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/enrollment-coverage/plan-overview-documents. 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 www.healthcare.gov/sbc-glossary/ or call 607.255.6363 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $0 / Family $0. Out-of-Network: Individual $400 / Family $800.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible.See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $4,000 / Family $8,000. Out-of-Network: Individual $4,000 / Family $8,000	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 Aetna's provider directory or call 1-877-480-4161 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	30% coinsurance / visit	None
	Specialist visit	$25 copay/visit	30% coinsurance / visit	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance /test	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance /test	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at studenthealthbenefits.cornell.edu/enrollment-coverage/using-your-student-health-plan/prescription-coverage	Generic drugs	Copay/prescription, deductible doesn't apply: $12 (retail)	30% coinsurance (retail)/prescription, after deductible	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-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $40 (retail)	30% coinsurance (retail)/prescription, after deductible	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $60 (retail)	30% coinsurance (retail)/prescription, after deductible	
	Specialty drugs	Copay/prescription, deductible doesn't apply: $60 (retail)	30% coinsurance (retail)/prescription, after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit, deductible doesn't apply	No coverage for non-emergency use. Copay waived if admitted.

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)	
	Emergency medical transportation	No Charge	No Charge	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay / visit	$50 copay / visit; deductible doesn't apply	No coverage for non-emergency use. Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required except for emergency admissions or services provided in NICU certified under Article 28
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $10 copay/visit Outpatient Services in OMH-licensed facility: $25 copay/visit All other outpatient services: 10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization Required except for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.
If you are pregnant	Office visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services. 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	30% coinsurance	40 visits/year
	Rehabilitation services	10% coinsurance	30% coinsurance	60 visits/condition per plan year combined therapies. Includes physical occupational therapy and speech. Applies to inpatient and outpatient care.
	Habilitation services	10% coinsurance	30% coinsurance	60 visits/condition per plan year combined therapies. Includes physical occupational

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)	
				therapy and speech. Applies to inpatient and outpatient care.
	Skilled nursing care	10% coinsurance	30% coinsurance	200 days per Plan Year.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse, vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No Charge	30% coinsurance	210 Day limit; 5 visits for family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance	1 exam/ 12-month period
	Children's glasses	50% coinsurance	50% coinsurance	1 pair of glasses/12-month period (lenses and frames).
	Children's dental check-up	No Charge	50% coinsurance	1 dental exam and cleaning/6-month period.

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
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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 plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids – one (1) or both ears once every three (3) years
- 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.

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 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 assistance, contact: the number on Your ID card.

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? **Not Applicable**

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, kwiijigo holne' 1-877-480-4161.

*To see examples of how this **plan** 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 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	**$25**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

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	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,380**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayments	**$25**
Hospital (facility) copayments	**$100**
Other coinsurance	**10%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

The plan would be responsible for the other costs of these EXAMPLE covered services.