aetna®

California Institute of Technology
Effective Date: 01-01-2024

Indemnity Out of Area Plan

**PLAN DESIGN & BENEFITS**
**MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

| PLAN FEATURES | |
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| Benefit limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information. | |
| **Deductible** (per calendar year) | $3,950 Individual<br>$7,900 Family |
| Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses do not apply towards the Deductible.<br>The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount. | |
| **Payment Limit** (per calendar year) | $6,250 Individual<br>$12,500 Family |
| Certain member cost sharing elements may not apply toward the Payment Limit.<br>Pharmacy expenses apply towards the Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.<br>The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount. | |
| **Lifetime Maximum** | Unlimited except where otherwise indicated. |
| **Primary Care Physician Selection** | Not Applicable |
| **Certification Requirements -** | Certification for Hospital Admissions must be obtained to avoid a reduction in benefits paid. Excluded amount applied separately to each type of expense is $500 per occurrence. |
| **Referral Requirement** | None |
| **PREVENTIVE CARE** | |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived |
| 1 exam every 12 months for members age 22 to age 65; 1 exam every 24 months for ages 65 and older. | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived |
| 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22. | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived |
| 1 obgyn exam and pap smear per year | |
| **Routine Mammograms** | Covered 100%; deductible waived |
| **Women's Health** | Covered 100%; deductible waived |
| Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived |
| Recommended: For covered males age 40 and over. | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived |

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| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered under Routine Adult Exams | |
| Recommended: For all members age 45 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | |
| 1 routine exam per 24 months. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived<br>routine exam per 12 months | 1 |
| **PHYSICIAN SERVICES** | | |
| **Office Visits to non-Specialist** | 20%; after deductible | |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | 20%; after deductible | |
| **Walk-in Clinics** | 20%; after deductible | |
| Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| **Allergy Testing** | 20%; after deductible | |
| **Allergy Injections** | 20%; after deductible | |
| **DIAGNOSTIC PROCEDURES** | | |
| **Diagnostic X-ray** | 20%; after deductible | |
| (other than Complex Imaging Services)<br>If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic Laboratory** | 20%; after deductible | |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **Diagnostic complex imaging** | 20%; after deductible | |
| If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing. | | |
| **EMERGENCY MEDICAL CARE** | | |
| **Urgent Care Provider** | 20%; after deductible | |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | |
| **Emergency Room** | 20%; after deductible | |
| **Non-Emergency Care in an Emergency Room** | Not Covered | |
| **Emergency Use of Ambulance** | 20%; after deductible | |
| **Non-Emergency Use of Ambulance** | Not Covered | |
| **HOSPITAL CARE** | | |
| **Inpatient Coverage** | 20%; after deductible | |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** | 20%; after deductible | |
| (includes delivery and postpartum care)<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Outpatient Hospital Expenses** | 20%; after deductible | |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |

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| **MENTAL HEALTH SERVICES** | |
| **Mental Health Inpatient** | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Mental Health Office Visits** | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |
| **Other Mental Health Services** | 20%; after deductible |
| **SUBSTANCE ABUSE** | |
| **Substance Abuse Inpatient** | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Residential Treatment Facility** | 20%; after deductible |
| **Substance Abuse Office Visits** | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | |
| **Other Substance Abuse Services** | 20%; after deductible |
| **OTHER SERVICES** | |
| **Skilled Nursing Facility** | 20%; after deductible |
| Limited to 100 days per calendar year.<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Home Health Care** | 20%; after deductible |
| Limited to 120 visits per calendar year.<br>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less. | |
| **Hospice Care - Inpatient** | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | |
| **Hospice Care - Outpatient** | 20%; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient stay. | |
| **Autism Behavioral Therapy** | 20%; after deductible |
| Covered same as any other Outpatient Mental Health benefit | |
| **Autism Applied Behavior Analysis** | 20%; after deductible |
| Covered same as any other Outpatient Mental Health Other Services benefit | |
| **Autism Physical Therapy** | 20%; after deductible |
| **Autism Occupational Therapy** | 20%; after deductible |
| **Autism Speech Therapy** | 20%; after deductible |
| **Outpatient Short-Term Rehabilitation** | 20%; after deductible |
| **Spinal Manipulation Therapy** | 20%; after deductible |
| Limited to 20 visits per calendar year. | |
| **Durable Medical Equipment** | 20%; after deductible |
| **Diabetic Supplies** | Covered same as any other expense. |
| **Orthotics** | 20%; after deductible |
| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | 100% covered; after deductible |
| **Affordable Care Act Mandated Women's Contraceptives** | 100% covered; after deductible |
| **Transplants** | 20%; after deductible |
| **Bariatric Surgery** | Not Covered |
| **Acupuncture** | 20%; after deductible |
| Limited to 20 visits per year | |

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| **FAMILY PLANNING** | |
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| **Infertility Treatment** | Your cost sharing is based on the type of service and where it is performed |
| Diagnosis and treatment of the underlying medical condition only. | |
| **Comprehensive Infertility Services** | Not Covered |
| **Advanced Reproductive Technology (ART)** | Not Covered |
| In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | |
| **Tubal Ligation** | 100% No Deductible/No Copay applied including associated ancillary services |
| **Vasectomy** | 20%; after deductible |

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| **PHARMACY** | | |
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| **Pharmacy Plan Type:** | Advanced Control Plan - Aetna | |
| **Preferred Generic Drugs:** | | |
| **Retail** | 0% | 0% |
| **Mail Order** | 0% | Not covered |
| **Preferred Brand-Name Drugs:** | | |
| **Retail** | 25% Maximum copay of $250 | 25% Maximum copay of $250 |
| **Mail Order** | 25% Maximum copay of $500 | Not Covered |
| **Non-Preferred Generic Brand-Name Drugs:** | | |
| **Retail** | 50% Maximum copay of $250 | 50% Maximum copay of $250 |
| **Mail Order** | 50% Maximum copay of $500 | Not Covered |

**Pharmacy Day Supply and Requirements**

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| **Retail** | Up to a 30-day supply from Aetna National Network<br>Percentage copays will not be doubled |
| **Mail Order** | A 31-90-day supply from CVS Caremark® Mail Service Pharmacy |
| **Specialty** | Up to a 30-day supply<br>First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.<br>Advanced Control Formulary Aetna Insured List |

**Choose Generics with Dispense as Written (DAW) override** - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.

**GENERAL PROVISIONS**

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**Dependents Eligibility** Spouse, children from birth to age 26 regardless of student status.

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| **Pre-existing Conditions Exclusion** | On effective date: Waived<br>After effective date: Waived |

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a

subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

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