

## Aetna Health Savings Account Addendum

The information below is intended to serve as an update to the January 1, 2009 Aetna H S A Summary Plan Description (SPD).

### Effective January 1, 2022

#### Out-of-network plan rate

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain **out-of-network providers**
- Not available from a **network provider**
- **Emergency services**

Aetna will calculate your cost share for involuntary services in the same way as if you received the services from a **network provider**. The cost share will be based on the median contracted rate. If you receive a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, contact Aetna immediately about your bill.

Aetna will authorize coverage only if the **provider** agrees to Aetna's usual terms and conditions for contracting **providers**.

#### Emergency services

When you, a plan participant, experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Your coverage for **emergency services** will continue until your condition is stabilized and:

- Your attending **physician** determines that you are medically able to travel or to be transported, by non- medical or non-emergency medical transportation, to another **provider** if you need more care
- You are in a condition to be able to receive from the **out-of-network provider** delivering services the notice and consent criteria with respect to the services
- Your **out-of-network provider** delivering the services meets the notice and consent criteria with respect to the services

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to your Benefit

Plan, *How your Medical plan works – precertification requirements* section, the *Coverage and exclusions* section(s) that fits your situation (for example, *Hospital care* or *Physician services*) and *Medical Necessity*. You can also contact Aetna, your **network physician** or your **primary care physician (PCP)**.

### **Non-emergency services**

If you go to an emergency room for a **non-emergency medical condition**, the plan may not cover your expenses. See your schedule of benefits for more information.

### **Effective January 1, 2021**

The individual maximum is increasing from \$3,550 to \$3,600 (\$50 increase)

The family maximum contribution limit is increasing from \$7,100 to \$7,200 (\$100 increase).

### **Effective January 1, 2020**

The individual maximum is increasing from \$3,500 to \$3,550 (\$50 increase)

The family maximum contribution limit is increasing from \$7,000 to \$7,100 (\$100 increase).

### **Routine Physical Exam Frequency**

Frequency changing from 2 per calendar year to 1 per calendar year for ages 22 and over.

### **Short Term Rehabilitation for Diagnosis of Autism**

For individuals with autism, short term rehabilitation is increasing to unlimited.

### **Transgender Benefits**

The H S A Plan's Transgender benefits have been expanded to include procedures previously considered "cosmetic" in nature, in accordance with coverage WPATH (World Professional Association for Transgender Health) guidelines. The list below is a summary of the covered procedures. If you have specific questions about the coverage, please contact Aetna at 877-371-2007.

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Facial feminization and masculinization surgery
- Forehead lift
- Jaw reduction (jaw contouring)
- Hair removal (e.g., electrolysis, laser hair removal)
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening

- Nipple reconstruction
- Nose implants
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin
- Rhinoplasty
- Tracheal shave
- Voice therapy/voice lessons

### **Effective January 1, 2019**

The individual maximum is increasing from \$3,450 to \$3,500 (\$50 increase)

The family maximum contribution limit is increasing from \$6,900 to \$7,000 (\$100 increase).

### **Effective January 1, 2018**

The family maximum contribution limit is decreasing from \$6,900 to \$6,850 (\$50 decrease).

The individual maximum remains unchanged \$3,450.

### **Effective January 1, 2017**

The contribution maximum for individuals is changing from \$3,350 to \$3,400 (\$50 increase).

Family remains unchanged \$6,750.

Hearing aids: Adults and children 13 and older, deductible, then reimbursed at 100% up to the \$1,500 per hearing aid per ear once every 4 years. Children 12 and under: deductible, then reimbursed at 100% up to \$1,500 per ear once every 2 years. (applies to both in-network and out of network). Repairs included.

### **Health Plan Documentation Requirements**

For new enrollees or newly added dependents, copies required:

Spouse: Marriage Certificate

Domestic Partner: Statement of Domestic Partnership

Child(ren): Birth Certificate or Visa/Passport

Adopted Child(ren): Court Order confirming custody of adopted child

### **Treatment of Infertility**

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this Plan as an employee, or be a covered dependent who is the employee's spouse or domestic partner. And:

#### **Exclusions and Limitations**

Unless otherwise specified in the Treatment of Infertility section of the Booklet, the following charges will be payable as covered expenses under this Plan.

ART services for a female without a male partner attempting to become pregnant who is unable to conceive or produce conception after at least 12 cycles of donor insemination.

## Effective September 1, 2017

### OptumRx

Gannett Pharmacy can fill up to a 90 day supply of maintenance medications at the Gannett Pharmacy on the Ithaca campus. (Filling a 90 day at retail is limited to Gannett Pharmacy only)

After deductible, you pay the mail order copay of Tier 1: \$10, Tier 2: \$60, Tier 3: \$90

## Effective January 1, 2016

The IRS has increased the Family Contribution Maximum for 2016:

Individual: \$3,350 (not changing)

Family: \$6,650 to \$6,750

(EE's age 55 and older can contribution an additional \$1000-not changing)

The plan includes all of the preventive care benefits mandated by the ACA (No longer Grandfathered).

### Preventive Care Covered at 100% In-network

- Routine Physical Exams
- Family Planning – Tubal Ligation
- Obesity Preventive Counseling
- Lactation Consultation
- Tobacco Preventative Counseling
- Contraceptive drugs and devices (except those covered by RX plan) including associated office visit (i.e., IUDs).
- Alcohol/Drug Abuse Counseling
- Breast Pumps and supplies
- Preventative Lung Cancer Screening
- Colorectal Cancer Screening (ie colonoscopy)
- Routine PSA and DRE
- Contraceptive Consultation
- Routine GYN and Pap
- Routine eye exam (includes pediatric) is covered at 100% every (instead of every year).
- Routine mammography
- Prenatal care covered at 100% (delivery & nursery care remain covered at 90%)
- Breast Pumps and supplies
- OptumRx Prescription Drug Plan covers: Oral Contraceptives, barrier methods, OTC contraceptives, Plan B and ella (prescription required)
- Pre-natal maternity office visits
- OptumRx Prescription Drug plan covers: Aspirin products, iron supplements, Vitamin D, Folic Acid & Prenatal Vitamins with prescription.

### The Prescription Drug Plan is changing from Express Scripts (ESI) to OptumRx

- The copays are not changing and remain \$5/\$30/\$50 after deductible for retail and \$10/\$60/\$90 after deductible Home Delivery in-network (except for preventive meds).
- The drug formulary is changing
- Some medications are excluded
- Home Delivery of maintenance medications/specialty medications can be delivered to your home

address or new for 2016, you can direct the delivery to Gannett Health Center Pharmacy on the Ithaca campus.

- Briova is the specialty pharmacy replacing ESI's Accredo
- Aspirin products, iron supplements, Vitamin D, Folic Acid & Prenatal Vitamins with prescription covered at \$0 copay (in-network)

## Effective April 1, 2015

### Documentation Requirements Effective 4/1/15-copies only

**Employee:** Social Security Card (or ITIN-Individual Taxpayer Identification Number for non-US Citizens). You must provide copies of documents to support your dependent's eligibility for coverage.

**Spouse or Domestic Partner:** Birth Certificate (or Visa/Passport accepted for non-US citizens), Social Security Card (or ITIN-Individual Taxpayer Identification Number for non-US citizens), Marriage Certificate, Domestic Partner Statement

**Children (biological), stepchild, adopted:** Birth Certificate (or Visa/Passport accepted for non-US citizens), Social Security Card, ITIN (Individual Taxpayer Identification Number) for non-US citizens, Proof of Disability, if applicable, Documentation establishing Paternity by Court Order acknowledging Paternity. If your child is neither of the above, you must also complete the Special Dependent Enrollment Form.

## Effective January 1, 2015

### Express Scripts Prescription Drug Plan Changes

- **Preferred Retail Pharmacy Network:** You pay deductible, then a \$5/\$30/\$50 copay at retail for up to a 30 day supply if you use pharmacies participating in the Preferred Retail Pharmacy Network. Pharmacies include: Kinney, Rite Aid, Target, Walmart, Wegmans, Quilans, Green Street Pharmacy, Gannett Student Health Center.
- **You pay deductible** then \$15/\$40/\$60, if you use CVS/Walgreens (Duane Reed), pharmacies not participating.

### Exclusionary Formulary

Certain medications that are available as generics or on the formulary are no longer covered as of 1/1/15. Members can appeal and ESI will review the clinical information provided by the physician.

### Social Security's Definition of a "Spouse"

As of January 1, 2015, the Social Security's definition of "spouse" has expanded to include a same-sex spouse for the purpose of determining Medicare primacy. Therefore, an active employee's same-sex spouse, age 65 or older, will be Aetna primary not Medicare primary.

### H S A contribution limit changing for January 1, 2015:

Individual: \$3,300 to \$3,350

Family: \$6,550 to \$6,650

(Employee age 55 and over can contribute up to an additional \$1000).

This includes Cornell's \$1,000 annual contribution (or if enrolling after open enrollment, it is pro-rated).

### Deductible and OOP maximum changing for 2015:

Deductible:

Individual: \$1,250 to \$1,500 (out of network: \$2,500 to \$3,000)

Family: \$2,500 to \$3000 (out of network: \$5,000 to \$6,000)

Updated 07/11/2022

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HSA Addendum

*Diversity and Inclusion are a part of Cornell University's heritage. We are a recognized employer and educator valuing AA/EEO, Protected Veterans, and Individuals with Disabilities. We also recognize a lawful preference in employment practices for Native Americans living on or near Indian reservations.*

Out of Pocket Max:

Individual: \$3,000 to \$3,250 (out of network: \$4,000 to \$4,250)

Family: \$5,000 to \$5,500 (out of network: \$7,000 to \$7,500)

### **Certificates of Creditable Coverage (HIPAA Certs) No Longer Required**

The Affordable Care Act prohibits the use of pre-existing condition clauses resulting in the need to provide certificates of creditable coverage no longer necessary. On February 24, 2014, the Treasury, the Department of Labor, and the Department of Health and Human Service jointly issued final regulations which eliminated the requirement for plan sponsors to issue the certificates after 12/31/14.

### **Grandfathered Health Plan Notice for January 1, 2015**

Cornell University believes your plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer or Aetna member services using the phone number on your member id card.

If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or HU [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)UH. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal governmental plan, you may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

### **Effective January 1, 2014**

#### **H S A contribution limit changing for January 1, 2014:**

Individual from \$3250 to \$3300

Family from \$6450 to \$6550

This includes Cornell’s \$1,000 annual contribution (or if enrolling after open enrollment, it is pro-rated).

### **Effective August 29, 2013**

On August, 29, 2013, the Internal Revenue released new federal tax guidelines for same-sex spouses. This is due to the Supreme Court’s ruling in United States v. Windsor that the Defense of Marriage Act (DOMA) provision prohibiting the recognition of same-sex marriages for federal law purposes was unconstitutional. The IRS determined that same-sex couples, legally married in jurisdictions that recognize their marriages, will be treated as married for federal tax purposes regardless of whether the couple lives in a jurisdiction that recognizes same-sex marriage. This means that if a same-sex couple is married in a state that recognizes same-sex marriage and moves to a state that does not recognize same-sex marriage, then he or she will still be considered married for federal tax purposes.

## Effective July 1, 2013

### Autism Spectrum Disorder

Autism and other pervasive developmental disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include applied behavioral analysis (ABA) and behavioral therapy as well as mental health therapy and testing services.

| PLAN FEATURES                   | NETWORK | OUT-OF-NETWORK |
|---------------------------------|---------|----------------|
| <b>Calendar Year Deductible</b> |         |                |
| Individual Deductible           | \$1,250 | \$2,500        |
| Family Deductible               | \$2,500 | \$5,000        |

| PLAN FEATURES  | NETWORK                                      | OUT-OF-NETWORK                                   |
|--|--|--|
| <b>Physician Services</b>  |  |  |
| <i>Office Visits</i>   | 90% per visit after Calendar Year deductible | 80% per visit after Calendar Year deductible     |
| <b>Outpatient Treatment Of Mental Disorders</b>                      |  |  |
| <i>Outpatient Services</i>   | 90% per visit after Calendar Year deductible | 80% per visit after the Calendar Year deductible |
| <b>Short Term Outpatient Rehabilitation Therapies</b>                |  |  |
| <i>Outpatient Physical, Occupational and Speech Therapy combined</i> | 90% per visit after Calendar Year deductible | 80% per visit after Calendar Year deductible     |
| Maximum Visit Limit per <i>Calendar Year</i> for Speech Therapy only | 50 visits                                    | 50 visits  |

Generally it includes the following primary services:

- Evaluation and treatment by a speech-language pathologist
- Audiological hearing evaluation
- Medical evaluation
- Behavior modification
- Intensive education interventions
- Medical therapy or psychotherapy

You must call to precertify psychological testing, neuropsychological testing and applied behavioral analysis.

**Not all services are covered.** Aetna considers the following procedures and services experimental and investigational because the peer-reviewed medical literature does not support the use of these procedures and services in the assessment and treatment of autism and other pervasive developmental disorders:

**Assessment:**

- Allergy testing (including food allergy for gluten, casein, candida, and other molds; allergen specific IgG and IgE)
- Electronystagmography (in the absence of dizziness, vertigo, or balance disorder)
- Erythrocyte glutathione peroxidase studies
- Event-related brain potentials
- Hair analysis for trace elements (see [CPB 0300 - Hair Analysis](#))
- Intestinal permeability studies
- Magnetoencephalography/magnetic source imaging (see [CPB 0279 - Magnetic Source Imaging/Magnetoencephalography](#))
- Neuroimaging studies such as CT, functional MRI (fMRI), MRI, MRS (see [CPB 0202 - Magnetic Resonance Spectroscopy \(MRS\)](#)), PET (see [CPB 0071 - Positron Emission Tomography \(PET\)](#)), and SPECT (see [CPB 0376 - Single Photon Emission Computed Tomography \(SPECT\)](#))
- Nutritional testing (e.g., testing for arabinose and tartaric acid)
- Provocative chelation tests for mercury
- Stool analysis
- Tests for celiac antibodies
- Tests for homocysteine (see [CPB 0763 - Homocysteine Testing](#))
- Tests for immunologic or neurochemical abnormalities
- Tests for micronutrients such as vitamin levels
- Tests for mitochondrial disorders including lactate and pyruvate
- Tests for thyroid function
- Tests for urinary peptides
- Tests for amino acids (except quantitative plasma amino acid assays to detect phenylketonuria), fatty acids (non-esterified), organic acids, citrate, silica, urine vanillylmandelic acid
- Tests for heavy metals (e.g., antimony, arsenic, barium, beryllium, bismuth, mercury)
- Tests for trace metals (e.g., aluminum, cadmium, chromium, copper, iron, lead, lithium, magnesium, manganese, nickel, selenium, zinc)
- Tympanometry (in the absence of hearing loss).

**Treatment:**

- Acupuncture
- Anti-fungal medications (e.g., fluconazole, ketoconazole, metronidazole, nystatin)
- Anti-viral medications (e.g., acyclovir, amantadine, famciclovir, isoprinosine, oseltamivir, valacyclovir)
- Auditory integration training (auditory integration therapy) (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
- Chelation Therapy (see [CPB 0234 - Chelation Therapy](#))
- Cognitive rehabilitation (see [CPB 0214 - Cognitive Rehabilitation](#))
- Elimination diets (e.g., gluten and milk elimination)
- Facilitated communication
- Herbal remedies (e.g., astragalus, berberis, echinacea, garlic, plant tannins, uva ursi)
- Floor time therapy
- Holding therapy
- Immune globulin infusion
- Manipulative therapies



- Massage therapy
- Music therapy and rhythmic entrainment interventions
- Neurofeedback/EEG biofeedback (see [CPB 0132 - Biofeedback](#))
- Nutritional supplements (e.g., dimethylglycine, glutathione, magnesium, megavitamins, omega-3 fatty acids, and high-dose pyridoxine)
- Secretin infusion
- Sensory integration therapy (see [CPB 0256 - Sensory and Auditory Integration Therapy](#))
- Stem cell transplantation
- Systemic hyperbaric oxygen therapy (see [CPB 0172 - Hyperbaric Oxygen Therapy \(HBOT\)](#))
- Tomatis sound therapy
- Vision therapy (see [CPB 0489 - Vision Therapy](#))
- Vitamins and minerals (calcium, germanium, magnesium, manganese, selenium, tin, tungsten, vanadium, zinc, etc.).
- Weighted blankets/vests.

Please refer to Aetna’s Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: [http://www.aetna.com/cpb/medical/data/600\\_699/0648.html](http://www.aetna.com/cpb/medical/data/600_699/0648.html).

### Transgender Health

Transgender, transsexual and gender nonconforming disorders will now be covered the same as any other expense based on the type and place of service. Coverage will include therapy and certain medical procedures related to gender identity confirmation procedures.

Generally it includes the following primary services:

- Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
- Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.
- Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic and not covered. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic and not covered.
- Please refer to Aetna’s Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: [http://www.aetna.com/cpb/medical/data/600\\_699/0615.html](http://www.aetna.com/cpb/medical/data/600_699/0615.html).

| PLAN FEATURES                    | NETWORK | OUT-OF-NETWORK |
|----------------------------------|---------|----------------|
| <b>Calendar Year Deductible*</b> |         |                |
| <b>Individual Deductible*</b>    | \$1,250 | \$2,500        |
| <b>Family Deductible*</b>        | \$2,500 | \$5,000        |

| PLAN FEATURES  | NETWORK   | OUT-OF-NETWORK  |
|--|---|---|
| <b>Physician Services</b>  |   |   |
| <i>Office Visits</i>   | 90% per visit after Calendar Year deductible                    | 80% per visit after Calendar Year deductible                    |
| <b>Outpatient Treatment Of Mental Disorders</b>                      |   |   |
| <i>Outpatient Services</i>   | 90% per visit after Calendar Year deductible                    | 80% per visit after the Calendar Year deductible                |
| <b>Short Term Outpatient Rehabilitation Therapies</b>                |   |   |
| <i>Outpatient Physical, Occupational and Speech Therapy combined</i> | 90% per visit after Calendar Year deductible                    | 80% per visit after Calendar Year deductible                    |
| Maximum Visit Limit per <i>Calendar Year</i> for Speech Therapy only | 50 visits   | 50 visits   |
| PLAN FEATURES  | NETWORK   | OUT-OF-NETWORK  |
| <b>Surgery</b>   |   |   |
| <i>Performed in a Hospital</i>                                       | 90% per visit/surgical procedure after Calendar Year deductible | 80% per visit/surgical procedure after Calendar Year deductible |
| <i>Performed in a Physician's Office</i>                             | 90% per visit after Calendar Year deductible                    | 80% per visit after Calendar Year deductible                    |

You can find a participating provider through Aetna's DocFind Site: <http://www.aetna.com/docfind>

- Select Directories and Resources on the left hand side of the page
- Click on GLTB provider resources
- From there, a disclaimer will pop up saying you are leaving the Aetna site and redirected to the GLTB site where you can go to "Resources" on the top of the page, then select "For Patients" and "Find a provider". If you encounter any problems accessing the site from DocFind, you can get there directly via [www.glma.org](http://www.glma.org).

Once you have selected the applicable provider, you will need to return to the Aetna DocFind to confirm if they are a participating provider in Aetna's network.

You can also call Aetna's Member Services at 877-371-2007, if you need assistance.

### Effect of Medicare

Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

Clarification for 1/1/13: This will also be done and regardless if the provider accepts Medicare assignment, if the provider does not accept Medicare assignment or if the provider opts-out of Medicare.

## **Business Travel Abroad Coverage**

Faculty and staff travelling abroad on university business can access help for medical attention through Aetna International, a unit that specializes in corporate travel. This is a rider to the Endowed Health Plans that uses an established network of local medical providers in over 160 countries, pays for care in local currency and virtually eliminates the need to pre-pay bills and seek reimbursement upon returning to the USA. Aetna International is fully insured rider which does not allow coverage for individuals age 70 and older, which is a concern for an academic institution. However, the CPHL plan continues to accept the liability for medically necessary treatment regardless of where that care is delivered and regardless of age.

For more information, please refer to our website

[https://www.hr.cornell.edu/benefits/health/new\\_coverage.html#international](https://www.hr.cornell.edu/benefits/health/new_coverage.html#international)

## **Effective 1/1/2013**

### **Express Scripts/Medco Prescription Drug Plan**

The Retail Refill Allowance (RRA) provision of the ES/Medco Prescription Drug Plan is eliminated.

### **Health Savings Account**

The individual contribution is increasing from \$3,100 to \$3,250

The family contribution is increasing from \$6,250 to \$6,450

This includes the amount Cornell contributes of \$1,000, spread out over your annual paycycle for current employees.

The deductible for the Aetna H S A is increasing for 2013:

Individual: from \$1,200 to **\$1,250** in-network (\$2,400/\$2,500 out of network)

Family: from \$2,400 to **\$2,500** in-network (\$4,800/\$5,000 out of network)

Payflex will administer the Aetna Health Savings Account

## **Effective 1/1/2011**

### **High Deductible Health Plan**

Office Visit copay is changing from \$18 to \$20

### **Health Savings Account**

The individual contribution is increasing from \$3,050 to \$3,100

The family contribution is increasing from \$6,150 to \$6,250

(These amounts include Cornell's contribution)

### **Same-Sex Partner coverage is changing to Domestic Partner**

coverage to include unmarried opposite sex partners. A Domestic Partnership Statement must be completed.

Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

### **Spouses of the same-sex**

married in New York State as well as the following jurisdictions: Connecticut, Iowa, Mass., New Hampshire, Vermont, Washington, DC and countries: The Netherlands, Belgium, Spain, Canada, South Africa, Norway, Sweden, Portugal, Iceland and Argentina, need only to provide a valid and current marriage certificate in order

to enroll their spouse for health benefits. Please refer to <http://hr.cornell.edu/benefits/partners.html> for more information.

Office Visit Copay is changing from \$18 to \$20

### **Medco Prescription Drug Copays Increasing (Except Generics)**

Retail copays changing from \$5/\$25/\$45 to \$5/\$30/\$50

Mail Order copays changing from \$10/\$50/\$75 to \$10/\$60/\$90

## **Changes Effective 1/1/2011**

### **High Deductible Health Plan**

Office Visit copay is changing from \$15 to \$18

### **Medco Retail Refill Allowance**

If a member continues to use the retail pharmacy instead of Medco By Mail to purchase maintenance medications, the member will pay a higher copay on the 4<sup>th</sup> refill for up to a 30 day supply. The copay will be \$5/\$40/\$65 (no change for generics) at retail instead of \$5/25/\$45.

### **Health Savings Account**

- Cornell's contribution will increase from \$500 to \$1,000 annually.
- The IRS penalty for using the Health Savings Account funds for non-qualified expenses will increase from 10% to 20%. Refer to your secure Aetna member website ([www.aetna.com](http://www.aetna.com)) for a list of qualified Health Savings Account expenses or visit the IRS website at [www.irs.gov](http://www.irs.gov) and select "Forms and Publications" to review Publication 502.
- Over-the-Counter (OTC) medications require a doctor's prescription, if you plan to use the Health Savings Account to pay for OTC medications. You will not need a prescription to use your Health Savings Account for other eligible OTC items like contact lens solutions and bandages.

### **Mental Health Treatment**

The Plan covers medically necessary counseling services provided by a qualified provider while you are participating in a Wilderness Program provided you submit an itemized bill outlining the counseling services provided by a qualified mental health provider. A Wilderness Program does not otherwise meet the Plan's requirements to be considered a residential treatment facility, therefore, room and board and other supplies provided during a stay are not covered. This information revises the information on Page 39 of the Booklet.

## **Aetna Claims, Appeals and External Review**

### **Filing Health Claims under the Plan**

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

### **Urgent Care Claims**

An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

### **Other Claims (Pre-Service and Post-Service)**

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

### **Ongoing Course of Treatment**

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the

course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

### **Health Claims – Standard Appeals**

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

### **Exhaustion of Internal Appeals Process**

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

### **Full and Fair Review of Claim Determinations and Appeals**

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this booklet). Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other

information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

## **Health Claims – Voluntary Appeals**

### **External Review**

“External Review” is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The

filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

### **Request for External Review**

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

### **Preliminary Review**

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

### **Referral to ERO**

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned



ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- (i) Your medical records;
- (ii) The attending health care professional's recommendation;
- (iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- (iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

### **Expedited External Review**

The Plan must allow you to request an expedited External Review at the time you receive:

- (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize
- (b) your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- (c) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

### **Referral of Expedited Review to ERO**

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

## **Effective 9/1/2010:**

### **High Deductible Health Plan**

#### **Coverage for Dependent Children**

Children between the ages of 19 and 26 are eligible to be covered under your plan. Children may be added regardless of their status. It does not matter if they are full time students, married, live at home or not, work for an employer that offers health insurance or are not your tax dependent. **IMPORTANT:** The tax law did not change. You could have under your health plan a dependent adult who is not a dependent for tax purposes. That means you'll pay a penalty plus taxes if you use the pretax dollars from your HSA to pay health expenses for your older covered dependent. You can call Aetna at 1-877-371-2007 if you have questions regarding this provision of the tax law.

Cornell will cover your child until December 31 of the year in which he or she reaches age 26.

## **Effective 1/1/2010**

### **High Deductible Health Plan**

- Copays are changing from \$12 to \$15
- Prescription Drug Copays are changing as follows:
  - Retail copays from \$5/\$20/\$40 to \$5/\$25/\$45 (no change for generic)
  - Mail: copays from \$10/\$40/\$60 to \$10/\$50/\$75 (no change for generic)
- Deductible :
  - In-Network individual from \$1,150 to \$1,200; family from \$2,300 to \$2,400
  - Out-of-Network individual from \$2,300 to \$2,400; family from \$4,600 to \$4,800
- Out of Pocket Maximum (OOP):
  - In-Network individual from \$2,500 to \$3,000; family from \$4,500 to \$5,000
  - Out-of-Network individual from \$3,500 to \$,4000; family from \$6,500 to \$7,000
  -

### **Mental Health Parity Adopted**

Recent federal legislation created an obligation for health plans to cover mental health and substance abuse treatment in the same manner as other medically necessary treatment. The endowed health plans for active and retired faculty and staff which include the Health Savings Account Plan, will comply with this new requirement as of January 1, 2010. Medical, surgical or mental health care will be considered for coverage using the same evidence-based criteria for treatment. (Visit Limits for behavioral health benefits have been removed; coinsurance is included as part of the medical plan deductible and OOP).