2027 Endowed Health Plan Comparison Chart

AETNA POS II* 3 PLAN OPTIONS	CORNELL PROGRAM FOR HEALTHY LIVING (CPHL)		WEILL CORNELL MEDICINE (WCM-PPO)		HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	
Plan Features	**In-Network Coverage (Preferred Benefit Level)**	**Out-of-Network Coverage ** (Non-Preferred Benefit Level)**	**In-Network Coverage (Preferred Benefit Level)**	**Out-of-Network Coverage* (Non-Preferred Benefit Level)**	**In-Network Coverage (Preferred Benefit Level)**	**Out-of-Network Coverage* (Non-Preferred Benefit Level)**
Deductible (per calendar year)	$200 Individual $400 Family	$1,250 Individual $2,500 Family	$300 Individual $600 Family	$750 Individual $1,500 Family	$1,750 Individual $3,500 Family	$3,000 Individual $6,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible and medical & Rx copays)	$3,000 Individual $6,000 Family	$3,750 Individual $7,500 Family	$2,300 Individual $4,600 Family	$3,750 Individual $7,500 Family	$3,250 Individual $5,500 Family	$4,250 Individual $7,500 Family
2027 Account-based Cornell Contribution	N/A	N/A	N/A	N/A	$1,000 per year, pro-rated if not enrolling during open enrollment	
2027 Contribution Maximums	N/A	N/A	N/A	N/A	$4,500 Individual, $9,000 Family (includes Cornell's contribution). Employees age 55 and older can contribute an additional $1000.	
PHYSICIAN SERVICES						
Allergy Testing, Treatments, Shots	Testing, treatment: 100% after $25 copay Shots: 90% after deductible	80% after deductible	Testing, treatment: 100% after $10 copay Weill network; 100% after $20 PCP co-pay/$30 Specialist Aetna Network. Shots: 100% no deductible	70% after deductible	90% after deductible	80% after deductible
Chiropractic Visits	100% after $25 copay	80% after deductible	100% after $10 copay Weill network; 100% after $30 copay Aetna network. 36 visit max.	70% after deductible. 36 visit max.	90% after deductible	80% after deductible
Diagnostic X-Ray/Laboratory	90% after deductible (except in physician office when it is 100% after $25 copay)	80% after deductible	X-ray: 100% after $10 copay Weill network; 90% after deductible Aetna network (except in physician office when office visit copay applies). Lab: 90% after deductible.	70% after deductible	90% after deductible	80% after deductible
Eye Exam (routine)	100% after $25 copay (1 exam per calendar year)	80% after deductible (1 exam per calendar year)	100% after $10 copay Weill network; 100% after $30 copay Aetna network. (1 exam per calendar year)	70% after deductible (1 exam per calendar year)	No deductible, $20 copay (1 exam per calendar year)	80% after deductible (1 exam per calendar year)
Preventive/Routine Vaccinations	100%	80% after deductible	100%	70% after deductible	No deductible, 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)	100% (1 gyn exam and pap test per calendar year)	70% after deductible (1 gyn exam and pap test per calendar year)	No deductible, 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 $25 copay (1 exam every 2 yrs)	80% after deductible (1 exam every 2 yrs)	100% after $10 copay Weill network; 100% after $30 copay Aetna network (1 exam per calendar year)	70% after deductible (1 exam per calendar year)	No deductible, $20 copay (1 exam every 2 yrs)	80% after deductible (1 exam every 2 yrs)
Hearing Aid Equipment	Adults & children 13 and older: reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear once every 3 yrs. Children age 12 and under: Reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear, once every 2 years. Excludes batteries.	Adults & children 13 and older: reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear once every 3 yrs. Children age 12 and under: Reimbursed at 100% no copay or deductible up to $3,000 per hearing aid per ear, once every 2 years. Excludes batteries.	Adults & children: reimbursed at 100% no copay and no deductible, max $3,000 total every 3 years. Excludes batteries.	Adults & children: reimbursed at 100% no copay and no deductible, max $3,000 total every 3 years. Excludes batteries.	Adults & children 13 and older: Deductible, reimbursed at 100% up to $3,000 per hearing aid per ear once every 3 yrs. Children age 12 and under: Deductible, reimbursed at 100% up to $3,000 per hearing aid per ear, once every 2 years. Excludes batteries.	Adults & children 13 and older: Deductible, reimbursed at 100% up to $3,000 per hearing aid per ear once every 3 yrs. Children age 12 and under: Deductible, reimbursed at 100% up to $3,000 per hearing aid per ear, once every 2 years. Excludes batteries.
Mammography Exam Routine	100%	80% after deductible	100%	70% after deductible	No deductible, 100%	80% after deductible
Office Visit	100% after $25 copay	80% after deductible	100% after $10 copay Weill network; 100% after $20 copay Aetna network. Does not include ob/gyn (refer to specialist)	70% after deductible. Does not include ob/gyn (refer to specialist)	90% after deductible	80% after deductible
Telemedicine Office Visit	100% after $25 copay	80% after deductible	100% after $10 copay Weill network; 100% after $20 copay Aetna network. Does not include ob/gyn (refer to specialist)	70% after deductible. Does not include ob/gyn (refer to specialist)	90% after deductible	80% after deductible
Routine Physical/Wellness Exam (Age 3 onward, 1 per calendar year)**	100%	80% after deductible	100%	70% after deductible	No deductible, 100%	80% after deductible
Physician Hospital Services	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	80% after deductible
Specialist Office Visits	100% after $25 copay	80% after deductible	100% after $10 copay Weill network; 100% after $30 copay Aetna network. Includes ob/gyn	70% after deductible. Includes ob/gyn.	90% after deductible	80% after deductible
Surgery	90% after deductible (except in physician office when office visit copay applies)	80% after deductible	90% after deductible (except in physician office when office visit copay applies)	70% after deductible	90% after deductible	80% after deductible
HOSPITAL						
Inpatient Coverage	90% after deductible	80% after deductible; pre-certification required	90% after deductible	70% after deductible; pre-certification required	90% after deductible	80% after deductible; pre-certification required
Outpatient Coverage	90% after deductible	80% after deductible; pre-certification required for certain procedures	90% after deductible	70% after deductible; pre-certification re-quired for certain procedures	90% after deductible	80% after deductible; pre-certification required for certain procedures
Emergency Room	90% after deductible	90% paid as in-network	90% after deductible	90% after in-network deductible	90% after deductible	80% after deductible (paid as in-network)
Non-emergency Use of Emergency Room	50% after deductible	50% after deductible	50% after deductible	50% after deductible	Deductible, then 50%	Deductible, then 50%
OTHER COVERED SERVICES						
Ambulance	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Artificially Assisted Fertilization	90% after deductible ($30,000 lifetime max per family for all covered services)	80% after deductible ($30,000 lifetime max per family for all covered services)	90% after deductible ($30,000 lifetime max per family for all covered services)	70% after deductible ($30,000 lifetime max per family for all covered services)	90% after deductible ($30,000 lifetime max per family for all covered services)	80% after deductible ($30,000 lifetime max per family for all covered services)
Durable Medical Equipment	90% after deductible	80% after deductible	90% after deductible	70% after deductible	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	90% after deductible; up to 200 visits per calendar year	70% after deductible; up to 200 visits per calendar year	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	100%	70% after deductible	Deductible, then 100%	80% after deductible
Maternity	Prenatal Care 100% (excludes lab work and ultrasounds; covered at 90% after deduct-ible) Delivery and routine nursery care 90% after deductible	80% after deductible	Prenatal Care 100% (excludes lab work and ultrasounds; covered at 90% after deduct-ible) Delivery and routine nursery care 90% after deductible	70% after deductible	Prenatal Care no deductible, 100% (ex-cludes lab work and ultrasounds; covered deductible, then 90%) Deductible, then 90% delivery and routine nursery care	80% after deductible
Breastfeeding Supplies and Counseling	100%	80% after deductible	100%	70% after deductible	No deductible, 100%	80% after deductible
Oral Surgery	100% after $25 copay in physician office (for accidental injuries, certain surgical extractions, periodontal surgery), otherwise 90% after deductible	80% after deductible (for accidental injuries, certain surgical extractions, periodontal surgery)	100% after $10 copay in Weill network physi-cian office and $30 copay in Aetna network physician office; 90% after deductible if per-formed inpatient/outpatient hospital (for acci-dental injuries, certain surgical extractions, periodontal surgery)	70% after deductible (for accidental injuries, certain surgical extractions, periodontal surgery)	90% after deductible (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	90% after deductible	70% after deductible.	90% after deductible	80% after deductible
Habilitative Services (PT/OT/ST)	100%	80% after deductible	100%	70% after deductible	90% after deductible	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	Not covered unless part of Home Health Care.	Not covered unless part of Home Health Care.	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	90% after deductible; up to 120 days per calendar year	70% after deductible; up to 120 days per calendar year	90% after deductible; up to 120 days per calendar year	80% after deductible; up to 120 days per calendar year
BEHAVIORAL HEALTH CARE						
Telemedicine for Behavioral Health***	100%	80% after deductible	100%	70% after deductible	90% after deductible	80% after deductible
Mental Health						
Inpatient Care	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	80% after deductible
Partial Hospitalization/Intensive Outpatient	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	80% after deductible
Outpatient Other	100%	80% after deductible	100%	70% after deductible	90% after deductible	80% after deductible
Outpatient Office Visit	100% after $25 copay	80% after deductible	100% after $10 copay	70% after deductible	90% after deductible	80% after deductible
Substance Disorder						
Inpatient Care	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	80% after deductible
Partial Hospitalization/Intensive Outpa-tient	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	80% after deductible
Halfway House	90% after deductible	Not covered	90% after deductible	Not covered	90% after deductible	Not covered
Outpatient Care	100% after $25 copay	80% after deductible	100% after $10 copay	70% after deductible	90% after deductible	80% after deductible
UTILIZATION MANAGEMENT						
Inpatient Pre-certification	Provider initiated	Member initiated.	Provider initiated	Member initiated.	Provider initiated	Member initiated
Failure to Pre-certify Inpatient	No penalty	$400 penalty per occurrence	No penalty	No penalty	No penalty	$400 penalty per occurrence
Outpatient Pre-certification	None	None	None	None	None	None
Failure to Pre-certify Outpatient	No penalty	No penalty	No penalty	No penalty	No penalty	No penalty
Claim Submission	Provider initiated	Member initiated	Provider initiated	Member initiated	Provider initiated	Member initiated
PRESCRIPTION DRUG ADMINISTERED BY OPTUMRX						
Retail Pharmacy (30 day supply only)	Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply	Contracted rate less applicable copay	Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply	Contracted rate less applicable copay	Deductible, then Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply	Deductible, contracted rate less applicable copay
Home Delivery: (90 day supply) Choose delivery to home address or Cornell Health Pharmacy; or fill 90 day exclu-sively at Cornell Health Pharmacy on Cornell campus	Tier 1: $10; Tier 2: $60; Tier 3: $90. Up to 90 day supply renewable up to a year for main-tenance/specialty meds	Not covered	Tier 1: $10; Tier 2: $60; Tier 3: $90. Up to 90 day supply renewable up to a year for main-tenance/specialty meds	Not covered	Deductible, then Tier 1: $10; Tier 2: $60; Tier 3: $90. Up to 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	Oral contraceptives and barrier methods (i.e. diaphragm): $0 copay for generic or single source brand	Contracted rate less applicable copay	Oral contraceptives and barrier methods (i.e. diaphragm): $0 copay for generic or single source brand	Deductible, contracted rate less applicable copay

***Note from the Comparison:** You may visit any provider for eligible medical necessary services, and will receive the greatest benefit by seeing an Aetna participating provider (in-network coverage). You will pay more when providers are non-participating with Aetna (out-of-network).

** The out-of-network reimbursement limit for the Aetna CPHL Plan, Weill Cornell Medicine PPO Plan, and Aetna HSA Plan is 275% of the Medicare allowable rate, amounts over this are not applicable to the deductible and out-of-pocket maximums. Please contact Aetna at 877-371-2007 for coverage or claims questions..

*** Telemedicine for Behavioral Health received through Teladoc are subject to a $25 copay per visit for the Aetna CPHL Plan and Weill Cornell Medicine Plan; whereas, the HDHP is covered at 90% after deductible per visit.

**** Birth through age 3 subject to any age and visit limits provided in the comprehensive guidelines supported by the American Academy of Pediatrics.

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. Please visit hr.cornell.edu/understand-your-benefits for more detail and contact information if you have any questions.

Plan summary does not guarantee coverage. Please contact Aetna (877-371-2007) or OptumRx (866-533-6977) for specific coverage details.

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