

CALTECH

2010 Comparison of Health Plan Benefits

Southern California

Medical

Anthem Blue Cross PPO
Anthem Blue Cross HMO (Power Advantage)
Kaiser Plan

Dental

Delta Dental
Safeguard Dental

Your Medical Plan Choices

The **Anthem Blue Cross PPO** pays benefits for covered services provided by *any* licensed doctor or hospital. However, you save money when you choose to receive services from doctors, hospitals and other providers who are in the plan's PPO (**preferred provider organization**). This is because PPO providers have contracted with Anthem Blue Cross to offer services at *negotiated* rates.

- When you use PPO providers, plan benefits are paid at a higher rate (80% of *negotiated* rates).
- When you use other providers, plan benefits are paid at a lower rate (in many cases 50% of *eligible charges*). *Eligible charges* are determined by using Anthem Blue Cross allowances that are based on reasonable and customary rates for the geographic area where services are provided.

In the **Anthem Blue Cross HMO** and **Kaiser** plans, you may receive health care services only from doctors, hospitals and other providers who have contracted with the plan (or are employed or owned by the plan). The exception is emergency services, which may be received from any licensed provider. For most services, you do not have to meet a deductible — you simply pay a flat-dollar copayment (copay) each time you receive care.

In the Anthem Blue Cross HMO, you must select a primary care physician (PCP) to provide or coordinate all of your health care (except in emergency situations).

Your Dental Plan Choices

The **Delta Dental** plan pays benefits for covered services you receive from *any* licensed dental provider. However, you save money when you choose to receive services from dental providers who contract with Delta Dental because they agree to offer services at negotiated rates.

- When you use Delta PPO providers, you save the most because they agree to the lowest negotiated rate.
- When you use Delta Premier providers who are not in the PPO, you save because they agree to a negotiated rate.
- When you use non-Delta dentists, you pay the most because they can charge any amount, and you are responsible for paying all charges above Delta's approved fee.

In the **Safeguard** plan, you must select a Safeguard dentist to provide or coordinate all of your health care, and you may receive dental services only from dental providers who have contracted with the plan. For most services, you do not have to meet a deductible — you simply pay a flat-dollar copayment (copay) each time you receive care.

Dependent Eligibility for Medical and Dental

Spouse, same-sex domestic partners, opposite sex domestic partners registered with the State of California (one of which must be age 62 or older) and unmarried children to age 19 or to age 25 if full-time student.

Newborn dependents automatically are covered for the first 31 days. To continue coverage beyond 31 days, you must enroll the child within 31 days from the child's date of birth.

Disabled dependents may be covered if they were covered continuously prior to age 19, either by a Caltech medical plan or by another plan if a Certificate of Creditable Coverage is provided.

Comparison of Medical Plan Benefits* changes for 2010 are highlighted

Anthem Blue Cross PPO Plan¹

Participating Provider

Non-Participating Provider

Customer Service	(866) 820-0765	
Web Site	www.anthem.com/ca/caltech	
Annual Deductible	\$500 per person; \$1,500 family maximum	
Coinsurance/ Copayment (Copay)	<i>Physician</i> — 80% of negotiated rate <i>Hospital</i> — 80% of negotiated rate	<i>Physician</i> — 50% of eligible charges <i>Hospital</i> — 50% of eligible charges
<p>Preservice and concurrent reviews are required for all hospital admissions, including residential treatment centers. If not obtained, a separate, non-certification deductible will apply — \$500 per inpatient admission. For details and to request preservice review, call Anthem Blue Cross at (866) 820-0765.</p>		
Out-of-Pocket Maximum**		
Per Person/Calendar Year	\$2,000	\$8,000
Per Family/Calendar Year	N/A	N/A
Maximum Benefit	\$5,000,000	
Prior Authorization	<p>Prior authorization is required for certain procedures (for example, bariatric weight-loss surgery, CT scans and MRIs). Make sure your doctor contacts Anthem Blue Cross before scheduling these procedures. Without prior authorization, these procedures are not covered. Contact Anthem Blue Cross for details.</p>	

Outline of Benefits

Acupuncture	80% of negotiated rate	50% of eligible charges
Allergy Test/Treatment	80% of negotiated rate	50% of eligible charges
Ambulance	80% of eligible charges	
Chiropractic Services	Covered under Physiotherapy	Covered under Physiotherapy
Durable Medical Equipment	80% of negotiated rate	50% of eligible charges
Emergency Care	80% of negotiated rate	80% of eligible charges for all emergencies 50% of eligible charges for non-emergency care
Family Planning		
Vasectomy	80% of negotiated rate	50% of eligible charges
Tubal Ligation	80% of negotiated rate	50% of eligible charges
Abortion (Therapeutic)	80% of negotiated rate	50% of eligible charges
Abortion (Elective)	80% of negotiated rate	50% of eligible charges
I.U.D.	80% of negotiated rate	50% of eligible charges
Infertility	Not covered	Not covered
In Vitro Fertilization	Not covered	Not covered
Birth Control Pills	Covered: See Prescription Drugs	Covered: See Prescription Drugs
Hearing Aids	80% of negotiated rate	50% of eligible charges
Combined (participating and non-participating) maximum of \$2,000 per calendar year		

Anthem Blue Cross HMO ²	Kaiser Plan ²
(866) 820-0765	(800) 464-4000
www.anthem.com/ca/caltech	my.kp.org/ca/caltech
No deductible	No deductible
\$15 or \$30 copay per doctor visit, depending on your primary care physician (PCP) selection; to determine which copay applies, go to www.anthem.com/ca/caltech or call Anthem Blue Cross at (866) 820-0765.	\$15 copay per doctor visit
\$1,000	\$1,500
\$2,000	\$3,000
Unlimited	Unlimited
Coordinated by your PCP	Coordinated by your Kaiser provider
\$15 copay per visit (24-visit maximum for acupuncture and chiropractic combined) Provided through ASHP network — call (800) 678-9133. No PCP referral IS required; however, if you are referred by your PCP, you pay the applicable PCP copay — \$15 or \$30 (see Coinsurance/Copay).	Not covered
No copay	\$15 copay for testing; no copay for treatment
No copay when determined to meet the criteria of an emergency or when ordered or approved by Medical Group	No copay when determined to meet the criteria of an emergency
Covered: See Acupuncture above	\$15 copay per visit (up to 20 visits per year)
No copay; \$5,000 maximum benefit per calendar year	No copay in accordance with the Durable Medical Equipment formulary, within the service area
\$50 copay for Emergency Room; waived if admitted If you receive emergency care treatment, you or a family member must notify your medical group. Follow-up care must be authorized by your medical group.	\$50 copay for Emergency Room; waived if admitted If you are hospitalized at an out-of-network facility, you, your doctor or a family member must notify Kaiser within 24 hours. Claims for non-hospital medical care must be submitted within 90 days or as soon as possible. Follow-up care is not covered.
\$50 copay	\$15 copay
\$150 copay	\$15 copay
\$15 or \$30 (see Coinsurance/Copay)	\$15 copay
\$150 copay	\$15 copay
\$15 or \$30 (see Coinsurance/Copay)	\$15 copay
50% for studies and tests (diagnosis only)	Covered (contact Kaiser for details)
Not covered	Not covered
Covered: See Prescription Drugs	Covered: See Prescription Drugs
Covered under Durable Medical Equipment	Not covered

Anthem Blue Cross PPO Plan¹

Participating Provider

Non-Participating Provider

Hospital

Number of Days Covered	No maximum	No maximum
Maximum Daily Room Benefit	80% of negotiated rate	50% of eligible charges
Hospital Extras	80% of negotiated rate	50% of eligible charges
Intensive Care	80% of negotiated rate	50% of eligible charges
Extended Care Facility	80% of negotiated rate	50% of eligible charges

Skilled Nursing Facilities benefit limited to 120 days each calendar year. Home Health Care benefit limited to 120 visits per calendar year. Hospice covered up to 12-month life expectancy. Family bereavement counseling covered. If preservice review is not obtained for hospital admission, \$500 deductible will apply. This penalty does not apply to emergency admissions.

Immunizations

Preventive	See Preventive Care	
Injectables (office-based)	80% of negotiated rate	50% of eligible charges

Medicare Eligibility

When Primary Benefits coordinated with Medicare, Parts A and B

Physician Services

Office Visit	\$25 copay	50% of eligible charges
Hospital Visit	\$25 copay	50% of eligible charges
Home Visit	\$25 copay	50% of eligible charges

Combined (participating and non-participating) 120-visit maximum per calendar year for home services rendered by a home health agency

Consulting Specialist	\$25 copay	50% of eligible charges
-----------------------	------------	-------------------------

Physiotherapy

(Physical/Medicine, Occupational, Speech)	80% of negotiated rate	50% of eligible charges
---	------------------------	-------------------------

Combined (participating & non-participating) 24-visit maximum per calendar year (includes chiropractic); Speech Therapy not subject to the 24-visit maximum

Prescription Drugs

Coverage is through WellPoint pharmacies.

Call (800) 700-2541 or go to www.anthem.com/ca/caltech.

Mail order available through WellPoint NextRx.

Call (800) 897-9116 or go to www.WellPointNextRx.com.

\$15 for generic, up to a 30-day supply

\$30 for brand, up to a 30-day supply

\$30 for generic mail order, up to a 90-day supply

\$60 for brand mail order, up to a 90-day supply

At participating WellPoint pharmacies, the plan pays 100% of eligible expenses after the applicable copay. At non-participating pharmacies, the plan reimburses 50% of eligible expenses after the applicable copay.

Preauthorization is required for some drugs; check with participating pharmacies, contact Wellpoint Pharmacy at (800) 700-2541 or go to www.anthem.com/ca/caltech, go to *Pharmacy Programs* section, and then scroll down to the *Prior Authorization* listing.

Certain non-preferred drugs are not covered unless your physician indicates "Dispense as Written" (DAW) or "Do Not Substitute" (DNS) on the prescription. Refer to the Web site at www.anthem.com/ca/caltech, go to *Pharmacy Programs* section, and then scroll down to *Preferred Drug Program* section and click on the prompt for the list of non-preferred drugs.

Pregnancy/Maternity Care

Treated as any other condition — includes routine nursery care

Anthem Blue Cross HMO²

Kaiser Plan²

No maximum

No copay (semi-private room)

No copay

No copay

No copay — Skilled Nursing covered up to 100 days per calendar year; Hospice covered up to 12-month life expectancy

No maximum

No copay; no maximum

No copay; no maximum (blood used in transfusions provided with no copay if replaced)

No copay

No copay — up to 100 days per benefit period

Custodial care not covered

See Preventive Care

\$15 or \$30 (see Coinsurance/Copay)

No copay

No copay

Benefits coordinated with Medicare, Parts A and B

Benefits coordinated with Medicare, Parts A and B

\$15 or \$30 (see Coinsurance/Copay)

No copay

\$15 or \$30 (see Coinsurance/Copay)

\$15 copay

No copay

No copay when in the service area. Up to 2 hours per visit, up to 3 visits per day, up to 100 visits per year.

\$15 or \$30 (see Coinsurance/Copay); PCP referral required

\$15 copay

\$15 or \$30 (see Coinsurance/Copay); PCP referral required; limited to a 60-day period of care after an illness or injury; additional visits available when approved by medical group

\$15 copay; per physician order

Coverage is through WellPoint pharmacies.

Call (800) 700-2541 or go to www.anthem.com/ca/caltech

Mail order available through WellPoint NextRx.

Call (800) 897-9116 or go to www.WellPointNextRx.com

\$15 for generic, up to a 30-day supply

\$30 for brand, up to a 30-day supply

\$30 for generic mail order, up to a 90-day supply

\$60 for brand mail order, up to a 90-day supply

Copays apply only at participating Wellpoint pharmacies.

Preauthorization is required for some drugs; check with participating pharmacies, contact Wellpoint Pharmacy at (800) 700-2541 or go to www.anthem.com/ca/caltech, go to *Pharmacy Programs* section, and then scroll down to the *Prior Authorization* listing.

Certain non-preferred drugs are not covered unless your physician indicates "Dispense as Written" (DAW) or "Do Not Substitute" (DNS) on the prescription. Refer to the Web site at www.anthem.com/ca/caltech, go to *Pharmacy Programs* section, and then scroll down to *Preferred Drug Program* section and click on the prompt for the list of non-preferred drugs.

\$10 copay per prescription for generic, up to a 100-day supply

\$30 copay per prescription for brand, up to a 100-day supply

\$10 copay for generic mail order, up to a 100-day supply

\$30 copay for brand mail order, up to a 100-day supply

Drugs prescribed by non-Kaiser physicians are not covered, except for dental prescriptions. Medications to shorten the duration of the common cold are not covered.

Compounded prescription drugs will only be covered if the product is on the drug formulary or if one of the ingredients requires a prescription by law.

For drugs that are being dispensed in limited amounts by pharmacists due to shortages in the market, the pharmacist may fill the prescription for a supply of less than 30 days, but still require the full copay.

Treatment for hair loss or hair growth is not covered.

Drugs for treatment of sexual dysfunction are covered at 50% of the member rate with a maximum of 27 doses for a 100-day supply.

\$15 or \$30 (see Coinsurance/Copay)

\$15 copay for initial visit; no charge for prenatal office visits after the initial visit

Anthem Blue Cross PPO Plan¹

Participating Provider

Non-Participating Provider

Preventive Care Routine Exams	<i>All ages:</i> \$25 copay each exam (including immunizations); \$250 maximum benefit per calendar year (children under the age of 7 are not subject to the \$250 maximum)	<i>Children under 7 years:</i> 50% of eligible charges for exam (limited to \$20 per exam); 50% of eligible charges for immunizations (limited to \$12 per immunization) <i>Age 7 and older:</i> Not covered
Psychiatric Care and Substance Abuse Inpatient Hospital and Outpatient Day Treatment	80% of negotiated rate Treated as any other condition (Federal Mental Health Parity)	50% of eligible charges
Outpatient and Inpatient Physician	\$25 copay Precertification for additional outpatient visits is required after 12 visits (separate limit for each individual provider)	50% of eligible charges
Surgery	80% of negotiated rate	50% of eligible charges
Vision Care	Coverage is through Vision Service Plan (VSP). Call VSP at (800) 877-7195 or go to www.vsp.com .	
Examinations	\$5 copay once every 12 months	\$5 copay once every 12 months (up to \$45 maximum)
Glaucoma Test	\$5 copay	\$5 copay
Refractions	\$5 copay	\$5 copay
Vision Care Materials		
<i>Lenses</i>	Covered once per 24-month period	Covered once per 24-month period
Single vision	No copay	Covered up to \$45 retail value
Lined bifocal	No copay	Covered up to \$65 retail value
Lined trifocal	No copay	Covered up to \$85 retail value
	Lens types and treatments that add to the appearance, durability and function of glasses are available at VSP's preferred member pricing.	
<i>Frames</i>	Covered once per 24-month period (up to \$120)	Covered up to \$47 retail value
<i>Contact Lenses</i> (includes fit, follow up and materials)	Covered once per 24-month period, up to \$120 retail value	Covered up to \$120 retail value
Laser Vision Correction	Discounts available through VSP. For participating providers, contact VSP at (800) 877-7195 or www.vsp.com .	Not covered
X-Ray & Lab (Outpatient)	80% of negotiated rate	50% of eligible charges

* See exclusions and limitations below.

** After a member pays the individual out-of-pocket maximum or the combined expenses of all covered family members reaches the family maximum in any calendar year, benefits are paid at 100%. The deductible, if applicable, and prescription drug copayments do not apply toward the out-of-pocket maximum. Contact your medical plan for details.

EXCLUSIONS/LIMITATIONS

Employees on out-of-state assignments at the request of the Institute may have other benefits available; contact local Human Resources.

None of the plans pay for these services: Workers' Compensation cases; care covered by any Federal Government Agency; rest cures; custodial care; cosmetic surgery; dental care; and services for which the member is not required to pay. See the Benefits Handbook for other specified exclusions.

¹ Participating physicians and hospitals may be found by calling Anthem Blue Cross at (866) 820-0765 or by going to www.anthem.com/ca/caltech.

If you choose to go to a non-participating provider, then you are responsible for paying any charges in excess of the covered amount.

² Benefits must be provided or authorized by a physician of the health plan and/or provider group selected by the member.

Anthem Blue Cross HMO²

Kaiser Plan²

\$15 or \$30 (see Coinsurance/Copay); includes immunizations

\$15 copay

Provided through Behavioral Health Network;
contact Anthem Blue Cross for details.

No copay

No copay

Treated as any other condition (Federal Mental Health Parity)

Outpatient: \$15 or \$30 copay per visit (see Coinsurance/Copay)
Inpatient: No copay

\$15 copay per visit/\$7 copay per group visit

Precertification for additional outpatient visits is required
after 12 visits (separate limit for each individual provider)

No copay

\$15 in doctor's office; no copay when hospitalized

Coverage is through Vision Service Plan (VSP), which provides access to participating and non-participating providers. Vision coverage under the Anthem Blue Cross HMO is the same as the vision coverage under the Anthem Blue Cross PPO. See Anthem Blue Cross PPO *Vision Care* at left for details.

Coverage for eye exams only

See Anthem Blue Cross PPO *Examinations* at left

\$15 copay

See Anthem Blue Cross PPO *Glaucoma Test* at left

\$15 copay

See Anthem Blue Cross PPO *Refractions* at left

\$15 copay

See Anthem Blue Cross PPO *Vision Care Materials* at left

Materials are not covered

See Anthem Blue Cross PPO *Laser Vision Correction* at left

Not covered

No copay

No copay

THIS HEALTH PLAN COMPARISON IS NOT A CONTRACT. It describes benefits in general terms. Consult the individual plan booklets for specific details of benefit coverage. To permit a brief summary of benefits and services, use of actual contract language has been minimized. The summary comparison does not replace the legal documents that establish the plans. Final interpretation of any provision of the plans will be governed by the master policies and service agreements, which are on file in the office of the plan Administrator.

Comparison of Dental Plan Benefits

Effective January 1, 2010

Benefits	Delta Dental PPO	Safeguard Dental
Customer Service	(800) 765-6003 www.deltadentalins.com/caltech	(800) 880-1800 www.safeguard.net/custom_sites/caltech/caltech.htm
Choice of Dentist	Choose any licensed dental provider ¹	Choose a participating Safeguard dentist
Deductible (Per Individual/Calendar Year)	\$50	None
Maximum Annual Allowable Benefit (Per Individual/Calendar Year)	When you use PPO providers: \$1,750 ² When you use other providers: \$1,500 ²	None
Emergency Dental Benefit	No separate emergency benefit; benefits paid according to plan benefits	Covered at 100% (less applicable charges) within service area; \$50 maximum outside service area, if verified that your dentist is unavailable ³
Types of Services		
Diagnostic & Preventive		
Oral Examinations or Routine Cleanings (Prophylaxis)	Covered at 100% (no deductible) (2 per calendar year, 3 for pregnancy)	No copay; covered twice per calendar year
Bitewing X-rays	Covered at 100% (no deductible) twice per calendar year for children under age 18; once per calendar year for adults over age 18	No copay
Full Mouth X-rays	Covered at 100% (no deductible) every 5 years	No copay; once, initially, and thereafter, when diagnostically needed
Space Maintainers ⁴	Covered at 100% (no deductible)	No copay
Basic Dental Services		
Fillings	80% (includes Amalgam, Silicate, Composite [Resin] Fillings)	No copay ⁵ (includes Amalgam, Composite [Resin Interior Only] Fillings)
Extractions	80%	No copay
Endodontics (Root Canal Therapy)	80%	No copay
Periodontic Services (Treatment of Gums and Supportive Tissue)	80%	No copay
Periodontal Scaling, Root Planing	80%	\$25 copay per quadrant
Sealants	80% ⁶	No copay ⁷
Major Dental Services		
Crowns (Restorative)	50% (covered on the same tooth only once per 5 years)	\$45 copay per unit ⁸
Fixed Bridges	50% after 6 months of continuous enrollment (covered only once per 5 years)	\$45 copay per unit ⁸
Partial & Complete Dentures	50% after 6 months of continuous enrollment (covered only once per 5 years)	\$50 copay each for upper or lower full or partial denture
Implants (including removal, repair and re-cementation)	50% after 6 months of continuous enrollment (covered once per 5 years; implant removal covered once per tooth per lifetime)	Not covered
Orthodontics	50% subject to \$1,000 lifetime maximum (dependent children only)	Charge \$1,350 for full-banded case

You save the most money when you use providers in the Delta Dental PPO network because they agree to accept the lowest negotiated fees, which are typically less than Delta's approved fee. If you choose a Delta Dental Premier provider who is not in the PPO network, you may be charged no more than your share of Delta's approved fee. If you use a non-Delta dentist, your cost is usually more because you are responsible for the difference if the dentist charges more than Delta's approved fee.

² All benefits apply to the annual maximum, except diagnostic & preventive procedures and orthodontia.

³ For Safeguard, emergency dental services means dental services provided for the relief of pain, bleeding or any condition which may result in disability or death. The plan covers only those emergency dental services required for such conditions, and your selected dentist must provide any further dental treatment or services. If you are within 25 miles of your selected dentist, contact your selected dentist to make reasonable arrangements for any required emergency dental services. If your dentist is unavailable, you may receive emergency dental services from any licensed dentist. Upon verification of the unavailability of your dentist, Safeguard will reimburse you for the cost of such emergency dental services, less any applicable charges, up to \$50. To request reimbursement, send evidence of payment (such as a bill marked paid) to Safeguard.

⁴ Space maintainers create and/or maintain space in a child's mouth to allow room for permanent teeth to come in.

⁵ Safeguard provides coverage for amalgam fillings for the front or back teeth and resin for front teeth only.

⁶ Coverage is for 1st molars through age 8 and 2nd molars through age 15 (covered only to permanent 1st and 2nd molars without decay, or restorations on the occlusal surface). Sealant benefits do not include the repair or replacement of a sealant on any tooth within 2 years of its application.

⁷ Sealants can be put on the tooth up until 4 years of eruption.

⁸ An additional fee of \$75 will be charged for porcelain on any molar crown or pontic.