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
The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.	
Member coinsurance	Covered 100%
Applies to all expenses except as noted.	
Out-of-pocket limit (per calendar year)	$1,500 per Individual $3,000 per Family
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 and copays. 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.	
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 network. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.	
Virtual care consultations - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to **Aetna.com** to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.	
CVS VIRTUAL CARE	**IN-NETWORK**
CVS Health Virtual Primary Care (VPC) - preventive care consultations	Covered 100%
Includes screening and counseling services through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for more information.	
CVS Health Virtual Primary Care (VPC) - consultations	Covered 100%
Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information.	
CVS Health Virtual Care (VC) - general medicine	Covered 100%
CVS Health Virtual Care (VC) - mental health	Covered 100%

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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 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	Covered 100%
Routine gynecological care exams 2 exams and pap smears per year, including related fees	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%
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
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	$10 copay
Allergy injections	$10 copay

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DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic X-ray (Other than complex imaging services)	$10 copay
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic laboratory	Covered 100%
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
Diagnostic complex imaging	$10 copay
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**
Urgent care provider	$35 office visit copay
Non-urgent use of urgent care provider	Not Covered
Emergency room	$50 copay
Copay waived if admitted	
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%
Non-emergency use of ambulance	Not Covered
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.	

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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.	
THERAPY SERVICES	**IN-NETWORK**
Spinal manipulation therapy	$10 copay
Outpatient short-term rehabilitation	$10 copay
Limited to 60 visits per year Includes physical, occupational, and speech therapies.	
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	Covered 100%
Autism related speech therapy	Covered 100%
Autism related behavioral therapy	$10 copay
These benefits are combined with outpatient mental health visits	
Autism related applied behavior analysis	Covered 100%
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	**IN-NETWORK**
Skilled nursing 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.	
Home health care	Covered 100%
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.	
Hospice care - inpatient	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.	
Hospice care - outpatient	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.	
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.

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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.
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.
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
FAMILY PLANNING	**IN-NETWORK**
Infertility treatment You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.	Your cost sharing amount depends on the type of service and where you receive it.
Advanced Reproductive Technology (ART) ART coverage is limited to three cycles per member's lifetime and includes in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, cryopreservation and storage. Also includes ovulation induction (OI). Maximum applies to all procedures covered by any of our plans except where prohibited by law.	Your cost sharing amount depends on the type of service and where you receive it.
Fertility preservation Includes coverage for cryopreservation and storage for iatrogenic infertility Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment	Your cost sharing depends on the type of service and where you receive it.
Vasectomy	Covered 100%
Tubal ligation	Covered 100%

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PHARMACY	IN-NETWORK
Pharmacy plan type	Standard Opt Out Plan - Aetna
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

Your prescription drug plan also includes:
• Diabetic supplies
• Insulin drugs covered 100%
• 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.

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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.

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.
• 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

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.