Traditional Choice

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	California Institute of Technology
Group policy number:	GP-866280
Control number:	CN-869103
Schedule of Benefits	1A
Group policy effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	October 28, 2019
Plan revision effective date:	January 1, 2020

Underwritten by Aetna Life Insurance Company in the state of California.

Schedule of benefits

This schedule of benefits lists the **copayments/coinsurance** that apply to the services you receive under this plan. You should review this schedule to become familiar with your **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- The **copayments/coinsurance** listed in the schedule of benefits below reflects the **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **copayments** and **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - Maximums

Important note:
All **covered benefits** are subject to the **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

Eligible health services	
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's** office	100% per visit No **deductible** applies
Covered persons through age 21: Maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies

Obesity and/or healthy diet counseling maximums:	
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Misuse of alcohol and/or drugs maximums:	
Maximum visits per 12 months	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Use of tobacco products maximums:	
Maximum visits per 12 months	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

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Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only (includes participation in the California Prenatal Screening Program	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	

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Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% (of the **recognized charge**) per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	
Breast feeding durable medical equipment	
Breast pump supplies and accessories	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.	
Family planning services – female contraceptives	
Education and counseling services	
Female contraceptive education and counseling services office visit	100% per visit No **deductible** applies

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Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit and follow up services	100% per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies
Eligible health services	
2. Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	100% (of the **recognized charge**) per visit No **deductible** applies
Telemedicine consultation by a **physician**	100% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1
Telemedicine consultation by a **specialist**	100% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per day	1
Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.

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Specialist	
Specialist office visits	
Office hours visits (non-surgical)	100% (of the **recognized charge**) per visit No **deductible** applies
Physician surgical services	
Physicians and **specialists** office visits	
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies

Eligible health services	
3. Hospital and other facility care	
Hospital care	
Inpatient **hospital**	100% (of the **recognized charge**) per admission No **deductible** applies
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	100% (of the **recognized charge**) per visit No **deductible** applies
Home health care	
Outpatient	100% (of the **recognized charge**) per visit No **deductible** applies
	Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours. Intermittent visits are considered periodic and recurring visits that skilled nurses or home health aides make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 14 days of discharge

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Hospice care	
Inpatient facility	100% (of the **recognized charge**) per admission No **deductible** applies

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Hospice care	
Outpatient	100% (of the **recognized charge**) per visit No **deductible** applies

	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Skilled nursing facility	
Inpatient facility	100% (of the **recognized charge**) per admission No **deductible** applies
Maximum Days per Calendar Year	120
Eligible health services	
4. Emergency services and urgent care	
Emergency services	
Hospital emergency room	100% (of the balance of the **recognized charge**) per visit. No **deductible** applies
Non-emergency care in a **hospital** emergency room	50% (of the **recognized charge**) per visit No **deductible** applies
Urgent Care	
Urgent medical care (at a non-**hospital** free standing facility)	100% (of the **recognized charge**) per visit No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
5. Specific conditions	
Birthing center and physician services	
Inpatient	100% (of the **recognized charge**) per admission No **deductible** applies
Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received.
Jaw joint disorder treatment	
Jaw joint disorder treatment	Covered according to the type of benefit and the place where the service is received
Maternity and related newborn care	
Inpatient	100% (of the **recognized charge**) per admission No **deductible** applies
Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	100% (of the **recognized charge**) per visit No **deductible** applies
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.
Pregnancy complications	
Inpatient	100% (of the **recognized charge**) per admission No **deductible** applies
Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility**	100% (of the **recognized charge**) per admission No **deductible** applies

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Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	100% (of the **recognized charge**) per visit No **deductible** applies
All other outpatient mental health services (as described in your[booklet-certificate)	100% (of the **recognized charge**) per visit No **deductible** applies
Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient residential treatment facility	100% (of the **recognized charge**) per admission No **deductible** applies
Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	100% (of the **recognized charge**) per visit No **deductible** applies
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms,	100% (of the **recognized charge**) per visit No **deductible** applies

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conditions as any other **illness**.	
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services.	100% (of the **recognized** charge) per visit No **deductible** applies

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	100% (of the **recognized charge**) per visit No **deductible** applies
Reconstructive surgery and supplies	
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received

Eligible health services*	

Transplant services facility and non-facility	
Inpatient **hospital** transplant services	100% (of the **recognized charge**) per transplant No **deductible** applies
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.

Eligible health services*	
Treatment of infertility	
Basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received

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Eligible health services	
6. Specific therapies and tests	
Diagnostic complex imaging services	
	100% (of the **recognized** charge) per visit No **deductible** applies
Diagnostic lab work	
	100% (of the **recognized** charge) per visit. No **deductible** applies.
Diagnostic radiological services	
	100% (of the **recognized** charge) per visit. No **deductible** applies.
Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy	
	Covered according to the type of benefit and the place where the service is received.

Outpatient radiation therapy	
Radiation therapy	Covered according to the type of benefit and the place where the service is received.
Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

Short-term rehabilitation services	
Outpatient Physical and Occupational Therapies	
	100% (of the **recognized** charge) per visit. No **deductible** applies.
Outpatient Speech Therapy	
	100% (of the **recognized** charge) per visit. No **deductible** applies.

Spinal manipulation	
Spinal manipulation	100% (of the **recognized charge**) per visit No **deductible** applies
Habilitation therapy services	
Outpatient physical and occupational therapies	
	Covered according to the type of benefit and the place where the service is received
*A visit is equal to no more than 1 hour of therapy. No visit limits apply to services for pervasive developmental disorder or autism.	
Outpatient speech therapy	
	Covered according to the type of benefit and the place where the service is received

Eligible health services	
7. Other services	

Acupuncture	
Acupuncture	Covered according to the type of benefit and the place where the service is received

Ambulance service	
Ground, air or water **ambulance**	100% (of the **recognized charge**) per trip No **deductible** applies.

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received

Durable medical equipment (DME)	
DME	100% (of the **recognized charge**) per item No **deductible** applies
Hearing aids and exams	
Hearing aid exams	Covered according to the type of benefit and the place where the service is received
Hearing aids	100% per item No **deductible** applies.
Hearing aids	One every 36 month consecutive period.
Non-preventive hearing exams	
For adults and children	100% (of the **recognized charge**) per visit No **deductible** applies.

Nutritional supplements	
Nutritional supplements	Covered according to the type of benefit and the place where the service is received
Osteoporosis	
Physician's office visits	Covered according to the type of benefit and the place where the service is received

Prosthetic devices	
Prosthetic and orthotic devices	100% (of the **recognized charge**) per item No **deductible** applies
Vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	100% per visit No **deductible** applies

Maximum visits per 12 consecutive month period	1 visit
All other outpatient services for which cost sharing is not shown above	
All other outpatient services	Covered according to the type of benefit and the place where the service is received

General coverage provisions

This section provides detailed explanations about the Maximums that are listed in the first part of this schedule of benefits.

Deductible provisions

Copayments

Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

The **maximum out-of-pocket limit** is unlimited.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit