FASHION INSTITUTE OF TECHNOLOGY
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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible (per calendar year)	None Individual None Family
Member coinsurance Applies to all expenses except as noted.	Covered 100%
Out-of-pocket limit (per calendar year) Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	$1,500 per Individual $3,000 per Family
Lifetime maximum Unlimited except where otherwise indicated.	
Primary care physician selection	Encouraged
Referral requirement	Not required
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine adult physical exams/ immunizations 1 exam every year	Covered 100%
Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam every 12 months from age 3 until age 22 years	Covered 100%
Routine gynecological care exams 2 exams and pap smears per year, including related fees	Covered 100%
Virtual primary care (VPC) preventive care consultations Includes screening and counseling services for members age 18 and older	Covered 100%
Routine mammogram Recommended: One per year for members age 40 and over	Covered 100%
Women's health 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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%
Pre-natal maternity	Covered 100%
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%

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Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%
Routine eye exams 1 routine exam per 24 months.	$10 copay
Routine hearing screening	Covered 100%
PHYSICIAN SERVICES	**IN-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay
Virtual primary care (VPC) consultations Includes basic medical service consultations for members age 18 and older	Covered 100%
Telehealth consultation with non-specialist	$10 office visit copay
Specialist office visits	$10 office visit copay
Telehealth consultation with specialist	$10 office visit copay
Hearing exams	Not Covered
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	$10 copay
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	$10 copay
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%
Diagnostic complex imaging When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	$10 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent care provider	$35 office visit copay
Non-urgent use of urgent care provider	Not Covered
Emergency room Copay waived if admitted	$50 copay
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%
Non-emergency use of ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient coverage	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage (includes delivery and postpartum care)	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital	Covered 100%
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - hospital	Covered 100%
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - freestanding facility	Covered 100%
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient non-biologically based	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental health office visits	$10 copay
Crisis intervention services	$10 copay
Mental health telehealth consultations	$10 office visit copay
Other mental health services	Covered 100%
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	Covered 100%
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	Covered 100%
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Substance abuse office visits	$10 copay
Substance abuse telehealth consultations	$10 office visit copay
Other substance abuse services	Covered 100%
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	

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THERAPY SERVICES	IN-NETWORK
Spinal manipulation therapy	$10 copay
Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies.	$10 copay
Habilitative physical therapy	Covered 100%
Habilitative occupational therapy	Covered 100%
Habilitative speech therapy	Covered 100%
Autism related physical therapy	Covered 100%
Autism related occupational therapy	Refer to MBH Outpatient Mental Health All Other
Autism related speech therapy	Refer to MBH Outpatient Mental Health All Other
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health
Autism related applied behavior analysis Covered same as any other Outpatient Mental Health benefit	Covered 100%
OTHER SERVICES	**IN-NETWORK**
Skilled nursing facility When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%
Home health care Private duty nursing not included. Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.	Covered 100%
Hospice care - inpatient When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	Covered 100%
Private duty nursing	Not Covered
Durable medical equipment	Covered 100%
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	$10 copay
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.
Hearing aids 1 hearing aid per ear every 2 years	Covered 100%
Transplants	Covered 100% In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%
Acupuncture Limited to 10 visits per year	$10 copay

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FAMILY PLANNING	IN-NETWORK
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.	
Comprehensive infertility services	Covered 100%
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	Covered 100%
Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law. Coverage includes cryopreservation, storage and for iatrogenic only unlimited storage and cryopreservation.	
ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage.	
Vasectomy	Covered 100%
Tubal ligation	Covered 100%
PHARMACY	**IN-NETWORK**
Pharmacy plan type	Aetna Standard Plan opt out with ACSF
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Generic drugs	
Retail	$5 copay
Mail order	$10 copay
Preferred brand-name drugs	
Retail	$15 copay
Mail order	$30 copay
Non-preferred brand-name drugs	
Retail	$30 copay
Mail order	$60 copay
Pharmacy day supply and requirements	
Retail	You can get up to a 30-day supply from Aetna National Network
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs You may fill your first prescription at any retail or specialty pharmacy. After that, all other fills must be through our preferred specialty pharmacy network. Standard Opt Out Aetna Insured List

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Your prescription drug plan also includes:
• Diabetic supplies
• Insulin up to a $100 member payment maximum per fill per 30-day supply
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
• A limited list of over-the-counter medications when filled with a prescription

Family planning
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements
Some covered prescription drugs need approval from us before we will cover the drug.
To get the most up-to-date precertification requirements, see your plan documents or go online to your member website.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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The following is a 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• 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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.