FASHION INSTITUTE OF TECHNOLOGY
Effective Date: 01-01-2024
Aetna Choice® POS II – ASC
Korea Plan

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-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	$500 per Individual $1,500 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.		
Member coinsurance Applies to all expenses except as noted.	Covered 100%	You pay 20%
Out-of-pocket limit (per calendar year)	$3,000 per Individual $9,000 per Family	$3,000 per Individual $9,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses do not count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. 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.		
Lifetime maximum Unlimited except where otherwise indicated.		
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Prevailing Charges
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Certification for certain types of Non-Preferred care are waived.		
Referral requirement	Not required	None
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.		

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PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine adult physical exams/ immunizations	Covered 100%	Not Covered 20%; after deductible for Immunizations
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		
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%	Covered 100%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, including related fees	Covered 100%	Not Covered
Routine mammogram	Covered 100%	20%; after deductible
One baseline mammogram for females age 35-39; one annual mammogram for females age 40 and over.		
Women's health	Covered 100%	20%; after deductible
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.		
Pre-natal maternity	Covered 100%	20%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%	Not Covered
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%	Not Covered
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%	Not Covered
Routine eye exams	Not Covered	Not Covered
Routine hearing screening	Covered 100%	Not Covered
Medications	Certain over-the-counter preventive medications covered 100% in network.	

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PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK
Office visits to primary care physician (PCP)	$25 office visit copay	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician and OBGYN.		
Telehealth consultation with non-specialist	$25 office visit copay	20%; after deductible
Specialist office visits	$50 office visit copay	20%; after deductible
Telehealth consultation with specialist	$50 office visit copay	20%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics	$25 copay **Designated Walk-in clinics** Covered 100%	20%; after deductible
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.		
Telehealth consultations for non-emergency services through a walk-in clinic	Your cost sharing amount depends on the type of service and where you receive it. **Designated Walk-in clinics** Covered 100%	20%; after deductible
We pay telehealth screenings and counseling services from a walk-in-clinic as a preventive care benefit.		
Allergy testing	Covered as either PCP or Specialist office visit	20%; after deductible
Allergy injections	Covered 100%	20%; after deductible
Flu Shots	Covered 100%	20%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (Other than complex imaging services)	$25 copay	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic laboratory	$25 copay	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
Diagnostic complex imaging	$25 copay	20%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent care provider	$50 office visit copay	20%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room Copay waived if admitted	$150 copay	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	Covered 100%	Same as in-network care
Non-emergency use of ambulance	Covered 100%	Same as in-network care

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HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient coverage	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
3 times per year per confinement maximum. Copay waived for newborn expenses 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)	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
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%	Covered 100%; after deductible
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	$50 copay	Covered 100%; after deductible
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	$50 copay	Covered 100%; after deductible
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**	**OUT-OF-NETWORK**
Inpatient	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	$25 copay	20%; after deductible
Mental health telehealth consultations	$25 office visit copay	20%; after deductible
Other mental health services	Covered 100%	20%; after deductible
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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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
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	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
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	$25 copay	20%; after deductible
Substance abuse telehealth consultations	$25 office visit copay	20%; after deductible
Other substance abuse services	Covered 100%	20%; after deductible
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.		
THERAPY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$25 copay	20%; after deductible
Outpatient rehabilitative physical and occupational therapy	$25 copay	20%; after deductible
Outpatient rehabilitative speech therapy	$25 copay	20%; after deductible
Habilitative physical therapy	Covered 100%	20%; after deductible
Habilitative occupational therapy	Covered 100%	20%; after deductible
Habilitative speech therapy	Covered 100%	20%; after deductible
Autism related physical therapy	Covered 100%	20%; after deductible
Autism related occupational therapy	Covered 100%	20%; after deductible
Autism related speech therapy	Covered 100%	20%; after deductible
Autism related behavioral therapy	$25 copay	20%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	Covered 100%	20%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		

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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled nursing facility Limited to 90 days per year 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%	20%; after deductible
Home health care Limited to 240 visits per year 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%	Covered 100% no deductible for first 200 visits; therefore covered 20%; after deductible
Hospice Care - Inpatient Limited to 210 days per lifetime. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%	Covered 100%; no deductible
Hospice Care - Outpatient Includes 5 Bereavement Counseling visits. Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%	Covered 100%; after deductible
Private duty nursing We count each period of up to 8 hours as one private duty nursing shift.	Covered 100%	20%; after deductible
Durable medical equipment	Covered 100%	20%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered 100% You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	20%; after deductible 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	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Fertility Drugs (oral and injectable) Physician charges included (oral and injectable fertility drugs will be covered under the medical portion of the plan subject to medical plan provisions).	Covered 100%	20%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 copay In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	$300 copay In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	Covered 100% after $300 per admission deductible; deductible waived Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.

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Bariatric surgery	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mouth, Jaws and Teeth (eligible oral surgery procedures, whether medical or dental in nature)	Your cost sharing is based on the type of service and where it is performed	20%; after deductible
Acupuncture	Covered either as a PCP or Specialist copay	20%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Covered 100%	20%; after deductible
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Covered 100%	20%; after deductible
Coverage includes Artificial Insemination limited to six courses of treatment per member's lifetime and Ovulation Induction limited to six courses of treatment per member's lifetime. Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		
Advanced Reproductive Technology (ART)	Covered 100%	20%; after deductible
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. 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.		
Vasectomy	Covered 100%	20%; after deductible
Tubal Ligation	Covered 100%	20%; after deductible
GENERAL PROVISIONS		
Dependents who are eligible to be on your plan	Spouse, domestic partner and children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

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.

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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.