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Aetna Student Health

Plan Design and Benefits Summary
Fashion Institute of Technology

Policy Year: 2019 – 2020
Policy Number: 686169

www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The Plan is available for Fashion Institute of Technology students and their dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Policy, the Master Policy will control.

Fashion Institute of Technology Health Services

FIT Health Services is the University's on-campus health facility. Staffed by nurse practitioners and registered nurses, it is open weekdays from 9:00 a.m.to 4:30 p.m., during the fall and spring semesters. For more information, call the Health Services at 212-217-4190. If you have an on-campus emergency, call the Department of Public Safety at extension 7-7777. If you have an off-campus emergency, call 911.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/15/2019	08/14/2020	09/15/2019
Fall	08/15/2019	01/14/2020	09/15/2019
Spring	01/15/2020	08/14/2020	02/15/2020

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/15/2019	08/14/2020	09/15/2019
Fall	08/15/2019	01/14/2020	09/15/2019
Spring	01/15/2020	08/14/2020	02/15/2020

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as the $8 for Travel Assistance Services. It DOES NOT include the school administrative fee - $25 fall term, $25 spring term.

Rates Undergraduates and Graduate Students			
	Annual	Fall Semester	Spring Semester
Student	$1,860	$930	$930
Spouse	$1,860	$930	$930
One Child	$1,860	$930	$930
Two or More Children	$3,720	$1,860	$1,860
Family (student, spouse, and 1 child)	$5,580	$2,790	$2,790
Family (student, spouse, and 2+ children)	$7,440	$3,720	$3,720

Student Coverage

Eligibility

All full-time domestic and international students with 12 credits or more are automatically enrolled and billed for the student health insurance plan. Graduate full-time students (9 credit hours overall) are also automatically enrolled and billed for the student health insurance plan. Part-time students may call Haylor at 1-866-535-0456 for eligibility and enrollment.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Students can be excused from the insurance if they have equal or better health coverage from another US-based company. To waive, students will have to submit a waiver form at haylor.com/FIT by the deadline date.

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, including same-sex marriage, domestic partner and dependent children up to the age of 26.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on the "Plans & Products Offered to You" link on the left hand side of the screen, or by calling customer service at (877) 480-4161 or Haylor at 1-866-535-0456. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to Aetna Student Health.

Special Enrollment Periods

You, your spouse or child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because you, your spouse or child are no longer eligible for coverage under the other health plan due to:

- Termination of employment;
- Termination of the other health plan;
- Death of the spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;

- Employer contributions toward a health plan were terminated; or
- A child no longer qualifies for coverage as a child under another health plan.

You, your Spouse or Child can also enroll 60 days from exhaustion of your COBRA or continuation coverage or if you become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and premium payment within 60 days of the loss of coverage. The effective date of your coverage will depend on when we receive your application. If your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

In addition, you, your spouse or child can also enroll for coverage within 60 days of losing (or gaining) eligibility for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

Participating Provider Network

Aetna Student Health offers Aetna's broad network of Participating Providers. You can save money by seeing Participating Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better, your out-of-pocket expenses will generally be lower when You receive benefits from a Participating Provider, and some benefits under the Plan may only be covered when received from a Participating Provider.

If you need care that is covered under the Plan but not available from a Participating Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from a Non-Participating Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Participating Providers.

Fashion Institute of Technology Health Services

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Pre-authorization

Some services have to be pre-authorized by Aetna beforehand if you want the Plan to cover them. Participating Providers are responsible for requesting pre-authorization for their services. You are responsible for requesting pre-authorization if you seek care from a Non-Participating Provider for any of the services listed in the Schedule of Benefits section of the Certificate. Pre-authorization is not required for Participating facilities certified by the New York office of alcoholism and substance abuse services.

If you want the Plan to cover a service from a Non- Participating Provider that requires pre-authorization, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-authorization, we will review the reasons for your planned treatment and determine if benefits are available.

You must contact Aetna to request pre-authorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when your provider recommends inpatient hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when your provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in an ambulatory surgical center.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-emergency condition.

You must also contact Aetna to provide notification after the fact as follows:

- As soon as reasonably possible when air ambulance services are rendered for an emergency condition.
- If you are hospitalized in cases of an emergency condition, you must call Aetna within 48 hours after your admission or as soon thereafter as reasonably possible.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Policy issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will control.

All coverage is based on the **Allowed Amount.**

"Allowed Amount" means the maximum amount Aetna will pay for the services or supplies covered under the certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted.

- The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Provider.
- The Allowed Amount for Non-Participating Facilities is 105% of the Medicare rate.
- The Allowed Amount for all other providers is 105% of the Medicare rate.

Our Allowed Amount is not based on the "usual, customary and reasonable charge." If a Non-Participating Provider's actual charge is more than the Allowed Amount, you are responsible for the difference. Call us at the number on your ID card or visit **www.aetnastudenthealth.com** for information on your financial responsibility when you receive services from a Non-Participating Provider.

This Plan will pay benefits in accordance with any applicable **New York** Insurance Law(s).

Metallic Level: Platinum, Tested at 92.79%.

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Medical Deductible • Individual • Family	None None	$50 None	
Out-of-Pocket Limit • Individual • Family	$6,350 $12,700	None None	
		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	

PREVENTIVE CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	
Sterilization Procedures for Women *	Covered in full	30% Coinsurance after Deductible	
Vasectomy	Covered in full	30% Coinsurance after Deductible	
Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
Screening for Prostate Cancer Performed in PCP Office	Covered in full	30% Coinsurance after Deductible	
Screening for Prostate Cancer Performed in Specialist Office	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance	0% Coinsurance Not Subject to Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance	0% Coinsurance Not Subject to Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	$100 Copayment then You pay 5% Coinsurance	$100 Copayment then You pay 5% Coinsurance Not Subject to Deductible	See benefit for description
Urgent Care Center	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services			See benefit for description
• Performed in a Specialist Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
Allergy Testing & Treatment			See benefit for description
• Performed in a PCP Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed in a Specialist Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
Ambulatory Surgical Center Facility Fee	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
Cardiac & Pulmonary Rehabilitation			See benefits for description
• Performed in a Specialist Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed as Inpatient Hospital Services	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	

Chemotherapy • Performed in a PCP Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
Chiropractic Services	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing • Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance	30% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in a Freestanding Center	5% Coinsurance	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance	30% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			Sixty (60) visits per condition

• Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	5% Coinsurance 5% Coinsurance 5% Coinsurance	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	
Home Health Care	5% Coinsurance	30% Coinsurance after Deductible	Forty (40) visits per Plan Year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	5% Coinsurance 5% Coinsurance 5% Coinsurance 5% Coinsurance	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions	Covered in full	30% Coinsurance after Deductible	Unlimited

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing	
Laboratory Procedures • Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	See Benefit For Description
• Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in a Freestanding Laboratory Facility	5% Coinsurance	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance	30% Coinsurance after Deductible	
Maternity & Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered In Full	30% Coinsurance after Deductible	See Benefit For Description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Dignostic Testing)	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services and Birthing Center	5% Coinsurance	30% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	5% Coinsurance	30% Coinsurance after Deductible	
• Breastfeeding Support,	Covered in Full	30% Coinsurance after	Covered for

Counseling and Supplies including Breast Pumps, Nursing Bras		Deductible	duration of breast feeding
• Postnatal Care	5% Coinsurance	30% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office [or Outpatient Facilities]			See benefit for description
• Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in Outpatient Facilities	5% Coinsurance	30% Coinsurance after Deductible	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	5% Coinsurance	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance	30% Coinsurance after Deductible	

Outpatient and Professional Services (for other than Mental Health and Substance Use) (Continued)	**Participating Provider – Member Responsibility for Cost-Sharing**	**Non-Participating Provider – Member Responsibility for Cost-Sharing**	
Therapeutic Radiology Services • Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	5% Coinsurance	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	5% Coinsurance	30% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	5% Coinsurance	30% Coinsurance after Deductible	Sixty (60) visits per Plan Year Speech and physical therapy are only Covered following a Hospital stay or surgery.
• Performed in a Specialist Office	5% Coinsurance	30% Coinsurance after Deductible	
• Performed in an Outpatient Facility	5% Coinsurance	30% Coinsurance after Deductible	
[Retail Health Clinic Care]	5% Coinsurance	30% Coinsurance after Deductible	
Second Opinions on the Diagnosis of Cancer, Surgery & Other	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description

Outpatient and Professional Services (for other than Mental Health and Substance Use) (Continued)	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Inpatient Hospital Surgery	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description All transplants must be performed at Designated Facilities
• Outpatient Hospital Surgery	5% Coinsurance	30% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	5% Coinsurance	30% Coinsurance after Deductible	
• Office Surgery	5% Coinsurance	30% Coinsurance after Deductible	
Telemedicine Program	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies, and Insulin (30-Day Supply)	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Diabetic Education	5% Coinsurance	30% Coinsurance after Deductible	
Durable Medical Equipment & Braces	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
External Hearing Aids	5% Coinsurance	30% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	5% Coinsurance	30% Coinsurance after Deductible	One (1) per ear per plan year
Hospice Care • Inpatient • Outpatient	5% Coinsurance 5% Coinsurance	30% Coinsurance after Deductible 30% Coinsurance after Deductible	Two hundred ten (210) days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal	5% Coinsurance 5% Coinsurance	30% Coinsurance after Deductible 30% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year Unlimited
INPATIENT SERVICES & FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description

INPATIENT SERVICES & FACILITIES (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Observation Stay	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	5% Coinsurance	30% Coinsurance after Deductible	Two hundred (200 days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	5% Coinsurance	30% Coinsurance after Deductible	unlimited
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	5% Coinsurance	30% Coinsurance after Deductible	unlimited
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • **Office Visits** • **All Other Outpatient Services**	5% Coinsurance 5% Coinsurance	30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions	5% Coinsurance	30% Coinsurance after Deductible	See benefit for description

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits	5% Coinsurance	30% Coinsurance after Deductible	Up to twenty (20) visits a plan year may be used for family counseling
• All Other Outpatient Services	5% Coinsurance	30% Coinsurance after Deductible	

PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF [and obtained at a participating pharmacy]	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Retail Pharmacy		
30-day supply Tier 1 (generic)	$15 Copayment then You pay 0% Coinsurance	30% of the Allowed Amount not subject to the Deductible
Tier 2 (formulary brand)	$35 Copayment then You pay 0% Coinsurance	30% of the Allowed Amount not subject to the Deductible
Tier 3 (non-formulary brand)	$70 Copayment then You pay 0% Coinsurance	30% of the Allowed Amount not subject to the Deductible
Mail Order Pharmacy		
30-day supply Tier 1 (generic)	Copayment $37.50 per supply of Mail Order Pharmacy Tier 1 Copayment per supply	Not Covered
Tier 2 (formulary brand)	Copayment $87.50 per supply of Mail Order Pharmacy Tier 2 Copayment per supply	Not Covered

Tier 3 (non-formulary brand)	Copayment $175.00 per supply of Mail Order Pharmacy Tier 3 Copayment per supply	Not Covered
Enteral Formulas Tier 1 (generic)	$15 Copayment per supply	30% of the Allowed Amount not subject to the Deductible
Tier 2 (formulary brand)	$35 Copayment then You pay 0% Coinsurance	30% of the Allowed Amount not subject to the Deductible
Tier 3 (non-formulary brand)	$70 Copayment then You pay 0% Coinsurance	30% of the Allowed Amount not subject to the Deductible
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**
Exercise Facility Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse	

PEDIATRIC DENTAL & PEDIATRIC VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Preventive	Covered in Full	Covered in full	
• Routine Dental Care	Covered in Full	Covered in full	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	$350 Copayment then you pay 0% Coinsurance Major Dental Requires Pre-authorization	$350 Copayment then you pay 0% Coinsurance Major Dental Requires Pre-authorization	
• Orthodontics	50% Coinsurance Orthodontia Requires Pre-authorization	50% Coinsurance not subject to Deductible Orthodontia Requires Pre-authorization	
PEDIATRIC DENTAL & PEDIATRIC VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Pediatric Vision Care • Exams	$20 Copayment then You pay 0% Coinsurance	30% Coinsurance not subject to Deductible	One (1) exam per twelve (12)-month period
• Lenses & Frames	$40 Copayment then You pay 0% Coinsurance	30% Coinsurance not subject to Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	$40 Copayment then You pay 0% Coinsurance	30% Coinsurance not subject to Deductible	

[All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services.]

Exclusions

No coverage is available under the certificate for the following:

Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Medically Necessary.

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services With No Charge.

We do not Cover services for which no charge is normally made.

Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section(s) of this Certificate.

War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Fully Insured Disclaimer

The Fashion Institute of Technology Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health[SM] is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-877-480-4161.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call 1-877-480-4161.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)

如欲使用免費語言服務，請致電 1-877-480-4161。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-480-4161. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161. (Italian)

言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)