# 2025 Endowed Retiree Pre-Medicare Health Plan

| Cornell University | AETNA RETIREE PRE-MEDICARE HEALTH PLAN | |
|---|---|---|
| **Plan Features** | **In-Network Coverage (Preferred Benefit Level)** | **Out-of-Network Coverage * (Non-Preferred Benefit Level)** |
| **Deductible (per calendar year)** | $150 Individual<br>$300 Family | $300 Individual<br>$600 Family |
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Out-of-Pocket Maximum per calendar year (includes deductible, and medical/Rx copays)** | $2,000 Individual<br>$4,000 Family | $3,500 Individual<br>$7,000 Family |
| **PHYSICIAN SERVICES** | | |
| **Allergy Testing, Treatments, Shots** | Testing, treatment: 100% after $20 copay<br>Shots: 90% after deductible | 80% after deductible |
| **Chiropractic Visits** | 100% after $20 copay | 80% after deductible |
| **Diagnostic X-Ray/Laboratory** | 90% after deductible (except in physician office when it is 100% after $20 copay) | 80% after deductible |
| **Eye Exam (routine)** | 100% after $20 copay (1 exam per calendar year) | 80% after deductible (1 exam per calendar year) |
| **Flu Vaccination (injection)** | 100% | 80% after deductible |
| **Gynecological Exams (routine)** | 100% (1 gyn exam and pap test per calendar year) | 80% after deductible (1 gyn exam and pap test per calendar year) |
| **Hearing Exam (routine)** | 100% after $20 copay (1 exam every 2 yrs) | 80% after deductible (1 exam every 2 yrs) |
| **Hearing Aid Equipment** | Adults and children 13 and older: Reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear, once every 3 yrs. Excludes batteries.<br><br>Children age 12 and under: Reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear, once every 2 yrs. Excludes batteries. | Adults and children 13 and older: Reimbursed at 100% no copay or deductible up to $1,500 per hearing aid per ear, once every 4 yrs. Excludes batteries.<br><br>Children age 12 and under: Reimbursed at 100% no copay or deductible up to $1,500 per hearing aid per ear, once every 2 yrs. Excludes batteries. |
| **Mammography Exam Routine** | 100% | 80% after deductible |
| **Office Visit** | 100% after $20 copay | 80% after deductible |
| **Physical Exams (routine)** | 100% (1 exam each year for ages 22 and older) | 80% after deductible (1 exam each year for ages 22 and older) |
| **Physician Hospital Services** | 90% after deductible | 80% after deductible |
| **Specialist Office Visits** | 100% after $20 copay | 80% after deductible |
| **Surgery** | 90% after deductible (except in physician office when office visit copay applies) | 80% after deductible |
| **Telehealth Visits** | 100% after $20 copay | 80% after deductible |
| **Well Child Care** | 100% (birth to age 22) | 80% after deductible (birth to age 22) |
| **HOSPITAL** | | |
| **Inpatient Coverage** | 90% after deductible | 80% after deductible; pre-certification required |
| **Outpatient Coverage** | 90% after deductible | 80% after deductible; pre-certification required for certain procedures |
| **Emergency Room** | 90% after deductible | 90% after in-network deductible |
| **Non-emergency Use of Emergency Room** | 50% after deductible | 50% after deductible |
| **OTHER COVERED SERVICES** | | |
| **Ambulance** | 90% after deductible if emergency | 90% after deductible if emergency |
| **Artificially Assisted Fertilization** | 90% after deductible ($20,000 lifetime max per family) | 80% after deductible ($20,000 lifetime max per family) |
| **Durable Medical Equipment** | 90% after deductible | 80% after deductible |
| **Home Health Care** | 90% after deductible; up to 120 visits per calendar year | 80% after deductible; up to 120 visits per calendar year |
| **Hospice Care** | 100% | 80% after deductible |

| Plan Features | In-Network Coverage (Preferred Benefit Level) | Out-of-Network Coverage * (Non-Preferred Benefit Level) |
|---|---|---|
| **OTHER COVERED SERVICES CONTINUED** | | |
| **Maternity** | Prenatal care 100% (excludes lab work and ultrasounds; covered at 90% after deductible) Delivery and routine nursery care 90% after deductible | 80% after deductible |
| **Breastfeeding Supplies and Counseling** | 100% | 80% after deductible |
| **Oral Surgery** | 100% after $20 copay in physician office; 90% after deductible if performed inpatient/outpatient hospital (for accidental injuries, certain surgical extractions, periodontal surgery) | 80% after deductible (for accidental injuries, certain surgical extractions, periodontal surgery) |
| **Physical/Occupational/Speech Therapy, and Cardiac Rehab** | 90% after deductible | 80% after deductible |
| **Habilitative Services** | 100% no deductible, no copay | 80% after deductible |
| **Private Duty Nursing** | 90% after deductible; up to 70, 8-hour shifts per calendar year | 80% after deductible; up to 70, 8-hour shifts per calendar year |
| **Skilled Nursing Facility** | 90% after deductible; up to 120 days per calendar year | 80% after deductible; up to 120 days per calendar year |
| **PRESCRIPTION DRUG ADMINISTRATION BY OPTUMRX** | | |
| **Retail Pharmacy** | Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply | Contracted rate less applicable copay |
| **Home Delivery: choose delivery to home address or safe and secure delivery to Cornell Health Pharmacy on Cornell Campus** | Tier 1: $10; Tier 2: $60; Tier 3: $90. Up to a 90 day supply renewable up to a year for maintenance/specialty meds | Not covered |
| **Prescription Contraceptives** | Oral contraceptives and barrier methods (i.e. diaphragm): $0 copay for generic, or single source brand | Contracted rate less applicable copay |
| **BEHAVIORAL HEALTH CARE** | | |
| **Telehealth Behavioral Health Services*** | 100%* | 80% after deductible |
| **Mental Health** | | |
| **Inpatient Care** | 90% after deductible | 80% after deductible |
| **Partial Hospitalization/Intensive Outpatient** | 90% after deductible | 80% after deductible |
| **Outpatient Other** | 100% no deductible, no copay | 80% after deductible |
| **Outpatient Office Visit** | 100% after $20 copay | 80% after deductible |
| **Substance Abuse** | | |
| **Inpatient Care** | 90% after deductible | 80% after deductible |
| **Partial Hospitalization/Intensive Outpatient** | 90% after deductible | 80% after deductible |
| **Halfway House** | 90% after deductible | Not covered |
| **Outpatient Care** | 100% after $20 copay | 80% after deductible |
| **UTILIZATION MANAGEMENT** | | |
| **Inpatient Pre-certification** | Provider initiated | Member initiated |
| **Failure to Pre-certify Inpatient** | No penalty | $400 penalty per occurrence |
| **Outpatient Pre-certification** | None | None |
| **Failure to Pre-certify Outpatient** | No penalty | No penalty |
| **Claim Submission** | Provider initiated | Member initiated |

**Telehealth Behavioral Health Services received through Teladoc are subject to a $20 copay.*

The out of network reimbursement limit for the RPHP is subject to reasonable and customary (R&C) limits. Amounts over R&C are not applicable to the deductible and out of pocket limit maximums. Please call Aetna's Retiree Service Center at 1-800-338-4533 (TTY: 711) if you have questions about the benefit provisions.

While every attempt has been made to ensure the accuracy of this Summary, in the event of any discrepancy the Summary Plan Description and Plan Document will prevail.

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.

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