




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) 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, visit our website [studenthealthbenefits.cornell.edu](http://studenthealthbenefits.cornell.edu). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [studenthealthbenefits.cornell.edu](http://studenthealthbenefits.cornell.edu) or call 607.255.6363 to request a copy.

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge	30% <a href="#">coinsurance</a> / visit	None
	<a href="#">Specialist</a> visit	No Charge	30% <a href="#">coinsurance</a> / visit	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No Charge	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://studenthealthbenefits.cornell.edu">https://studenthealthbenefits.cornell.edu</a> .	Generic drugs	<a href="#">Copay</a> /prescription, <a href="#">deductible</a> doesn't apply: No Charge (retail)	30% <a href="#">coinsurance</a> (retail)/prescription, after <a href="#">deductible</a>	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 charge for preferred generic FDA-approved women's contraceptives in- <a href="#">network</a> .  Review your <a href="#">formulary</a> for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	<a href="#">Copay</a> /prescription, <a href="#">deductible</a> doesn't apply: No Charge (retail)	30% <a href="#">coinsurance</a> (retail)/prescription, after <a href="#">deductible</a>	
	Non-preferred brand drugs	<a href="#">Copay</a> /prescription, <a href="#">deductible</a> doesn't apply: No Charge (retail)	30% <a href="#">coinsurance</a> (retail)/prescription, after <a href="#">deductible</a>	
	<a href="#">Specialty drugs</a>	<a href="#">Copay</a> /prescription, <a href="#">deductible</a> doesn't apply: No Charge (retail)	30% <a href="#">coinsurance</a> (retail)/prescription, after <a href="#">deductible</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.studenthealthbenefits.cornell.edu](http://www.studenthealthbenefits.cornell.edu).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge	No Charge	No coverage for non-emergency use. <a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Non-emergency transport: not covered, except if pre-authorized.
	<a href="#">Urgent care</a>	No Charge	\$50 <a href="#">copay</a> / visit; <a href="#">deductible</a> doesn't apply	No coverage for non-emergency use. <a href="#">Copay</a> waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% <a href="#">coinsurance</a>	Penalty of \$500 for failure to obtain <a href="#">pre-authorization</a> for out-of-network care.
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: No Charge/visit	Office & other outpatient services: 30% <a href="#">coinsurance</a> / visit	None
	Inpatient services	No Charge / admission	30% <a href="#">coinsurance</a> / admission	None
If you are pregnant	Office visits	No Charge	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No Charge	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	30% <a href="#">coinsurance</a> / visit	40 visits/year
	<a href="#">Rehabilitation services</a>	No Charge	30% <a href="#">coinsurance</a> / visit	60 visits/condition per plan year combined therapies. Includes physical occupational therapy and speech. Applies to inpatient and outpatient care.
	<a href="#">Habilitation services</a>	No Charge	30% <a href="#">coinsurance</a> / visit	60 visits/condition per plan year combined therapies. Includes physical occupational therapy and speech. Applies to inpatient and outpatient care.
	<a href="#">Skilled nursing care</a>	No Charge	30% <a href="#">coinsurance</a> / visit	200 days per Plan Year

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	No Charge	30% <a href="#">coinsurance</a>	Limited to 1 <a href="#">durable medical equipment</a> for same/similar purpose. Excludes repairs for misuse/abuse, vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No Charge	30% <a href="#">coinsurance</a>	210 Day limit; unlimited family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	No Charge	50% <a href="#">coinsurance</a>	1 exam/ 12-month period
	Children's glasses	No Charge	50% <a href="#">coinsurance</a>	1 pair of glasses/12-month period (lenses and frames).
	Children's dental check-up	No Charge	50% <a href="#">coinsurance</a>	1 dental exam and cleaning/6-month period.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs - Except for required <a href="#">preventive services</a>.</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• <b>Acupuncture</b></li> <li>• <b>Bariatric surgery</b></li> <li>• <b>Chiropractic care</b></li> <li>• <b>Routine Dental Care (Adult)</b></li> <li>• <b>Routine eye care (Adult)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids -1) or both ears once every three (3) years</li> <li>• Infertility treatment – Limited to the diagnosis &amp; treatment of underlying medical condition, artificial insemination, ovulation induction &amp; oral &amp; injectable fertility drugs.</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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>. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or

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assistance, contact: [insert applicable contact information from instructions].

### **Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### **Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-480-4161.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-480-4161.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-480-4161.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-480-4161.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). 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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$25
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$60</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$0
- Hospital (facility) [copayments](#) \$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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$0</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.