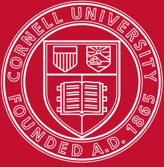

Cornell University
Division of Human Resources

2008 Endowed Health Plan Charts

Endowed Health Plan Comparison Charts

This is a brief summary of the benefits available for each of Cornell's five health plans for endowed staff and faculty.** See individual plan booklets for details or go to the web, at: <http://www.ohr.cornell.edu/benefits/programs/index.html>.

See the back page of this booklet for additional notes on in-network and out-of-network maximums, CPHL copays, mental health and substance abuse services, and the prescription drug programs.

Two New Health Plans

Cornell Program for Healthy Living

Staff and faculty enrolled in the Cornell Program for Healthy Living (CPHL) are eligible for an enhanced wellness benefit. When you enroll, you must choose a PCP from the custom network of PCPs electing to participate in the CPHL and must complete a Health Risk Assessment. Your PCP will evaluate your Health Risk Assessment to determine the level of effort and services that will be needed to get you on a path to better wellness. In cases where minor interventions are needed, the plan will help pay for the services rendered, usually periodic visits to your PCP or other medical services as listed in the chart below.

Enhanced Wellness Benefit for the CPHL:

Member schedules appointment with PCP	Plan Pays:
1) complete routine physical exam	100%
2) review of Health Risk Assessment	100%
3) application of protocols to assess wellness	100%
4) written wellness plan by the PCP in partnership with the member	100%
PCP's assessment is low/moderate risk:	**You Pay:**
PCP monitoring and guidance	$12 copay

PCP's assessment is moderate/high risk:	You Pay:
Refer to Cayuga Center for Healthy Living	
Health Behavior Assessment	$12 copay
Health Risk Assessment interpretation	$12 copay
Nutrition Therapy	$12 copay
Medically Supervised Exercise	$12 copay
Team Conference	$12 copay
Preventive Medical Counseling	$12 copay
Diabetes Education	$12 copay
Smoking Cessation	$12 copay
Stress Management	$12 copay

Aetna Health Savings Account Plan

The health savings accounts distinguish this plan from the other health care plans you may enroll in during the Open Enrollment period. Here are some important features.

Important Features of the HSA Plan	
Aetna VISA Debit Card	See the fee schedules that apply to use of the debit card <http://www.ohr.cornell.edu/benefits/programs/endowHealthHSA.html>
Invest your health savings account with no report-able income from interest.	First $2,000 earns market interest rate (tax free) Accounts above $2,000 may be moved to J.P. Morgan Chase investment funds.
Withdrawals	Tax Free if used to pay qualifying medical bills under the IRS regulations.
IRS Restrictions:	You must participate exclusively in a health plan with a high deductible to use the health savings accounts You cannot participate in Select Benefits Medical if you use a health savings account You cannot participate in this plan if you are eligible for Medicare You cannot be claimed as a dependent on another's tax return. You should read the J.P. Morgan/ Chase Bank fee schedule and Custodial Agreement prior to enrolling.

**Some restrictions may apply. In case of discrepancy between this summary and the Plan Document, the Plan Document will govern.

Your Health. Your Choice.

CORNELL PROGRAM FOR HEALTHY LIVING

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Members of the Cornell Program for Healthy Living (CPHL) must choose a primary care physician (PCP) from the custom network of PCPs electing to participate in the CPHL and each must complete a Health Risk Assessment. **See cover for the Enhanced Wellness Benefits for the CPHL.**		
Deductible (per calendar year)	No deductible	$400 Individual $800 Family
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible)	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family
PHYSICIAN SERVICES		
Allergy Testing, Treatments, Shots	Testing, treatment: 100% after $12 copay Shots: 90%	80% after deductible
Chiropractic Visits	100% after $12 copay	80% after deductible
Diagnostic X-Ray/Laboratory	90% (except in physician office when it is 100% after $12 copay)	80% after deductible
Eye Exam (routine)	100% after $12 copay (1 exam every 24 months)	80% after deductible (1 exam every 24 months)
Flu Vaccination (injection)	100% after $12 copay	80% after deductible
Gynecological Exams (routine)	100% after $12 copay (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 $12 copay (1 exam every 2 yrs)	80% after deductible (1 exam every 2 yrs)
Hearing Aid Equipment	Adults & children 13 and older: Reimbursed at 90% up to $1,500 per hearing aid per ear, once every 4 yrs. Children age 12 and under: Reimbursed at 90% up to $1,500 per hearing aid per ear, once every 2 yrs.	Adults & children 13 and older: 80% up to $1,500 per hearing aid per ear after deductible, once every 4 yrs. Children age 12 and under: 80% up to $1,500 per hearing aid per ear after ded., once every 2 yrs.
Mammography Exam	90%	80% after deductible
Office Visits (except mental health)	100% after $12 copay	80% after deductible
Physical Exams (routine)	100% after $12 copay (routine exams & immunizations: 1 exam each year for ages 2 - 19; 1 exam every 2 years ages 19 and over)	80% after deductible (routine exams & immunizations: 1 exam each year for ages 2 - 19; 1 exam every 2 years ages 19 and over)
Physician Hospital Services	90%	80% after deductible
Specialist Office Visits	100% after $12 copay	80% after deductible
Surgery	90% (except in physicians office when office visit copay applies)	80% after deductible
Well Baby Care	100% after $12 copay (birth to age 2)	80% after deductible (birth to age 2)
HOSPITAL		
Inpatient Coverage	90%	80% after deductible; pre-certification required
Outpatient Coverage	90%	80% after deductible; pre-certification required for certain procedures
Emergency Room	90%	90% after in-network deductible
Non-emergency Use of Emergency Room	50%	50% after deductible
OTHER COVERED SERVICES		
Ambulance	90%	90% if emergency, after in-network deductible, 50% after deductible if non-emergency
Artificially Assisted Fertilization	90% ($20,000 lifetime max)	80% after deductible ($20,000 lifetime max)
Durable Medical Equipment	90%	80% after deductible
Home Health Care	90%; up to 120 visits per calendar year	80% after deductible; up to 120 visits per calendar year
Hospice Care	Inpatient - 90% up to 30 days lifetime; Outpatient - 90% up to $10,000 lifetime	Inpatient - 80% after deductible up to 30 days lifetime; Outpatient - 80% after deductible up to $10,000 lifetime

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Maternity	100% after $12 copay (copay on initial visit only), 90% (for pre-natal, post-natal, delivery, and for routine nursery care)	80% after deductible (for pre-natal, post-natal, and delivery) 80% after deductible (for routine nursery care)
Oral Surgery	100% after $12 copay in physician's office (for accidental injuries, certain surgical extractions, periodontal surgery), otherwise 90%	80% after deductible (for accidental injuries, certain surgical extractions, periodontal surgery)
Physical/Occupational/Speech Therapy, and Cardiac Rehab	90%	80% after deductible
Private Duty Nursing	90%; 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%; up to 90 days per calendar year	80% after deductible; up to 90 days per calendar year
PRESCRIPTION DRUG ADMINISTERED BY MEDCO		
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5; Tier 2: $20; Tier 3: $40. Up to 30 day supply	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
Medco By Mail	Tier 1: $10; Tier 2: $40; Tier 3: $60. Up to a 90 day supply for home delivery	Not covered
Prescription Drug Non-Participating Pharmacies	Not applicable	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
MENTAL HEALTH CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
SUBSTANCE ABUSE CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Halfway House	90% (up to 60 days per calendar year; 120 days lifetime maximum)	Not covered
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
Claim Submission	Provider initiated to ValueOptions	Member initiated to ValueOptions
UTILIZATION MANAGEMENT		
Inpatient Pre-certification	Provider initiated	Member initiated. Mental Health and Substance Abuse (MH&SA) benefits must be pre-certified to receive coverage. No benefits payable if not pre-certified.
Failure to Pre-certify Inpatient	No penalty	$400 penalty per occurrence on Medical Plan
Outpatient Pre-certification	None	None
Failure to Pre-certify Outpatient	No penalty	No penalty
Claim Submission	Provider initiated	Member initiated

AETNA HEALTH SAVINGS ACCOUNT

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
See cover for a list of some important features of the HSA Plan.		
2008 Contribution Maximums	$2,900 Individual, $5,800Family. For employees age 55 and older can contribute an additional $900.	
Deductible (per calendar year)	$1,100 Individual $2,200 Family	$2,200 Individual $4,400 Family
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible)	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family
PHYSICIAN SERVICES		
Allergy Testing, Treatments, Shots	Deductible, then 90%	Deductible, then 80%
Chiropractic Visits	Deductible, then 90%	Deductible, then 80%
Diagnostic X-Ray/Laboratory	Deductible, then 90%	Deductible, then 80%
Eye Exam (routine)	No deductible, $12 copay (1 exam every 24 months)	Deductible, then 80% (1 exam every 24 months)
Flu Vaccination (injection)	No deductible, $12 copay	Deductible, then 80%
Gynecological Exams (routine)	No deductible, $12 copay (1 gyn exam and pap test per calendar year)	Deductible, then 80% (1 gyn exam and pap test per calendar year)
Hearing Exam (routine)	No deductible, $12 copay (1 exam every 2 yrs)	Deductible, then 80% (1 exam every 2 yrs)
Hearing Aid Equipment	Adults & children 13 and older: Deductible, reimbursed at 90% up to $1,500 per hearing aid per ear, once every 4 yrs. Children age 12 and under: Deductible at 90% up to $1,500 per hearing aid per ear, once every 2 yrs.	Adults & children 13 and older: Deductible, then 80% up to $1,500 per hearing aid per ear, once every 4 yrs. Children age 12 and under: Reimbursed at 80% up to $1,500 per hearing aid per ear, once every 2 yrs.
Mammography Exam	No deductible, $12 copay	Deductible, then 80%
Office Visits (except mental health)	Deductible, then 90%	Deductible, then 80%
Physical Exams (routine)	No deductible, $12 copay (routine exams & immunizations: 1 exam each year for ages 2 - 19; 1 exam every 2 years ages 19 and over)	Deductible, then 80%
Physician Hospital Services	Deductible, then 90%	Deductible, then 80%
Specialist Office Visits	Deductible, then 90%	Deductible, then 80%
Surgery	Deductible, then 90%	Deductible, then 80%
Well Baby Care	No deductible, $12 copay (birth to age 2)	Deductible, then 80%
HOSPITAL		
Inpatient Coverage	Deductible, then 90%	Deductible, then 80%; pre-certification required
Outpatient Coverage	Deductible, then 90%	Deductible, then 80%; pre-certification required for certain procedures
Emergency Room	Deductible, then 90%	Deductible, then 90%
Non-emergency Use of Emergency Room	Deductible, then 90%	Deductible, then 50%
OTHER COVERED SERVICES		
Ambulance	Deductible, then 90%	90% if emergency, after in-network deductible, 50% after deductible if non-emergency
Artificially Assisted Fertilization	Deductible, then 90% ($20,000 lifetime max)	Deductible, then 80% ($20,000 lifetime max)
Durable Medical Equipment	Deductible, then 90%	Deductible, then 80%
Home Health Care	Deductible, then 90%; up to 120 visits per calendar year	Deductible, then 80%; up to 120 visits per calendar year
Hospice Care	Inpatient - Deductible, then 90% up to 30 days lifetime; Outpatient - deductible, then 90% up to $10,000 lifetime	Inpatient - Deductible, then 80% up to 30 days lifetime; Outpatient - deductible, then 80% up to $10,000 lifetime

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Maternity	Deductible, then 90%	Deductible, then 80%
Oral Surgery	Deductible, then 90% (for accidental injuries, certain surgical extractions, periodontal surgery)	Deductible, then 80% (for accidental injuries, certain surgical extractions, periodontal surgery)
Physical/Occupational/Speech Therapy, and Cardiac Rehab	Deductible, then 90%	Deductible, then 80%
Private Duty Nursing	Deductible, then 90%; up to 70 8-hour shifts per calendar year	Deductible, then 80%; up to 70 8-hour shifts per calendar year
Skilled Nursing Facility	Deductible, then 90%; up to 90 days per calendar year	Deductible, then 80%; up to 90 days per calendar year
PRESCRIPTION DRUG ADMINISTERED BY MEDCO		
Local Participating Pharmacies (including insulin; generics required when available)	Deductible, then Tier 1: $5; Tier 2: $20; Tier 3: $40. Up to 30 day supply (deductible waived for preventive meds)	Deductible, applies, then reimbursed 100% of the Medco negotiated rate, less the applicable copay (deductible waived for preventive meds)
Medco By Mail	Deductible, then Tier 1: $10; Tier 2: $40; Tier 3: $60. Up to a 90 day supply for home delivery (deductible waived for preventive meds)	Not covered
Prescription Drug Non-Participating Pharmacies	Not applicable	Deductible, applies, then reimbursed 100% of the Medco negotiated rate, less the applicable copay (deductible waived for preventive meds)
MENTAL HEALTH CARE ADMINISTERED BY AETNA		
Inpatient Care	Deductible, then 90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	Deductible, then 70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Outpatient Care	Deductible, then 90% (up to 50 visits per calendar year combined total for in- and out-of-network visits)	Deductible, then 70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
SUBSTANCE ABUSE CARE ADMINISTERED BY AETNA		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses, except Aetna HSA Plan)	Deductible, then 90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	Deductible, then 70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Halfway House	Deductible, then 90% (up to 60 days per calendar year; 120 days lifetime maximum)	Not covered
Outpatient Care	Deductible, then 90% (up to 50 visits per calendar year combined total for in- and out-of-network visits)	Deductible, then 70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
Claim Submission	Provider initiated to Aetna	Member initiated to Aetna
UTILIZATION MANAGEMENT		
Inpatient Pre-certification	Provider initiated	Member initiated. Mental Health and Substance Abuse (MH&SA) benefits must be pre-certified to receive coverage. No benefits payable if not pre-certified.
Failure to Pre-certify Inpatient	No penalty	$400 penalty per occurrence on Medical Plan
Outpatient Pre-certification	None	None
Failure to Pre-certify Outpatient	No penalty	No penalty
Claim Submission	Provider initiated	Member initiated

HEALTHNOW PPO

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Deductible (per calendar year)	None	$300 Individual $750 Family
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
PHYSICIAN SERVICES		
Allergy Testing, Treatments, Shots	100% after $12 copay	70% after deductible
Chiropractic Visits	100% after $12 copay	70% after deductible
Diagnostic X-Ray/Laboratory	90% (except in physician's office when office visit copay applies)	70% after deductible
Eye Exam (routine)	100% after $12 copay (1 refractory exam every 24 months)	Not covered
Flu Vaccination (injection)	100% after $12 copay	Not covered
Gynecological Exams (routine)	100% after $12 copay (1 exam and pap test per calendar year)	Not covered
Hearing Exam (routine)	100% after $12 copay (1 exam every 2 yrs)	Not covered
Hearing Aid Equipment	Adults & children 13 and older: Reimbursed at 90% up to $1,500 per hearing aid per ear, once every 4 yrs. Children age 12 and under: Reimbursed at 90% up to $1,500 per hearing aid per ear, once every 2 yrs.	Not covered
Mammography Exam	90%	70% after deductible
Office Visits (non-surgical; except mental health)	100% after $12 copay	70% after deductible
Physical Exams (routine)	100% after $12 copay (1 exam per year ages 2-19; 1 exam every 2 years for ages 19 and over)	Not covered
Physician Hospital Services	90%	70% after deductible
Specialist Office Visits	100% after $12 copay	70% after deductible
Surgery	90% (except in physician's office when office visit copay applies)	70% after deductible (pre-certification required for some procedures)
Well Baby Care	100% after $12 copay (birth to age 2)	Not covered
HOSPITAL		
Inpatient Coverage	90%	70% after deductible; pre-certification required
Outpatient Coverage	90%	70% after deductible; pre-certification required for certain procedures
Emergency Room	90% after $25 copay (waived if admitted)	90% after $25 copay (waived if admitted)
Non-emergency Use of Emergency Room	Not covered	Not covered
OTHER COVERED SERVICES		
Ambulance	90%	70% after deductible
Artificially Assisted Fertilization	90% ($20,000 lifetime maximum)	70% after deductible ($20,000 lifetime max)
Durable Medical Equipment	90%	70% after deductible
Home Health Care	100% (maximum of 300 visits per calendar year; each 4 hours of home health aide care equals one visit; each visit by a nurse or therapist equals one visit.)	70% after deductible (maximum of 300 visits per calendar year; each 4 hours of home health aide care equals one visit; each visit by a nurse or therapist equals one visit.)
Hospice Care	100%	70% after deductible

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Maternity	100% after $12 copay (copay on initial visit only) 90% (for pre-natal, post-natal, and delivery)	70% after deductible
Oral Surgery	100% after $12 copay (for accidental injuries, certain surgical extractions, periodontal surgery)	70% after deductible (for accidental injuries, certain surgical extractions, periodontal surgery)
Physical/Occupational/Speech Therapy, and Cardiac Rehab	90%	70% after deductible
Private Duty Nursing	90% (up to 70 days per calendar year; 8-hour shift equals 1 day)	70% after deductible (up to 70 days per calendar year; 8-hour shift equals 1 day)
Skilled Nursing Facility	90% (up to 60 days per calendar year)	70% after deductible (up to 60 days per calendar year)
PRESCRIPTION DRUG ADMINISTERED BY MEDCO		
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5; Tier 2: $20; Tier 3: $40. Up to 30 day supply	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
Medco By Mail	Tier 1: $10; Tier 2: $40; Tier 3: $60. Up to a 90 day supply for home delivery	Not covered
Prescription Drug Non-Participating Pharmacies	Not applicable	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
MENTAL HEALTH CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
SUBSTANCE ABUSE CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Halfway House	90% (up to 60 days per calendar year; 120 days lifetime maximum)	Not covered
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
Claim Submission	Provider initiated to ValueOptions	Member initiated to ValueOptions
UTILIZATION MANAGEMENT		
Inpatient Pre-certification	Provider initiated	Member initiated. Mental Health and Substance Abuse (MH&SA) benefits must be pre-certified to receive coverage. No benefits payable if not pre-certified.
Failure to Pre-certify Inpatient	No penalty	$400 penalty per occurrence on Medical Plan
Outpatient Pre-certification	Provider initiated	Member initiated
Failure to Pre-certify Outpatient	No penalty	$400 penalty per occurrence on Medical Plan
Claim Submission	Provider initiated	Member initiated

AETNA PPO

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Deductible (per calendar year)	$150 Individual $300 Family	$400 Individual $800 Family
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible)	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family
PHYSICIAN SERVICES		
Allergy Testing, Treatments, Shots	Testing, treatment: 100% after $12 copay Shots: 90% after deductible	80% after deductible
Chiropractic Visits	100% after $12 copay	80% after deductible
Diagnostic X-Ray/Laboratory	90% after deductible	80% after deductible
Eye Exam (routine)	100% after $12 copay (1 exam every 24 months)	80% after deductible (1 exam every 24 months)
Flu Vaccination (injection)	100% after $12 copay	80% after deductible
Gynecological Exams (routine)	100% after $12 copay (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 $12 copay (1 exam every 2 yrs)	80% after deductible (1 exam every 2 yrs)
Hearing Aid Equipment	Adults & children 13 and older: Reimbursed at 90% up to $1,500 per hearing aid per ear after deductible, once every 4 yrs. Children age 12 and under: Reimbursed at 90% up to $1,500 per hearing aid per ear after deductible, once every 2 yrs.	Adults & children 13 and older: Reimbursed at 80% up to $1,500 per hearing aid per ear after deductible, once every 4 yrs. Children age 12 and under: Reimbursed at 80% up to $1,500 per hearing aid per ear after deductible, once every 2 yrs.
Mammography Exam	90% after deductible	80% after deductible
Office Visits (except mental health)	100% after $12 copay	80% after deductible
Physical Exams (routine)	100% after $12 copay (routine exams & immunizations: 1 exam each year for ages 2 - 19; 1 exam every 2 years ages 19 and over)	80% after deductible
Physician Hospital Services	90% after deductible	80% after deductible
Specialist Office Visits	100% after $12 copay	80% after deductible
Surgery	90% after deductible (except in physicians office when office visit copay applies)	80% after deductible
Well Baby Care	100% after $12 copay (birth to age 2)	80% after deductible
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 deductible
Non-emergency Use of Emergency Room	50% after deductible	50% after deductible
OTHER COVERED SERVICES*		
Ambulance	90% after deductible	80% after deductible
Artificially Assisted Fertilization	90% after deductible ($20,000 lifetime max)	80% after deductible ($20,000 lifetime max)
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	Inpatient - 90% after deductible up to 30 days lifetime; Outpatient - 90% after deductible up to $10,000 lifetime	Inpatient - 80% after deductible up to 30 days lifetime; Outpatient - 80% after deductible up to $10,000 lifetime

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage* (Non-Preferred Benefit Level)
Maternity	100% after $12 copay (copay on initial visit only), 90% after deductible (for pre-natal, post-natal, and delivery), 90% after deductible (for routine nursery care)	80% after deductible (for pre-natal, post-natal, and delivery) 80% after deductible (for routine nursery care)
Oral Surgery	100% after $12 copay in 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
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 90 days per calendar year	80% after deductible; up to 90 days per calendar year
PRESCRIPTION DRUG ADMINISTERED BY MEDCO		
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5; Tier 2: $20; Tier 3: $40. Up to 30 day supply	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
Medco By Mail	Tier 1: $10; Tier 2: $40; Tier 3: $60. Up to a 90 day supply for home delivery	Not covered
Prescription Drug Non-Participating Pharmacies	Not applicable	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
MENTAL HEALTH CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
SUBSTANCE ABUSE CARE ADMINISTERED BY ValueOptions		
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	90% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)	70% (up to 45 days per calendar year combined total for in- and out-of-network visits; residential treatment counts as inpatient care)
Partial Hospitalization/Intensive Outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient	Counts as inpatient care; 2:1 trade for partial hospitalization; 4:1 trade for intensive outpatient
Halfway House	90% (up to 60 days per calendar year; 120 days lifetime maximum)	Not covered
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	100% after $12 copay (up to 50 visits per calendar year combined total for in- and out-of-network visits)	70% (up to 50 visits per calendar year combined total for in- and out-of-network visits)
Claim Submission	Provider initiated to ValueOptions	Member initiated to ValueOptions
UTILIZATION MANAGEMENT		
Inpatient Pre-certification	Provider initiated	Member initiated. Mental Health and Substance Abuse (MH&SA) benefits must be pre-certified to receive coverage. No benefits payable if not pre-certified.
Failure to Pre-certify Inpatient	No penalty	$400 penalty per occurrence on Medical Plan
Outpatient Pre-certification	None	None
Failure to Pre-certify Outpatient	No penalty	No penalty
Claim Submission	Provider initiated	Member initiated

AETNA 80/20

Plan Features	Coverage*
Deductible (per calendar year)	$400 Individual $800 Family
Lifetime Maximum	Unlimited
Out-of-Pocket Maximum per calendar year (includes deductible)	$3,000 Individual $6,000 Family
PHYSICIAN SERVICES	
Allergy Testing, Treatments, Shots	80% after deductible
Chiropractic Visits	80% after deductible
Diagnostic X-Ray/Laboratory	80% after deductible
Eye Exam (routine)	Not covered
Flu Vaccination (injection)	80% after deductible. Applies to employees only.
Gynecological Exams (routine)	Women may have either a routine gynecological exam or a routine physical exam every other year. No deductible; 80% up to $150 every other year for employees under 40; $250 every other year for employees over 40. Applies to employees only.
Hearing Exam (routine)	80% after deductible (1 exam every 2 years)
Hearing Aid Equipment	Adults & children 13 and older: Reimbursed at 80% up to $1,500 per hearing aid per ear after deductible, once every 4 years. Children age 12 and under: Reimbursed at 80% up to $1,500 per hearing aid per ear after deductible, once every 2 years.
Mammography Exam	No deductible; 80%. Age-related: women 35-39 reimbursed for one. Women 40-49 reimbursed for one every other year. Women age 50 or above reimbursed for one every year.
Office Visits (except mental health)	80% after deductible
Physical Exams (routine)	Women may have either a routine physical exam or a routine gynecological exam every other year. No deductible; 80% up to $150 every other year for employees under 40; $250 every other year for employees over 40. Applies to employees only.
Physician Hospital Services	80% after deductible
Specialist Office Visits	80% after deductible
Surgery	80% after deductible
Well Baby Care	80%; no deductible (age 2 and under: $200 annual limit per child)
HOSPITAL	
Inpatient Coverage	80% after deductible; pre-certification required
Outpatient Coverage	80% after deductible
Emergency Room	80% after deductible
Non-emergency Use of Emergency Room	80% after deductible
OTHER COVERED SERVICES	
Ambulance	80% after deductible (if for emergency or part of other pre-certified care)
Artificially Assisted Fertilization	80% after deductible ($20,000 lifetime max)
Durable Medical Equipment	80% after deductible
Home Health Care	80% after deductible (Home health care plan must be approved. Plan pays up to 120 visits per calendar year. Each 4 hours of home health aide care equals one visit.)
Hospice Care	Inpatient - 80% after deductible up to 30 days lifetime; Outpatient - 80% after deductible up to $3,000 lifetime maximum

Plan Features	Coverage*
Maternity	80% after deductible
Oral Surgery	80% after deductible (for surgical extraction of 4 impacted wisdom teeth and accidental injury within 12 months)
Physical/Occupational/Speech Therapy, and Cardiac Rehab	80% after deductible
Private Duty Nursing	80% after deductible (only if medically necessary)
Skilled Nursing Facility	80% after deductible (only if medically necessary)
PRESCRIPTION DRUG ADMINISTERED BY MEDCO	
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5; Tier 2: $20; Tier 3: $40. Up to a 30 day supply
Medco By Mail	Tier 1: $10; Tier 2: $40; Tier 3: $60. Up to a 90 day supply for home delivery.
Prescription Drug Non-Participating Pharmacies	Reimbursed 100% of the Medco negotiated rate, less the applicable copay
MENTAL HEALTH CARE	
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	80% up to 50 days per calendar year
Partial Hospitalization/Intensive Outpatient	Not covered
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	50% up to 20 visits or 40 visits per calendar year following inpatient treatment; no credit toward out-of-pocket
SUBSTANCE ABUSE CARE	
Inpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	80% up to 45 days per inpatient treatment; pre-certification required
Partial Hospitalization/Intensive Outpatient	Not covered
Halfway House	Not covered
Outpatient Care (No credit toward medical plan deductible and out-of-pocket expenses.)	80% up to 60 visits; 20 visits can be used for family
Claim Submission	Required; submitted by claimant to Aetna
UTILIZATION MANAGEMENT	
Inpatient Pre-certification	Employee initiated
Failure to Pre-certify Inpatient	50% of hospital charges up to $1,000 (no credit toward out-of-pocket maximum)
Outpatient Pre-certification	Not required
Failure to Pre-certify Outpatient	Not applicable
Claim Submission	Required; submitted by claimant

In-Network and Out-of-Network Maximums

Aetna PPO, Cornell Program for Healthy Living, and the Aetna HSA Plan: Maximums indicated are a combined limit for in-network and out-of-network services. (Mental health and substance abuse benefits, visits and day limits are combined.)

HealthNow PPO: the in-network and out-of-network calendar year maximums are not combined. (Mental health and substance abuse benefits, visits and day limits are combined.)

***Note from the comparison charts:** the out-of-network reimbursement limit for the HealthNow PPO Plan and the Aetna PPO Plan, Aetna HSA Plan, and reimbursement under the Aetna 80/20 Plan, are subject to reasonable and customary (R&C) limits.

Amounts over R&C are not applicable to the deductible and out-of-pocket maximums. Please call Benefit Services at (607) 255-3936 if you have any questions.

CPHL Wellness Benefit Copays

As indicated in the chart on page 1, initial PCP wellness services (1-4) are covered at 100%; enrollees pay no copay for those services. Those services for which your PCP refers you in order to improve your health are covered at 100% after you pay the copay of $12, per session or office visit.

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services are managed and administered by ValueOptions for the HealthNow PPO Plan, Aetna PPO Plan, and the Cornell Program for Healthy Living.

- To receive the in-network benefit level, you must contact a ValueOptions' provider and all care must meet ValueOptions' criteria for medical necessity. ValueOptions can be reached at (800) 895-2799.
- Inpatient care must meet medical necessity requirements. Failure to meet medical necessity requirements may result in no coverage.
- If you see an in-network provider, the provider is responsible for ensuring that all care provided meets ValueOptions' criteria for medical necessity.
- If you see an out-of-network provider, it is your responsibility to notify the provider of the need to confirm medical necessity with ValueOptions.
- Benefits do not count toward the medical plan's deductible and out-of-pocket expenses.
- The inpatient calendar year maximum of 45 days is a combined limit for both mental health and substance abuse care received in-network and out-of-network.
- The outpatient calendar year maximum of 50 days is a combined limit for both mental health and substance abuse care received in-network and out-of-network.

HSA Plan: Mental Health and Substance Abuse services are managed and administered by Aetna Behavioral Health for the HSA high deductible health plan.

- To receive the in-network benefit level, you must go to a participating provided. All care must meet Aetna Behavioral Health's criteria for medical necessity.
- Inpatient Behavioral Health: if you see a participating Aetna provider precertification is not required. If you see a non-participating provider it is your responsibility to precertify. Stays not precertified are subject to a $400 penalty.
- Outpatient Behavioral Health: members are not required to precertify outpatient care. Some intensive outpatient services do require precertification if the member is going out of network.
- The inpatient calendar year maximum of 45 days is a combined limit for both mental health and substance abuse care received in-network and out-of-network.
- The outpatient calendar year maximum of 50 days is a combined limit for both mental health and substance abuse care received in-network and out-of-network.
- To find a participating Aetna Behavioral Health provider, call Aetna at (800) 424-4047.

Prescription Drug Program

The Prescription Drug Programs for the Cornell Program for Healthy Living Plan, the Aetna PPO Plan, the HealthNow PPO Plan, and the Aetna 80/20 Plan are administered by Medco.

The Aetna HSA Plan is also administered by Medco. For information on which drugs are considered preventive and not subject to the deductible in the HSA Plan, go to <http://ohr.cornell.edu/benefits/programs/endowHealthHSA.html>.

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Produced by the Division of Human Resources at Cornell University

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