FASHION INSTITUTE OF TECHNOLOGY
Effective Date: 01-01-2023
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
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)	None Individual None Family	$500 Individual $1,500 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. 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.		
Member Coinsurance	Covered 100%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$3,000 Individual $9,000 Family	$3,000 Individual $9,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. 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. Pharmacy expenses do not apply towards the Payment Limit. 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	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Non-Preferred care are waived.		
Referral Requirement	None	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%	Not Covered 20%; after deductible for Immunizations and Flu vaccines Only
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%	Covered 100%; after deductible
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%	Not Covered
1 exam and pap smear per calendar year, includes related fees.		
Routine Mammograms	Covered 100%	20%; after deductible
One baseline mammogram for females age 35-39; one annual mammogram for females age 40 and over.		

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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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%	Not Covered
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%	Not Covered
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	Not Covered
Recommended: For all members age 45 and over.		
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.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$25 office visit copay	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician and OBGYN.		
Telemedicine Consultation with Non-Specialist	$25 office visit copay	20%; after deductible
Specialist Office Visits	$50 office visit copay	20%; after deductible
Telemedicine Consultation with Specialist	$50 office visit copay	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	20%; after deductible
Walk-in Clinics	$25 copay **Designated Walk-in Clinics** Covered 100%	20%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic	Your cost sharing is based on the type of service and where it is performed **Designated Walk-in Clinics** Covered 100%	20%; after deductible
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the 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

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	$25 copay	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 Laboratory	$25 copay	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	$25 copay	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	**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%	20%; after deductible
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 Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 100%	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	$50 copay	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	$50 copay	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$25 copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	$25 office visit copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%	20%; after deductible

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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
Substance Abuse Office Visits	$25 copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Substance Abuse Telemedicine Consultations	$25 office visit copay	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%	20%; after deductible
Limited to 90 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%	Covered 100% deductible waived for first 200 visits; therefore covered 20%; after deductible
Limited to 240 visits per year. Private Duty Nursing not included. 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	Covered 100%	Covered 100%; deductible waived
Limited to 210 days per lifetime. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%	Covered 100%; after deductible
Includes 5 Bereavement Counseling visits. Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered 100%	20%; after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	$25 copay	20%; after deductible
Outpatient Rehabilitative Speech Therapy	$25 copay	20%; after deductible
Outpatient Physical and Occupational Therapy	$25 copay	20%; after deductible
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		

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Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	Covered 100%	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%	20%; after deductible
Affordable Care Act mandated Women's Contraceptives	Covered 100%	Not Covered
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Not Covered
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Fertility Drugs (oral and injectable)	Covered 100%	20%; after deductible
Physician charges included (oral and injectable fertility drugs will be covered under the medical portion of the plan subject to medical plan provisions).		
Acupuncture	Covered either as a PCP or Specialist copay	20%; after deductible
Gene-based, Cellular, and other Innovative Therapies™ (GCIT)	Your cost sharing is based on the type of service and where it is performed $50 copay In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Vision Eyewear	Not Covered	Not Covered
Transplants	$300 copay Preferred coverage is provided at an IOE contracted facility only.	Covered 100% after $300 per admission deductible; deductible waived
Bariatric Surgery	$300 copay	Covered 100% after $300 per admission deductible; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
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

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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 Eligibility	Spouse, domestic partner and children from birth to age 26 regardless of student status.	

Plans are provided by: Aetna Life Insurance Company. 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 the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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.
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