

# 2006 Comparison of Health Plan Benefits Southern California

## Medical

Blue Cross PPO  
Blue Cross HMO  
Kaiser Plan

## Dental

Delta Dental  
Safeguard Dental

## CALIFORNIA INSTITUTE OF TECHNOLOGY

### Comparison of Medical Plans

As an eligible employee, you may enroll in one of three different medical plans. One is a fee-for-service group medical insurance plan. Two are prepaid plans or health maintenance organizations (HMOs).

The **fee-for-service plan**, underwritten by Blue Cross, pays benefits for covered services provided by *any* licensed physician or hospital. This plan offers a **preferred provider organization** (PPO) component. A PPO is a group of doctors, hospitals and other providers who have contracted with Blue Cross to offer services at *negotiated* rates. When you use these contracted providers, plan benefits are paid at a higher rate (80% of *negotiated* rates). If you choose to use non-contracted providers, then plan benefits are paid at a lower rate (in many cases 50% of *eligible charges*). *Eligible charges* are determined by using Blue Cross allowances that are based on reasonable and customary rates for the geographical area where services are provided.

**Under the HMO plans**, except for emergency situations, health care services are provided by physicians employed or contracted by the plan and in hospitals and other facilities owned or contracted by the plan. With very few exceptions, no deductible is required. Charges, or copayments (copays), are applied to some covered services.

### Comparison of Dental Plans

As an eligible employee, you have a choice between two different dental plans. One is a fee-for-service dental insurance plan. The other plan is a prepaid dental plan that works like an HMO.

The **fee-for-service dental plan**, underwritten by Delta Dental, pays benefits for covered services you receive from *any* licensed dental provider. Most covered services are paid at 80%. Delta dentists have agreed to abide by Delta's determination of the allowed fee. If you use a Delta dentist, you may be charged no more than your share of the dentist's fees allowed by Delta. If you use a non-Delta dentist, you will be responsible for the difference if the dentist charges more than Delta's allowed fees. Delta dentists are paid on a different fee base than non-Delta dentists. This may result in higher out-of-pocket costs to you when you visit a non-Delta dentist.

Under the Safeguard Dental **prepaid plan**, dental services are provided by dentists who have contracted with the plan. No deductible is required. Charges, or copayments (copays), are applied to some covered services.

### Dependent Eligibility for Medical and Dental

Spouse, same-sex domestic partners of any age, 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.



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# Comparison of Medical Plan Benefits\*

<b>Blue Cross PPO Plan<sup>1</sup></b>		
<b>Participating Provider</b>		<b>Non-Participating Provider</b>
<b>Customer Service</b>	(866) 820-0765	
<b>Web Site</b>	<a href="http://www.bluecrossca.com/clients/caltech/">http://www.bluecrossca.com/clients/caltech/</a>	
<b>Annual Deductible</b>	\$500 per person; \$1,500 family maximum	
Per Person/Calendar Year		
<b>Coinsurance/ Copayment (Copay)</b>	<i>Physician</i> — 80% of negotiated rate <i>Hospital</i> — 80% of negotiated rate  Preservice and concurrent reviews are required for all hospital admissions. If preservice review is not obtained, a separate, non-certification deductible will apply — \$500 per inpatient admission. For details and to request preservice review, call Blue Cross at (866) 820-0765.	<i>Physician</i> — 50% of eligible charges <i>Hospital</i> — 50% of eligible charges
<b>Out-of-Pocket Maximum**</b>		
Per Person/Calendar Year	\$2,000	\$8,000
Per Family/Calendar Year	N/A	N/A
<b>Maximum Benefit</b>	\$2,000,000 each member	
Per Person/Lifetime		
<b>Outline of Benefits</b>		
<b>Acupuncture</b>	80% of negotiated rate	50% of eligible charges
<b>Allergy Test/Treatment</b>	80% of negotiated rate	50% of eligible charges
<b>Ambulance</b>	80% of eligible charges	
<b>Chiropractic Services</b>	Covered under Physiotherapy	Covered under Physiotherapy
<b>Durable Medical Equipment</b>	80% of negotiated rate	50% of eligible charges
<b>Emergency Care</b>	80% of negotiated rate	80% of eligible charges for all emergencies 50% of eligible charges for non-emergency care
<b>Family Planning</b>		
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
<b>Hearing Aids</b>	80% of negotiated rate	50% of eligible charges
Combined (participating and non-participating) maximum of \$2,000 per calendar year		

Blue Cross HMO <sup>2</sup>	Kaiser Plan <sup>2</sup>
(866) 820-0765	(800) 464-4000
<a href="http://www.bluecrossca.com/clients/caltech/">http://www.bluecrossca.com/clients/caltech/</a>	<a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>
No deductible	No deductible
\$15 copay per doctor visit	\$15 copay per doctor visit
\$1,000	\$1,500
\$2,000	\$3,000
Unlimited	Unlimited
\$15 copay per visit (24-visit maximum combined with chiropractic); no PCP referral required; provided through ASHP network — contact Blue Cross for details	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
\$15 copay per visit (24-visit maximum combined with acupuncture); no PCP referral required; provided through ASHP network — contact Blue Cross for details	Not covered
No copay; \$2,000 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.	\$35 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 copay	\$15 copay
\$150 copay	\$15 copay
\$15 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

# Blue Cross PPO Plan<sup>1</sup>

## 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. 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

Consulting Specialist	\$25 copay	50% of eligible charges
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### Physiotherapy

(Physical Therapy/Medicine, Speech, Occupational)	80% of negotiated rate	50% of eligible charges
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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.** Contact WellPoint at (800) 700-2541 or  
**Mail order available through PrecisionRx** at (800) 897-9116 or g

- \$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 <http://www.bluecrossca.com/clients/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 <http://www.bluecrossca.com/clients/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 illness — includes routine nursery care

### Preventive Care

Routine Exams	All ages: \$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)	Children under 7 years: 50% of eligible charges for exam (limited to \$20 per exam); 50% of eligible charges for immunizations (limited to \$12 per immunization) Age 7 and older: Not covered
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## Blue Cross HMO<sup>2</sup>

## Kaiser Plan<sup>2</sup>

No maximum  
 No copay (semi-private room)  
  
 No copay  
 No copay  
 No copay — up to 100 days per calendar year

No maximum  
 No copay  
 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 copay

No copay  
 No copay

Benefits coordinated with Medicare, Parts A and B

Benefits coordinated with Medicare, Parts A and B

\$15 copay  
 No copay  
 \$15 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 copay (primary care physician referral required)  
 \$15 copay; must be referred by primary care physician; limited to a 60-day period of care after an illness or injury; additional visits available when approved by medical group

\$15 copay  
 \$15 copay; per physician order

go to <http://www.bluecrossca.com/clients/caltech/>  
 o to [www.precisionrx.com/wpx](http://www.precisionrx.com/wpx)

\$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 <http://www.bluecrossca.com/clients/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 <http://www.bluecrossca.com/clients/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 copay  
 \$15 copay (includes immunizations)

\$15 copay for initial visit; no charge for other covered services  
 \$15 copay

# Blue Cross PPO Plan<sup>1</sup>

	Participating Provider	Non-Participating Provider
<b>Psychiatric Care***</b>		
Inpatient Hospital and Outpatient Day Treatment	80% of negotiated rate  Combined (participating & non-participating, including Substance Abuse) 60-day maximum per 24 months	50% of eligible charges
Outpatient and Inpatient Physician	50% coverage; \$25 maximum benefit each visit  Combined (participating and non-participating, including Substance Abuse) 50-visit maximum per calendar year for Substance Abuse only	50% coverage; \$25 maximum benefit each visit
<b>Substance Abuse</b> Covered under the Psychiatric Care benefit		
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<b>Surgery</b>	80% of negotiated rate	50% of eligible charges
<b>Vision Care</b> Coverage is through Vision Service Plan (VSP). For participating providers, contact VSP at (800) 877-7195 or 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 \$115)	Covered up to \$47 retail value
<i>Contact Lenses</i> (includes fit, follow up and materials)	Covered once per 24-month period, up to \$105 retail value	Covered up to \$105 retail value
Laser Vision Correction	Discounts available through VSP. For participating providers, contact VSP at (800) 877-7195 or www.vsp.com.	Not covered
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<b>X-Ray &amp; Lab (Outpatient)</b>	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 certain copayments (for example, PPO office visit copay, mental/nervous, substance abuse and prescription drug copayments) do not apply toward the out-of-pocket maximum. Contact your medical plan for details.

\*\*\* For California enrollees, day/visit limits do not apply for diagnoses as defined by AB88, and coinsurance/copayments for AB88 diagnoses are the same as those for other medical conditions. In addition, day/visit limitations do not apply to the following mental health diagnoses: schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; bulimia nervosa; and severe emotional disturbances of a child as identified in the most recent edition of DSM and meeting the criteria of California law.

**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.

<sup>1</sup> Participating physicians and hospitals may be found by calling Blue Cross at (866) 820-0765 or by going to <http://www.bluecrossca.com/clients/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.

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

## Blue Cross HMO<sup>2</sup>

## Kaiser Plan<sup>2</sup>

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

No copay for up to 30 days per calendar year

\$20 copay per visit

20-visit maximum per calendar year for psychiatric care;  
50-visit maximum per calendar year for Substance Abuse

Outpatient/Inpatient — covered under Psychiatric Care benefit  
Inpatient detoxification covered at no charge

No copay

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

See Blue Cross PPO *Examinations* at left

See Blue Cross PPO *Glaucoma Test* at left

See Blue Cross PPO *Refractions* at left

See Blue Cross PPO *Vision Care Materials* at left

See Blue Cross PPO *Laser Vision Correction* at left

No copay

No copay for up to 45-day maximum

\$15 copay per visit/\$5 copay per group visit

20-visit maximum per calendar year

Outpatient visits — \$15 individual; \$5 group  
Inpatient detoxification covered at no charge  
Transitional residential recovery services covered up to 60 days per calendar year at \$100 per admission but no more than 120 days in any 5 consecutive calendar year period

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

\$15 copay

\$15 copay

\$15 copay

Materials are not covered

Not covered

No copay

**NOTE:** 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.

**NOTE:** 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, 2006

Benefits	Delta Dental	Safeguard Dental
<b>Customer Service</b>	(800) 765-6003	(800) 880-1800
<b>Choice of Dentist</b>	Choose any licensed dental provider <sup>1</sup>	Choose a participating Safeguard dentist
<b>Deductible</b> (Per Individual/Calendar Year)	\$50	None
<b>Maximum Allowable Benefit</b> (Per Individual/Calendar Year)	\$1,250 <sup>2</sup>	None
<b>Emergency Dental Benefit</b>	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 the member's dentist is unavailable <sup>3</sup>
<b>Types of Services</b>		
<b>Diagnostic &amp; Preventive</b>		
Oral Examinations or Cleanings (Prophylaxis)	Covered at 100% (no deductible) twice per calendar year	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; covered once every 6 months
Full Mouth X-rays	Covered at 100% (no deductible) every 5 years	No copay; once, initially, and thereafter, when diagnostically needed
Space Maintainers <sup>4</sup>	Covered at 100% (no deductible)	No copay
<b>Basic Dental Services</b>		
Fillings (Amalgam, Silicate, Composite [Resin] Fillings)	80%	No copay <sup>5</sup>
Extractions	80%	No copay
Endodontics (Root Canal Therapy)	80%	No copay
Periodontic Services (Treatment of Gums and Supportive Tissue)	80%	No copay
Periodontal Scaling and Root Planing	80%	\$25 copay per quadrant
Sealants	80%; first molars through age 8 and second molars through age 15; covered only to permanent first and second molars without decay, or restorations on the occlusal surface	\$5 copay per tooth <sup>6</sup>
<b>Major Dental Services</b>		
Crowns (Restorative)	50% (covered on the same tooth only once per 5 years)	\$45 copay per unit <sup>7</sup>
Fixed Bridges	50% after 6 months of continuous enrollment (covered only once per 5 years)	\$45 copay per unit <sup>7</sup>
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
Orthodontics	50% subject to \$1,000 lifetime maximum (dependent children only)	Charge \$1,350 for full-banded case

<sup>1</sup> Delta dentists have agreed to abide by Delta's determination of the allowed fee. If you use a Delta dentist, you may be charged no more than your share of the dentist's fees allowed by Delta. If you use a non-Delta dentist, you will be responsible for the difference if the dentist charges more than Delta's allowed fees. Delta dentists are paid on a different fee base than non-Delta dentists, and this may result in higher out-of-pocket costs to you when you visit a non-Delta dentist.

<sup>2</sup> All benefits (except orthodontics) apply to the annual maximum, including preventive procedures.

<sup>3</sup> For Safeguard, emergency dental services means dental services rendered 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 any further dental treatment or services must be provided by the member's selected dentist. If the member is within 25 miles of the member's selected dentist and is in need of emergency dental services, the member shall contact their selected dentist who will make reasonable arrangements for emergency dental services. If the member's dentist is unavailable, the member may obtain emergency dental services from any licensed dentist. Upon verification of the unavailability of the member's dentist, Safeguard will reimburse the member for the cost of such emergency dental services, less any applicable charges, up to \$50. To request reimbursement, the member should send evidence of payment (such as a bill marked paid) to Safeguard.

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

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

<sup>6</sup> Sealants can be put on the tooth up until 4 years of eruption.

<sup>7</sup> An additional fee of \$75 will be charged for porcelain on any molar crown or pontic.