aetna[®]

. Cornell University Student Health Plan - Plus

Coverage Period: 08/01/2021-06/30/2022 Coverage for: Individual | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>https://www.aetnastudenthealth.com/</u> or by calling 1-877-480-4161. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$0 / Family \$0. Out-of-Network: Individual \$400 / Family \$800.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network:</u> Individual \$3,000 / Family \$6,000. Out-of-Network: Individual \$3,000 / Family \$6,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-877-480-4161 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No Charge	30% <u>coinsurance</u>	None
If you visit a health	Specialist visit	No Charge	30% coinsurance	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	30% coinsurance, except no charge for well child & immunizations up to age 19	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	00% coinsurance	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	No Charge	00% coinsurance	None
If you need drugs to treat your	Generic drugs	No Charge	30% <u>coinsurance</u> (<u>retail</u>)/prescription, <u>deductible</u> doesn't apply	
illness or condition More information	Preferred brand drugs	No Charge	30% coinsurance (retail)/prescription, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (retail); 3 copays per 90 day Supply. Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No
about prescription drug coverage is available at https://www.aetna.c	Non-preferred brand drugs	No Charge	30% coinsurance (retail)/prescription, deductible doesn't apply	charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
families/pharmacy.h	Specialty drugs	No Charge	30% <u>coinsurance</u> (retail)/prescription, <u>deductible</u> doesn't apply	processing and on the another the coverage.
If you have	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No Charge	30% coinsurance	None

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Emergency room care	No Charge	\$100 <u>copay,</u> <u>deductible</u> doesn't apply	No coverage for non-emergency use. Copay waived if admitted.	
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	Non-emergency transport: not covered, except if pre-authorized.	
attention	<u>Urgent care</u>	No Charge	\$50 <u>copay,</u> <u>deductible</u> doesn't apply	No coverage for non-urgent use.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
1105pital Stay	Physician/surgeon fees	No Charge	30% coinsurance	None	
If you need mental health, behavioral health, or	Outpatient services	No Charge	Office & other outpatient services: 30% coinsurance	None	
substance abuse services	Inpatient services	No Charge	30% <u>coinsurance</u>	None	
	Office visits	No charge	00% coinsurance		
If you are pregnant	Childbirth/delivery professional services	No Charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e.	
	Childbirth/delivery facility services	No Charge	30% <u>coinsurance</u>	ultrasound) for which <u>coinsurance</u> may apply.	
	Home health care	No Charge	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	40 visits/year	
If you need help	Rehabilitation services	No Charge	30% coinsurance	60 visits/year. Includes physical, occupational	
recovering or have other special	Habilitation services	No Charge	30% coinsurance	therapy and speech.	
health needs	Skilled nursing care	No Charge	30% coinsurance	None	
	Durable medical equipment	No Charge	30% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	

			What You Will Pay			
	Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
		Hospice services	No Charge	30% coinsurance	210 Day limit; unlimited family bereavement counseling.	
		Children's eye exam	No Charge	50% <u>coinsurance,</u> after <u>deductible</u>	1 routine eye exam/ <u>plan</u> year up to age 19.	
		Children's glasses	No Charge	50% <u>coinsurance,</u> after <u>deductible</u>	1 pair of glasses/ <u>plan</u> year (lenses and frames) per plan year; \$200 maximum for frames.	
		Children's dental check-up	No charge	50% <u>coinsurance,</u> after <u>deductible</u>	Coverage limited to 1 exam every 6 months	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care

Private-duty nursing

- Routine foot care
- Weight loss programs Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental Care (Adult)
- Vision Care (Adult)

- Hearing aids 1 hearing aid per ear/per plan year.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & oral & injectable fertility drugs.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Permanent hair removal for transgender services

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

• For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

• State Consumer Assistance Program, if other than state insurance department contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

Your Grievance and Appeals Rights:

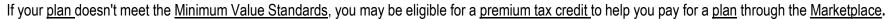
There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-480-4161.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.



-----To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

\$0
\$0
\$0
\$60
\$60

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$(
■ Specialist copayment	\$2
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400	
In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Joe would pay is	\$60	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$0	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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 the number on your ID card.

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: 1-860-262-7705)

Email: 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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-480-4161-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.

Cherokee - $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y} \theta \circ \mathcal{Y} \theta \circ \mathcal{Y} d \circ \mathcal{Y$

Chinese - 欲取得繁體中文語言協助, 請撥打 1-877-480-4161, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-877-480-4161.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.

French - Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.

lbo - Maka enyemaka asusu na Igbo kpoo 1-877-480-4161 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.

Japanese - 日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。

Karen - လာတၢိမာစားတၢိကတိၤကျိဉ်အင်္ဂါ ကျိုဉ် ကိုး 1-877-480-4161 လာတအိဉ်ဒီးတၢ်လာ၁်ဘူဉ်လာ၁်စ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-877-480-4161

برای راهنمایی به زبان فارسی با شماره 4161-877-480 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.

Mon-Khmer, សម្**រាប់ជំនួយភាសាជា ភាសាខ្**មរ៉ែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-877-480-4161 ដ**ោយឥតគិតថ្**ល។ៃ Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161

Nepali - (नेपाली) मा निःशूल्क भाषा सहायता पाउनका लागि 1- 877-480-4161 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-877-480-4161 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4161-877-480 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Portuguese - Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-480-4161

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-480-4161 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-480-4161. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.

Syriac - K = 32K K & p241 abk = 24 K oai, K or 24 iopK 161, 20 1-877-480-4161 ap

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-877-480-4161 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-480-4161 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-480-4161 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.

ا رورک ل کست م رب 1-877-480-4161 <u>می ل کست</u>ن و اعمین الی ل روم و در ا

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đến số 1-877-480-4161.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.