Schedule of Benefits

Employer:	**Cornell University**
ASA:	397366
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Schedule:	8A
Booklet Base:	8

For: Cornell Program for Healthy Living

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	CPHL ENHANCED WELLNESS AND IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	None	$400
Family Deductible*	None	$800

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties, non-**covered expenses** and charges over the **Recognized charge**.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $2,000.
- For **out-of-network** expenses: $3,500.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $4,000.
- For **out-of-network** expenses: $7,000.

Lifetime Maximum Benefit per Person	Unlimited	Unlimited

How the Cornell Program for Healthy Living Works

The Cornell Program for Healthy Living (CPHL) is a comprehensive health plan that encourages your progress to healthier living. This is achieved by focusing on your total health through an Enhanced Wellness Program. There are two components: the underlying Medical Plan and the Enhanced Wellness Program.

Highlights of the Medical Plan (Choice POSII)

	In-Network	**Out-of-Network**
Level of Health Plan Support	Higher so you pay less out of pocket: No Deductible $20 office visit copay 90% for other services *Pharmacy is administered by Optum RX*	Lower so you pay more out of pocket: $400 deductible 80% thereafter *Pharmacy is administered by Optum RX*
PCP Requirement	Applies to enhanced wellness benefit only (see back page for details).	N/A
Referral Requirement to a Specialist	No referrals needed.	No referrals needed.
Preventive Care	Covered at 100%, regardless of where you live and the network PCP you choose.	Covered at 80% after deductible.
Broad National Network of Physicians and Hospitals	Fully available at discount prices.	You may use out-of-network providers but it will cost you more.
Balance Billing *(the amount billed by your provider that is over the insurance company's allowed amount)*	Providers have agreed not to bill you over allowed amount.	Providers are free to bill you over the allowed amount.
Certification for Inpatient Hospital and Other Medical Services	Participating provider precertifies for you.	You precertify by calling the toll-free number on your ID card. Failure to precertify may result in substantially reduced benefits.
Claim Forms to File	No.	Yes.

The Enhanced Wellness Program

The Enhanced Wellness Benefits are available only if you chose to utilize a PCP from a select list of Ithaca based In-Network Providers. Please note: there is NO PCP selection required if you and your family members elect not to take part in the Enhanced Wellness Exam and related services.

Step 1 **To Receive an Enhanced Wellness Exam** ***Select a PCP***	All covered family members, including children, must select a PCP from a select list of Ithaca based In-Network providers if you would like to take advantage of the Enhanced Wellness Program. These PCPs have committed to support this plan and a play a pivotal role in helping you reach your wellness goals for the year. You can select your PCP at the time of enrollment through Benefit Services, or after enrollment through Aetna Navigator or by calling Aetna Member Services at 1-877-371-2007. You can find the names of the Ithaca based PCP's at https://www.hr.cornell.edu/benefits/health/cphl_directory.pdf.
Step 2 ***Schedule Physical Exam and Lab Work***	You and your enrolled adult family members (spouse, domestic partner and children ages 1 and over) schedule annual comprehensive physical exam(s) and lab work with your Enhanced Wellness PCP unless otherwise directed by your PCP. Your comprehensive exam and routine preventive lab work are covered at 100%.
Step 3 ***Complete a Sustainable Health Questionnaire SHQ/HRA***	You and your enrolled adult family members (spouse, domestic partner and children ages 18 and over) will complete a Sustainable Health Questionnaire (SHQ)/Health Risk Assessment (HRA) once a year. This SHQ/HRA must be completed no more than one week prior to your annual comprehensive physical exam with your PCP. Children age 1 through 17 will complete a pediatric assessment in their PCP's office.
Step 4 ***Comprehensive Exam and Wellness Report***	Once you have completed your SHQ/HRA, you are ready for a comprehensive physical exam and a review of your SHQ results with your Enhanced Wellness PCP. There is no cost to you. Once the exam and review have been completed, your PCP will provide you with an Annual Wellness Report from which you and your PCP will develop a healthy living action plan.
Step 5 ***The Healthy Living Wellness Resources***	Your Wellness Report and healthy living action plan may include referrals to local resources, or to additional services within your PCP's office, to assist you in achieving your goals. These additional services for smoking cessation, nutritional counseling and diabetic education are covered at 100%. In addition, if you have medical complications or need special attention, your PCP may refer you to the Cayuga Center for Healthy Living (CCHL) for advanced wellness counseling and support for the following services. The costs for these services at CCHL are ➢ Health Behavior Assessment $20 copay ➢ Health Risk Assessment Interpretation $20 copay ➢ Medically Supervised Exercise $20 copay ➢ Team Conference $20 copay ➢ Preventive Medical Counseling $20 copay ➢ Stress Management $20 copay Faculty and Staff are also eligible to receive a $15 monthly discount from either the Ithaca YMCA, Island Fitness or the Cornell Wellness Program (the discount makes the Cornell Wellness free). Spouses and domestic partners who are Cornell employees are eligible if they are covered under CPHL. The CPHL Aetna ID Card and Cornell ID are required to be presented to the fitness centers to confirm eligibility for the discount.
Step 6 ***Follow-up Visits***	Following your Enhanced Wellness exam, your PCP may decide to have you return for up to 3 monitoring or counseling check-ups during the year. These extra visits are also covered at 100% under the Enhanced Wellness benefit. You are strongly encouraged to see your Enhanced Wellness PCP at least once every year to complete steps 2-5 above unless otherwise directed by your PCP.

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Benefits			
Routine Physical Exams			
Office Visits	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*
Covered Persons ages 3 to 19: Maximum Visits per Calendar Year	4 visits	1 visit	1 visit
Covered Persons age 19 and over: Maximum Visits per Calendar Year	4 visits	1 visit	1 visit

Preventive Care Immunizations			
Performed in a facility or ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	100% per visit No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	80% per visit after Calendar Year **deductible** Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*
Screening & Counseling Services - ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Obesity and/or Healthy Diet			
Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	Unlimited	26 visits *(however, of these only* 10 *visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)**	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardio cardiovascular and diet-related chronic disease)**

*****Note: ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.***

Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	Same as In-Network	5 visits *	5 visits *

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products Maximum Visits per Calendar Year	Same as In-Network	8 visits *	8 visits *

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Sexually Transmitted Infections Benefit Maximums Maximum Visits per Calendar Year	Same as In-Network	2 visits *	2 visits *

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Lung Cancer Screening Maximum	Same as In-Network	One screening every 12 months*	One screening every 12 months*

****Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.***

Routine Cancer Screenings Outpatient	Same as In-Network	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.*

Well Woman Preventive Visits			
Office Visits Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	Same as In-Network	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**
Well Woman Preventive Visits			
Maximum Visits per Calendar Year	Same as In-Network	1 visit	1 visit
Prenatal Care Office Visits	Same as In-Network	100% per visit No **deductible** applies.	80% per visit after Calendar Year **deductible**
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			
Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services - Facility or Office Visits	Same as In-Network	100% per visit No **deductible** applies.	80% per visit after Calendar Year **deductible**
Lactation Counseling Services Maximum Visits either in a group or individual setting	Same as In-Network	6* visits per **Calendar Year**	Not Applicable
***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.			
Breast Pumps & Supplies *Electric Breast Pump limited to 1 per 36 months*	Same as In-Network	100%per item. No copay or deductible applies.	80% per item after Calendar Year **deductible**
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.			
Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	Same as In-Network	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	Same as In-Network	2* visits per 12 months	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*			
Family Planning Services - Female Contraceptives			
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed by a **Physician** during an-Office Visit.	Same as In-Network	100% per item No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Family Planning Services - Other Voluntary Termination of Pregnancy			
Outpatient	Same as In-Network	90% per visit No Calendar Year **deductible.**	80% per visit after Calendar Year **deductible.**
Voluntary Sterilization for Males			
Outpatient	Same as In-Network	90% per visit No Calendar Year **deductible.**	80% per visit after Calendar Year **deductible.**
Family Planning Services - Female Voluntary Sterilization			
Inpatient	Same as In-Network	100%per visit. No **copay** or **deductible** applies.	80%per visit after Calendar Year **deductible.**
Outpatient	Same as In-Network	100% per visit. No **copay** or **deductible** applies.	80%per visit after Calendar Year **deductible..**

PLAN FEATURES	**CPHL ENHANCED WELLNESS**	**IN-NETWORK**	**OUT-OF-NETWORK**
Vision and Hearing Care			
Eye Examinations (including refraction)	Same as In-Network	$20 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80%per exam after Calendar Year **deductible.**
Maximum Benefit per Calendar Year		1 exam	1 exam

Hearing Exam *Children under 19 when exam performed by the PCP*	Same as In-Network	$20 per exam **copay** then the plan pays 100% No Calendar **deductible** applies. 100% per exam No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible** 80% per visit after Calendar Year **deductible**.
Maximum Exams per 2 Calendar Years		1 exam	1 exam
Hearing Aids child age 12 and under once every two Calendar Years adults and children age 13 and over once every four Calendar Years $1,500 max per aid per ear Excludes batteries and repairs.	Same as In-Network	90% per item No Calendar **deductible** applies.	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	AETNA NETWORK	OUT-OF-NETWORK
Physician Services			
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	Same as In-Network	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible.**
Specialist Office Visits	Same as In-Network	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible.**
Physician Office Visits-Surgery	Same as In-Network	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible.**

Walk-In Clinic Visit (Non-Emergency)			
Preventive Care Services*			
Immunizations	Same as In-Network	100% per visit No **copay** or **deductible** applies For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	80% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	Same as In-Network	100% per visit No **copay** or **deductible** applies	80% per visit after Calendar Year **deductible**
Maximum Benefit per visit - individual Screening and Counseling Services for Tobacco Use	Same as In-Network	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that apply to these types of services
Individual Screening and Counseling Services for Obesity	Same as In-Network	100% per visit No **copay** or **deductible** applies	80% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Same as In-Network	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that apply to these types of services
*Important Note: Not all preventive care services are available at all **Walk-In Clinics**. The type of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.			
All Other Services	Same as In-Network	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible.**

Physician Services for Inpatient Facility and Hospital Visits	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	Same as in-Network	90% per procedure No Calendar Year **deductible** applies.	80% per procedure after Calendar **deductible**
Allergy Testing and Treatment	Same as In-Network	$20 exam copay then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar **deductible**
Allergy Injections	Same as In-Network	90% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Emergency Medical Services			
Hospital Emergency Facility and Physician	Same as In-Network	90% per visit No Calendar Year **deductible** applies	Paid the same as the Network level of benefits. See Important Note Below
Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.			
Non-Emergency Care in a Hospital Emergency Room	Same as In-Network	50% per visit No Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Same as In-Network	50% per visit No Calendar Year **deductible** applies	50% per visit after Calendar Year **deductible**
PLAN FEATURES	**CPHL ENHANCED WELLNESS**	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing			
Diagnostic Laboratory Testing			
Diagnostic Laboratory	Same as In-Network	90% per test No Calendar Year **deductible** applies	80% per test after Calendar Year **deductible**
Complex Imaging Services			
Complex Imaging	Same as In-Network	90% per procedure No Calendar Year **deductible** applies	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)			
Diagnostic X-Rays	Same as In-Network	90% per procedure No Calendar Year **deductible** applies	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgery			
Outpatient Surgery	Same as In-Network	90% per visit/surgical procedure No Calendar Year **deductible** applies	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses			
Birthing Center	Same as In-Network	90% per admission	80 per admission after Calendar. Year **deductible**
Hospital Facility Expenses			
Room and Board (including maternity)	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year		90 days	90 days

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Specialty Benefits			
Home Health Care (Outpatient)	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar **deductible**
Maximum Visits per Calendar Year	Same as In-Network	120 visits	120 visits

Skilled Nursing Care (Outpatient)	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Private Duty Nursing (Outpatient)	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Maximum Visit Limit *per Calendar Year*	Same as In-Network	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	Same as In-Network	100% per admission No Calendar Year **deductible** applies	80% per admission after the Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	Same as In-Network	100% per admission No Calendar Year **deductible** applies	80% per admission after the Calendar Year **deductible**
Maximum Benefit per lifetime	Same as In-Network	Unlimited days	Unlimited days
Hospice Outpatient Visits	Same as In-Network	100% per visit No Calendar Year **deductible** applies	80% per visit after the Calendar Year **deductible**
PLAN FEATURES	**CPHL ENHANCED WELLNESS**	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment			
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Same as In-Network	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Comprehensive Infertility Expenses	Same as In-Network	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses	Same as In-Network	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum per lifetime	$20,000	$20,000	$20,000

The AAF benefit is a limited provision expressed as a lifetime maximum dollar amount that applies to all endowed health plans one may join over time. The lifetime maximum benefit limit is $20,000 per household, meaning that the maximum lifetime benefit will not be provided more than once to an employee's household, regardless of how that household may change over time or the number of Cornell employees in the household.

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders			
MENTAL DISORDERS *Hospital Facility Expenses*			
Room and Board	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Physician Services	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders			
Outpatient Services	Same as In-Network	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80%per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Physician Services	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse			
Outpatient Treatment			
Office Visits	Same as In-Network	$20 per visit then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical			
Outpatient Obesity Treatment (non - surgical)	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	Same as In-Network	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery	Same as In-Network	90% per service No Calendar Year **deductible** applies	80% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Same as In-Network	Unlimited	Unlimited

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	90% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses			
Acupuncture in-lieu of anesthesia	Same as In-Network	$20 **copay** per service then the plan pays 100% in office setting; otherwise 90%	80% per service after Calendar Year **deductible**
Ground, Air or Water Ambulance	Same as In-Network	90% per trip No Calendar Year **deductible** applies	90% per trip after Calendar Year **deductible**
Durable Medical and Surgical Equipment	Same as In-Network	90% per item No Calendar Year **deductible** applies	80% per item after Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)			
Performed in a Physician's Office or Home Care	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Routine Patient Costs			
Performed in a Physician's Office or Home Care	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Performed in a Physician's Office or Home Care	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Prosthetic Devices	Same as In-Network	90% per item No Calendar Year **deductible** applies	90% per item after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Therapies			
Chemotherapy Performed in a Physician's Office or Home Care	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Infusion Therapy (Performed in a Physician's Office or Home Care)	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Radiation Therapy Performed in a Physician's Office or Home Care	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical and Occupational combined	Same as In-Network	90%per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies			
Speech Therapy Only	Same as In-Network	90%per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Speech Therapy Maximum visits per Calendar Year combined	Same as In-Network	50 visits	50 visits

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder			
Autism - Physical Therapy, Occupational Therapy, and Speech Therapy	Same as In-Network	90%per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Autism - Behavioral Therapy	Same as In-Network	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Autism - Applied Behavior Analysis	Same as In-Network	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Autism Speech Therapy Maximum visits per Calendar Year combined	Same as In-Network	50 visits	50 visits

Transgender Reassignment (Sex Change) Surgery
Covered expenses include charges in connection with a **medically necessary** Transgender Reassignment (sometimes called Sex Change) Surgery as long you or a covered dependent have obtained **precertification** from **Aetna**. Please refer to the Benefit Plan Booklet for additional information. You can also 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.

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Transgender Reassignment Surgery	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Office Visits (includes surgery performed in the office)	Same as In-Network	$20 per visit / surgical procedure **copay** then the plan pays 100%	80% per visit/surgical procedure after Calendar Year **deductible**.
Outpatient Treatment of Mental Disorders	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**.
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Occupational and Speech Therapy combined	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Maximum Visit Limit per *Calendar Year* for Speech Therapy only	Same as In-Network	50 visits	50 visits

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Spinal Manipulation (Chiropractor)			
	Same as In-Network	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $400 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.

OptumRX Three-Tier Prescription Drug Plan
for Endowed Faculty and Staff
Effective January 1, 2016

Tier One: **Covered generic drugs**
Tier Two: **Covered brand-name drugs on OptumRx Formulary**
Tier Three: **Covered brand-name drugs not on OptumRx Formulary****

Plan Features	**In-Network Coverage (Preferred Benefit Level)***	**Out-of-Network Coverage (Non-Preferred Benefit Level)**
Retail Pharmacy (including insulin)	Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply	Contracted rate less the applicable copay Up to 30 day supply
Home Delivery – NEW two choices: - Gannett Health Center Pharmacy on Cornell campus for safe and secure delivery, Or - Delivery to your home	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

***H S A Plan covers deductible, then copay (except preventive meds)**Some medications are excluded and alternative medications are available, check with your physician**

Prescription Contraceptives	**CPHL, PPO, H S A** **In-Network**	**CPHL, PPO, H S A** **Out of Network**
Oral contraceptives, Barrier methods (i.e. diaphragm),	$0 copay for generic or single source brand ***	Contracted rate less the applicable copay
Over the Counter Contraceptives: Female condom, sponge, spermicide, Plan B and ella (Prescription required)	Same as above for contraceptives	Same as above for contraceptives

***If not a generic or single source brand, refer to the above ES tier schedule for the 2nd or 3rd tier copays.
+ If your doctor determines that the generic or single source contraceptive would be medically inappropriate, they can prescribe a medically appropriate multisource contraceptive.

Note: Contraceptives that are injectable or implantable continue to be covered under the Aetna medical plans as part of the office visit. Under CPHL, Aetna PPO, H S A, the visit is covered at 100% in-network.

There may be additional limits on quantity or authorizations needed for medications you are taking. On or after January 1, 2016, you can find more information at **optumrx.com/myCatamaranRx**

To access the OptumRx Formulary on the OptumRx Website, there are two options. For both options you will:

1. Visit: optumrx.com/myCatamaranRx and log in.
2. You will need to create an account (login and password) if you have not already done so.

Option 1 – Drug List - defines the copayment tier status of the most commonly prescribed medicines. It may not include all drugs covered by your prescription drug benefit

1. Select "Tools & Resources" (on the left side of the screen)
2. Click Forms/Documents (on the left side of the screen) and then click on "Preferred Drug List" on the page

Option 2 – Drug Lookup – allows you to search for a specific medication

1. Select "Tools & Resources" (on the left side of the screen) and then "Drug Lookup" (on the left side of the screen)
2. You can either search from the most common medications or enter a specific medication name
3. Select your medication or enter the medication name and hit "Search"
4. The drug name, available dosage, formulary status and whether the drug is generic or brand name will be provided
5. Contact OptumRx Member Services at 866-533-6977 with questions