Schedule of Benefits

Employer:	**Cornell University**
ASC:	397366
Issue Date:	September 1, 2010
Effective Date:	September 1, 2010
Schedule:	11A
Booklet Base:	11

For: 80/20 Plan for Retired Employees Over Age 65 and Dependents

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

Comprehensive Medical Plan – 80/20 Plan

PLAN FEATURES	
Calendar Year **Deductible***	$500
Family Deductible*	$1,000

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

Individual Out of Pocket Maximum: $3,500

Family Out of Pocket Maximum: $7,000

The **Out-of-Pocket Maximum** includes the plan **deductible** but excludes **precertification** penalties.

PLAN FEATURES	
Lifetime Maximum Benefit	Unlimited

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 That Follows.

PLAN FEATURES	
Wellness Benefits	
Routine Physical Exams – Adults *(coverage for employees only)* Includes coverage for immunizations.	80% No **deductible** applies.
Routine Physical Exam Maximum Note: Other routine services such as Prostate Specific Antigen Test, Colonoscopy, Gynecological Exam including Pap apply toward dollar maximums.	$250 every 2 years
Well Child Exams – Children to Age 3 Includes coverage for immunizations.	80% No **deductible** applies.
Well Child Exam Maximums Birth to age 3 Calendar Year Maximum	 7 exams in first year; 1 exam second year $200
Routine Hearing Exam	80% per exam after Calendar Year **deductible**
Exams per every 2 years	1 exam
Hearing Aids Child age 12 and under: $1,500 maximum per hearing aid per ear every 2 calendar years Adults and children age 13 and over: $1,500 maximum per hearing aid per year every 4 calendar years Excludes batteries and repairs	80% after Calendar Year **deductible**

PLAN FEATURES	
Routine Cancer Screenings	
Routine Mammography	80% per test No **deductible** applies.
Females age 35 - 39	1 baseline
Females age 40 - 49	1 every 2 calendar years
Females age 50 and older	1 per calendar year

PLAN FEATURES	
Vision Care	
Vision Supplies Covers first pair of glasses or contacts following cataract surgery	100%

PLAN FEATURES	
Physician Services	
Physician Office Visits *(non-surgical)*	80% per visit after Calendar Year **deductible**
Specialist Office Visits *(all Specialists except those specifically listed in this schedule)*	80% per visit after Calendar Year **deductible**
Physician Office Visit (Surgery)	80% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	80% per procedure after Calendar Year **deductible**
Allergy Injections	80% per procedure after Calendar Year **deductible**

Immunizations (when not part of the physical exam)	80% per visit after Calendar Year **deductible**
Prenatal Visits	80% per procedure after Calendar Year **deductible**
PLAN FEATURES	
Emergency Medical Services	
Hospital Emergency Facility	80% per visit after Calendar Year **deductible**
Non-Emergency Care in a Hospital Emergency Room	50% after Calendar Year **deductible**
PLAN FEATURES	
Urgent Medical Services	
Urgent Medical Care *(at a non-hospital free standing urgent care facility)*	80% per visit after Calendar Year **deductible**
Urgent Medical Care *(at other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.
PLAN FEATURES	
Outpatient Diagnostic and Preoperative Testing	
Diagnostic and Preoperative Testing (except complex imaging services)	80% per procedure after Calendar Year **deductible**
Complex Imaging Services	
Complex Imaging	80% per procedure after Calendar Year **deductible**
Diagnostic Laboratory Testing	
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)	
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**
PLAN FEATURES	
Outpatient Surgery	
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	
Inpatient Facility Expenses	
Birthing Center	80% per admission after Calendar Year **deductible**
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**

PLAN FEATURES	
Specialty Benefits	
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift

Hospice Benefits	
Hospice Care – Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**
Hospice Care (Other Expenses during a stay)	80% per admission after Calendar Year **deductible**
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Infertility Treatment	
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	80% per visit after Calendar Year deductible
Advanced Reproductive Technology (ART) Expenses or Artificially Assisted Fertilization	80% per visit after calendar year deductible
The 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.	$20,000
PLAN FEATURES	
Inpatient Treatment of Mental Disorders	
Mental Disorders	
Room and Board	80% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility	80% per admission after the Calendar Year **deductible**
Outpatient Treatment of Mental Disorders	
Outpatient Services	80% per visit after Calendar Year **deductible**
PLAN FEATURES	
Inpatient Treatment of Substance Abuse	
Hospital Facility Expenses	
Room and Board	80% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility	80% per admission after the Calendar Year **deductible**

Outpatient Services	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Obesity Treatment Surgical and Non Surgical	
Outpatient Obesity Treatment (non surgical)	80% per visit after Calendar Year **deductible**
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after Calendar Year **deductible**
Related Outpatient Morbid Obesity Surgery Services	80% per service after Calendar Year **deductible**

PLAN FEATURES	**Instutues Of Excellence Facility**
Transplant Expenses	
Facility Expenses	80% per admission after Calendar Year **deductible**
Physician Services (including office visits)	80% per admission after Calendar Year **deductible**

PLAN FEATURES	
Other Covered Health Expenses	
Acupuncture in-lieu of anesthesia	80% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	80% per visit after Calendar Year **deductible**
Prescription Drugs Covered through Medco	
Medical coverage limited to Contraceptive devices and Norplant in physician's office only	80% after Calendar Year **deductible** *Please refer to page 11 for Prescription Drug coverage through Medco*
Prosthetic Devices	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Outpatient Therapies	
Chemotherapy	80% per visit after Calendar Year **deductible**
Infusion Therapy	80% per visit after Calendar Year **deductible**
Radiation Therapy	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Spinal Manipulation	
Spinal Manipulation	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

Calendar Year Deductible
This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. The Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

The Calendar Year family **deductible** applies to you and your covered family members as a group. When the combined covered expenses of you and your family reach the family **deductible**, you and your family will be considered to have met all of your individual deductibles for that Calendar Year.

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.

Out-of-Pocket Limit
The **Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Out-of-Pocket Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year.

This plan has an Individual **Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Coinsurance Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the Family **Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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 to which a copayment is applied;
- Any **covered expenses** which are payable by **Aetna** at 50%,
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), 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**.

Calendar Year **Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

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 reduced payment percentage of 50% will apply separately to the eligible expenses incurred for each type or service.

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.

Plan Features for Prescription Drug

Prescription Drug Services

Plan Features	In-Network Coverage	Out-of-Network Coverage
	Managed by Medco	**Managed by Medco**
Local Participating Pharmacies *(including insulin; generics required when available)*	Tier 1: $5; Tier 2: $25; Tier 3: $45. Up to a 30 day supply	Reimbursed 100% of the Medco Health negotiated rate, less the applicable copay.
Home Delivery	Tier 1: $10; Tier 2: $50; Tier 3: $75. Up to a 90 day supply	Not covered

Medco has a broad network that includes more than 58,000 pharmacies nationwide, a convenient home-delivery service for easy ordering of refills, a full complement of Internet services at www.medco.com, sophisticated drug use checks and balances, a round-the-clock clinical hotline for patients, and well-trained member service representatives.

You can call Medco Member Services at 800-230-0508 or log on to www.medco.com to find out whether a particular pharmacy is participating, order identification cards, or confirm if your medication has a generic version.

You will receive a Medco Identification Card once your enrollment materials have been completed and submitted to Cornell University's Benefits Services. Note: The I.D. number is your Employee I.D. number, not your Social Security Number. If you have questions about your employee I.D. number, call Benefits Services at 607-255-3936.