTICES

Enrollment Rights Under the Health Insurance Portability and Accountability Act (HIPAA) and California Law

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance (such as your spouse's or domestic partner's employer's plan), you may be able to enroll yourself and your dependents in a Caltech plan if you or your dependents lose eligibility for that other coverage (or your spouse's or domestic partner's employer stops contributing toward the coverage). You must request enrollment within 31 days of the date the other coverage ends (or the other employer changes its contributions). If the other coverage is Medicaid or Children's Health Insurance Program (CHIP), you must request enrollment within 60 days.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. You will also need to provide reasonable proof of dependent status (for example, a marriage or birth certificate).

For more information, please contact Campus Human Resources or the JPL Benefits Office.

Grandfathered Health Plan: Kaiser Mid Atlantic

The Kaiser Mid Atlantic HMO (available to JPL employees in the Mid-Atlantic region) believes that each of its health plans is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act, also called Health Care Reform). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact Campus Human Resources or the JPL Benefits Office.

REQUIRED LEGAL BENEFIT NOTICES

Notice of Creditable Prescription Drug Coverage

If you or your family members aren't currently covered by Medicare (i.e., eligible for) and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read this notice carefully. It has information about prescription drug coverage with Caltech and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving Caltech coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by a Caltech prescription drug plan, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under a Caltech plan will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your Caltech coverage. In this case, the Caltech plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Caltech coverage, Medicare will be your only payer. You can re-enroll in the Caltech plan at annual enrollment or if you have a special enrollment event.

You should know that if you waive or leave coverage with Caltech and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if the Caltech coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

REQUIRED LEGAL BENEFIT NOTICES

- Visit w**ww.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, please contact Campus Human Resources or the JPL Benefits Office.

REQUIRED LEGAL BENEFIT NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

REQUIRED LEGAL BENEFIT NOTICES

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

REQUIRED LEGAL BENEFIT NOTICES

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

REQUIRED LEGAL BENEFIT NOTICES

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2026).

REQUIRED LEGAL BENEFIT NOTICES

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), each medical plan provides coverage for the following breast reconstruction procedures in connection with mastectomies:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage is provided in a manner determined in consultation with the attending physician and the patient. The deductible and the copayment requirements that apply to other covered services also apply to these post-mastectomy reconstructive and treatment services. Therefore, deductible and coinsurance apply. If you would like more information on WHCRA benefits, contact Campus Human Resources or the JPL Benefits Office.

Newborns' and Mothers' Health Protection Act Notice

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). If you would like more information on maternity benefits, contact Campus Human Resources or the JPL Benefits Office.

HIPAA Privacy Notices

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Plan to provide Privacy Notices and how you can obtain the notices. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice or for more information on the Plan's privacy policies or your rights under HIPAA. contact Campus Human Resources or the JPL Benefits Office

REQUIRED LEGAL BENEFIT NOTICES

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

REQUIRED LEGAL BENEFIT NOTICES

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.
Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Benefits of Using In-Network Providers and Facilities-
The above protections are very important. There are still some benefits of using in-network providers and facilities whenever reasonably possible and medically appropriate. For example, if you intend on voluntarily seeing a network provider after stabilization of your emergency for that condition, in some cases it may be a smoother transition if the emergency care was also provided by an in-network provider or facility. Furthermore, for a provider or facility to be treated as in-network, the provider or facility is subject to credentialing and oversight by Anthem, the Network Administrator. If you have questions about network provider availability for emergency care, visit anthem.com/ca and choose Blue Cross PPO (Prudent Buyer) – Large Group.

Subrogation and Reimbursement to the Plan from a Recovery (Applicable to any health benefits self-insured by the Institute; for subrogation and reimbursements provisions applicable to fully-insured health benefits, check the applicable insurer's EOC and related materials).

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 Third party may 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 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

REQUIRED LEGAL BENEFIT NOTICES

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 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

REQUIRED LEGAL BENEFIT NOTICES

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.

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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 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, 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:

REQUIRED LEGAL BENEFIT NOTICES

- 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 you or your dependents' right to be made whole. The "make whole" rule does not apply under the Plan.

Transparency in Coverage Machine-Readable Files

The Transparency in Coverage Rules (the "TiC Rules") require most group health plans and health insurance issuers to make available on a public website, information regarding in-network rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. The TiC Rules require plans and issuers to publish all applicable rates, which may include one or more of the following: negotiated rates, underlying fee schedule rates, or derived amounts for all covered items and services in the In-network Rate File. The machine-readable files for our Plans administered and or insured by Anthem will be made accessible through anthem.com/ca. For our Plans insured by Kaiser, machine-readable files will be made accessible through https://healthy.kaiserpermanente.org/southern-california/front-door/machine-readable.

REQUIRED LEGAL BENEFIT NOTICES

Important Notice of COVID-19 Relief Ending

Dear Caltech Community Member,

The Federal government has announced that it will end the COVID-19 Public Health Emergency (PHE) on May 11, 2023 and the National Emergency (NE) ended on April 10, 2023. The State of CA also provided an extension on COVID-19 services for eligible medical plans until 11/11/2023. Below is information on how the ending of the PHE, NE, and the CA extension will affect you and your Caltech benefits:

If you are enrolled in a Caltech Anthem or Kaiser California medical plan, COVID-19 services incurred on or after November 12, 2023 will change to the following:**

- **COVID-19 Tests and Treatment (including virtual) will no longer be covered at 100%*. Cost-sharing, including copayments and deductibles, will apply.**
- **COVID-19 Vaccines will be considered preventative and will be covered at 100% for in-network providers only. You may visit www.anthem.com/ca/caltech or www.kp.org to find in-network providers.**

Review the below grid for additional coverage details on these upcoming changes.

****If enrolled in a Kaiser Washington Plan, these changes are effective May 12, 2023.***

In addition to COVID-19 services changing, effective July 10, 2023, the following deadlines will resume:

- **Health Plan Rules: The deadline to request a HIPAA Special Enrollment (e.g., certain qualified life events), and to submit certain Claims and Appeals will revert back to their standard deadline.**
- **COBRA Rules: Giving notice of COBRA qualifying events, second qualifying events, COBRA election periods, COBRA disability extension notices, and timely payment of all COBRA premium payments will revert back to their standard deadlines.**

Questions?

- **Anthem**: Call (866) 820-0765 or visit anthem.com/ca/Caltech. You may also contact Caltech's Anthem Concierge, Ruben Rodrguez, by calling 626-395-6628 or emailing RubenA.Rodriguez@anthem.com
- **Kaiser California**: Call (800) 464-4000 or visit my.kp.org/Caltech/.
- **Kaiser Washington**: Call (800) 813-2000 or visit my.kp.org/Caltech/.
- **Additional Assistance**: If you still need assistance, please contact the Human Resources Benefits Office at hrbenefits@caltech.edu or (626) 626-395-6443.

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Reference the below grid to see the upcoming changes for Caltech's Kaiser California and Anthem PPO plans.**

	During the emergency period	Starting November 12, 2023[1]
COVID-19 vaccines, including boosters	Members pay $0 for the vaccine at any location.	Members pay $0 for the vaccine at **in-network** locations.
COVID-19 at-home test kits, also known as over-the-counter, or OTC test kits	Members pay $0 for select test kits. Plans cover eight OTC COVID-19 tests per month with a $0 member cost share, if obtained at a pharmacy, or with a post-service reimbursement claim.	Members will pay the retail cost of test kits. They are no longer covered. Members will be able to get an at-home test kit for an estimated cost of $12 per test, or $24 for a box of two from CVS® and other retailers. Members can also use funds from a health savings account or a flexible spending account toward test
COVID-19 lab tests	Members pay $0 for lab tests, including rapid diagnostic and swab-and-send tests, at in-network locations.	Members will pay their copay, coinsurance or deductible at in-network locations, for FDA-approved and medically necessary tests. It will be applied to their outpatient testing benefit, which is part of their medical plan.
Evaluation & Management Visit (E&M) - Telemedicine, Urgent Care, ER and Office Visits Associated with COVID-19 tests	Members pay $0 for COVID-19 associated visits (INN and OON) when there's an associated COVID-19 test done within 2 days before or 2 days after.	Members will pay their copay, coinsurance or deductible for medically necessary COVID-19 associated visits (INN and OON) when there's an associated COVID-19 test done.
COVID-19 anti- viral medications or treatments, like Paxlovid**	Members pay $0 for these prescriptions.	Members will pay their copay, coinsurance or deductible at in-network locations.
Pharmacist Assessment and Prescribing of Paxlovid program	Members pay $0 for pharmacist assessment and prescribing of Paxlovid at pharmacies, including CVS.	No change.
COVID-19 monoclonal antibody treatments	Members pay normal cost sharing for EUA-approved monoclonal antibody treatments.***	No change. Members will continue to pay normal cost sharing for EUA-approved monoclonal antibody treatments.***

[1]Effective May 12, 2023, if you are seeing an out of network (OON) provider, anything over usual and customary will be the member's responsibility.

***If enrolled in a Kaiser Washington Plan, these changes are effective May 12, 2023.*

****Under an Emergency Use Authorization (EUA) declaration, the FDA may authorize unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life- threatening diseases or conditions.*

Certain state COVID-19 coverage requirements may have expiration dates that are not tied to the end of the federal emergencies. Insurance carriers will follow all federal and state mandates, as required.

If you have questions about these legal notices, please contact the Human Resources Benefits Office:

Campus Benefits Office: E-mail hrbenefits@caltech.edu or call (626) 395-6443.

JPL Benefits Office: E-mail benefits@jpl.nasa.gov or call (818) 354-4447.

REQUIRED LEGAL BENEFIT NOTICES

Employee Notice of Coverage Options

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and the medical coverage offered by Caltech.

What is the Health Insurance Marketplace?

The Marketplace is designed to help many Americans find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Can I shop at the Marketplace?

Most Americans who aren't already enrolled in programs like Medicare, Medicaid or a Veteran's plan can shop the Marketplace. However, if you're eligible for Caltech benefits, the Caltech medical plans will most likely be significantly more cost effective for you (and your eligible dependents) than the Marketplace options. This is because Caltech pays a significant share of the cost for your Caltech coverage for you and your eligible dependents. However, you have the option to shop in the marketplace if you'd like.

Can I receive financial assistance from the government if I choose insurance through the Marketplace?

Nearly all Caltech employees who are benefits-eligible will not qualify for government-provided financial assistance through the Marketplace. This is because Caltech's medical plan options meet the minimum value standard and are considered affordable under the ACA.

However, you may qualify for a tax credit that lowers your insurance premium and/or a reduction in certain cost sharing, if:

You're not eligible for Caltech medical coverage.

OR

You're eligible for Caltech medical coverage, but the premium contribution is more than a percentage (set annually by the Internal Revenue Service) of your household income for the year. That percentage is available on the IRS website, https://www.irs.gov. For 2024, the premium contribution for you only, in the lowest cost Caltech plan, is $**59** per month, which is $**708** per year. Please note that very few — if any — benefits-eligible Caltech employees will qualify for this financial assistance.

The financial assistance that you might be eligible for depends on your household income. Visit HealthCare.gov for details.

ACA Standards

An employer-sponsored health plan meets the ACA's "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

An employer-sponsored health plan is considered "affordable" under the ACA if the employee-only coverage level for the lowest-cost plan costs less than 8.39% of an employee's W-2 wages.

What happens to my Caltech coverage if I choose Marketplace insurance?

If you purchase insurance through the Marketplace instead of through Caltech, you'll lose Caltech's contribution toward coverage. Also, keep in mind that your share of the cost for Caltech coverage is paid on a pre-tax basis, which means it is excluded from your income for federal and state income tax purposes. If you choose insurance through the Marketplace, your payments are made on an after-tax basis.

REQUIRED LEGAL BENEFIT NOTICES

How can I get more information?

For more information about your Caltech medical plans and costs, please contact the Caltech benefits team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Visit **HealthCare.gov** for more information, including an online application for Marketplace coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about Your Caltech Medical Coverage

This section contains information about coverage offered by Caltech. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td>3. Employer Name
California Institute of Technology</td><td colspan="2">4. Employer Identification Number (EIN)
95-1643307</td></tr>
<tr><td>5. Employer Address
1200 East California Blvd.</td><td colspan="2">6. Employer Phone Number
626-395-6811</td></tr>
<tr><td>7. City
Pasadena</td><td>8. State
California</td><td>9. ZIP code
91125</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
JPL Employees: JPL Benefits Office
Campus Employees: Campus Benefits Department</td></tr>
<tr><td colspan="2">11. Phone number (if different than above)
JPL Employees: (818) 354-4447
Campus Employees: (626) 395-6443</td><td>12. Email address
JPL Employees: benefits@jpl.nasa.gov
Campus Employees: hrbenefits@caltech.edu</td></tr>
</table>

Here is some basic information about health coverage offered by Caltech:

- Caltech offers medical coverage to benefits-eligible employees. **Benefits-eligible employees include:**
  - JPL employees and Campus staff members regularly scheduled to work 20 or more hours per week (including temporary staff on an assignment expected to last four months or more);
  - Faculty members; and
  - Postdoctoral scholars (eligibility may vary based on funding source).
- We also offer medical coverage to eligible dependents. **Eligible dependents include:**
  - Your spouse.
  - Your Registered Domestic Partner (RDP). An RDP is:
    - An opposite-sex partner. Registration with the California Secretary of State is required.

REQUIRED LEGAL NOTICES

  - A same-sex domestic partner. Registration with the California Secretary of State is required (unless enrolled prior to January 1, 2011).

— Your children up to age 26.*

— Your children aged 26 and over who are incapable of employment because of a physical or mental disability. (Eligibility is subject to review and approval by the insurance carrier.)*

— Any child for whom you're required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

**This includes natural children, stepchildren, adopted children, children of an RDP, and children for whom you're a court appointed guardian.*

- All of Caltech's medical plans meet the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

***NOTE:** You may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible. If, for example, your wages vary from week to week (perhaps you are an hourly employee), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. Visit* **HealthCare.gov** *for details.*

- If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

- To find out if you can get a tax credit to lower your monthly premiums, you'll enter the following information when you visit **HealthCare.gov**: The cost for employee-only coverage in Caltech's lowest cost plan for 2024 is $59 per month, which is $708 for the year.