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 deductible?	In Network:$0 Individual / $0 Family; Out of Network:$400 Individual / $800 Family	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.	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 https://www.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?	For preferred providers $3,000 individual / $6,000 family; for non-preferred providers $3,000 individual / $6,000 family	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, and health care this plan doesn't cover.	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.aetnastudenthealth.com or call 1-800-859-8475 for a list of preferred 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
		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 copay/office visit, deductible does not apply	$25 copay/office visit, deductible does not apply	30% coinsurance	None
	Specialist visit	$25 copay/office visit, deductible does not apply	$25 copay/office visit, deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/individuals-families/find-a-medication.html	Generic drugs	$12 copay/prescription (retail), deductible does not apply	$12 copay/prescription (retail), deductible does not apply	30% coinsurance (retail), deductible does not apply	Covers up to a 30-day supply (retail prescription); 3 copays per 90 day Supply (Maintenance Drugs).
	Preferred brand drugs	$40 copay/prescription (retail), deductible does not apply	$40 copay/prescription (retail), deductible does not apply	30% coinsurance (retail), deductible does not apply	
	Non-preferred brand drugs	$60 copay/prescription (retail), deductible does not apply	$60 copay/prescription (retail), deductible does not apply	30% coinsurance (retail), deductible does not apply	
	Specialty drugs	$60 copay/prescription (retail), deductible does not apply	$60 copay/prescription (retail), deductible does not apply	30% coinsurance (retail), deductible 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% coinsurance	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	$100 copay/visit	Copay waived if admitted. Non-Preferred emergency room care cost-share same as Preferred. No coverage for non-emergency care.
	Emergency medical transportation	No Charge	No Charge	No Charge	Non-Preferred cost-share same as Preferred.
	Urgent care	$50 copay/visit	$50 copay/visit	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/visit	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	Physician: No Charge Surgeon: 10% coinsurance	Physician: No Charge Surgeon: 10% coinsurance	Physician: No Charge Surgeon: 10% coinsurance	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 copay/office visit, deductible does not apply	$10 copay/office visit, deductible does not apply	30% coinsurance	None
	Inpatient services	$250 copay/visit	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	No Charge	No Charge	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$250 copay/visit	10% coinsurance	30% coinsurance	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	Home health care	$25 copay/visit	$25 copay/visit	30% coinsurance	40 visits/year
	Rehabilitation services	$25 copay/visit	$25 copay/visit	30% coinsurance	60 visits/year. Includes physical, occupational therapy and speech.
	Habilitation services	$25 copay/visit	$25 copay/visit	30% coinsurance	
	Skilled nursing care	$250 copay/visit	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	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)	
	Hospice services	No Charge	No Charge	30% coinsurance	210 Day limit; unlimited family bereavement counseling
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	50% coinsurance	None
	Children's glasses	50% coinsurance	50% coinsurance	50% coinsurance	Coverage limited to one pair of glasses/year (lenses & Frames) per policy year.
	Children's dental check-up	No Charge	No Charge	50% coinsurance	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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
- Infertility treatment except for Advanced Reproductive Technology
- Non-emergency care when traveling outside the U.S
- Medical Evacuation and Repatriation

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 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， ☒☒打☒个号☒**1-800-859-8475**.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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)*

Total Example Cost	$12,800

In this example, Peg would pay:

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

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

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

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)*

Total Example Cost	$1,900

In this example, Mia would pay:

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

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