



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, <http://www.aetnastudenthealth.com> or by calling 1-800-555-2525. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-555-2525 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In Network: \$0 Individual / \$0 Family; Out of Network: \$400 Individual / \$800 Family	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 <u>deductible</u> ?	Yes.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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 limit</u> for this <u>plan</u> ?	For <u>preferred providers</u> \$3,000 individual / \$6,000 family; for non- <u>preferred providers</u> \$3,000 individual / \$6,000 family	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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or call 1-800-859-8475 for a list of <u>preferred providers</u> .	This <u>plan</u> uses a provider <u>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 charge</u> 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</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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Non-Preferred 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 <u>copay</u> /office visit, <u>deductible</u> does not apply	\$25 <u>copay</u> /office visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /office visit, <u>deductible</u> does not apply	\$25 <u>copay</u> /office visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need 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)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.aetna.com/individuals-families/find-a-medication.html">www.aetna.com/individuals-families/find-a-medication.html</a>	Generic drugs	\$12 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	\$12 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	30% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	Covers up to a 30-day supply (retail prescription); 3 copays per 90 day Supply (Maintenance Drugs).
	Preferred brand drugs	\$40 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	\$40 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	30% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	\$60 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	30% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	\$60 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	\$60 <u>copay</u> /prescription (retail), <u>deductible</u> does not apply	30% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Non-Preferred <u>emergency room care</u> cost-share same as Preferred. No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	No Charge	No Charge	No Charge	Non-Preferred cost-share same as Preferred.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	<b>Physician:</b> No Charge <b>Surgeon:</b> 10% <u>coinsurance</u>	<b>Physician:</b> No Charge <b>Surgeon:</b> 10% <u>coinsurance</u>	<b>Physician:</b> No Charge <b>Surgeon:</b> 10% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /office visit, <u>deductible</u> does not apply	\$10 <u>copay</u> /office visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Inpatient services	\$250 <u>copay</u> /visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	No Charge	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	During the initial 48 or 96 hours; no pre-certification is required for the mother or her newly born child.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	40 visits/year
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	60 visits/year. Includes physical, occupational therapy and speech.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Excludes comfort or convenience items, over-the-counter durable medical equipment, vehicle modifications, home modifications, exercise, and bathroom equipment.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Non-Preferred Provider (You will pay the most)	
	<u>Hospice services</u>	No Charge	No Charge	30% <u>coinsurance</u>	210 Day limit; unlimited family bereavement counseling
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	50% <u>coinsurance</u>	None
	Children's glasses	50% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage limited to one pair of glasses/year (lenses & frames) per policy year.
	Children's dental check-up	No Charge	No Charge	50% <u>coinsurance</u>	Coverage is 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.)

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|---|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Private Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment except for Advanced Reproductive Technology</li> <li>• Non-emergency care when traveling outside the U.S</li> <li>• Medical Evacuation and Repatriation</li> </ul> |
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**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:

- For more information on your rights to continue coverage, contact the plan at 1-800-859-8475.
- You may also contact Cornell University Office of Student Health Benefits at, (607) 255-6363.

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 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: Aetna at **1-800-859-8475**. You may also contact your state insurance department at,

**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.

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 **1-800-859-8475**.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-859-8475**.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码**1-800-859-8475**.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-859-8475**.

-----*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 preferred pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$250
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$250
Coinsurance	\$320
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$670</b>

**Managing Joe's type 2 Diabetes**

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

- The plan's overall deductible \$0
- Specialist copayment \$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*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$2,200</b>

**Mia's Simple Fracture**

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$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*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$250</b>