2024 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 $300 Family	$300 Individual $600 Family
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible, and medical/Rx copays)	$2,000 Individual $4,000 Family	$3,500 Individual $7,000 Family
PHYSICIAN SERVICES		
Allergy Testing, Treatments, Shots	Testing, treatment: 100% after $20 copay 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 $1,500 per hearing aid per ear, once every 4 yrs. Excludes batteries. 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.	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. 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	90% after deductible
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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