Schedule of Benefits

Employer: **Cornell University**

ASA: 397366

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For: Choice POS II Retiree Pre-Medicare Health Plan for Under 65 Retirees and Dependents

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	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$150	$300
Family Deductible*	$300	$600

*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.

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

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	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams ***Office Visits***	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*
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	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.*	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	100% per visit	80% per visits after Calendar Year **deductible**
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***	No **copay** or **deductible** applies.	
Obesity and/or Healthy Diet Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	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 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	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	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	2 visits**	2 visits**
Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		
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	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit
Hearing Exam	$20 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per exam after Calendar Year **deductible**
Maximum exams every 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 maximum per hearing aid per ear Excludes batteries and repairs	100% per item No Calendar Year **deductible** applies.	100% per item No Calendar Year **deductible** applies.
Routine Cancer Screening Outpatient	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.*

Lung Cancer Screening Maximum	One screening every Calendar Year*	One screening every Calendar Year*

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.

Prenatal Care		
Office Visits	100% per visit No **copay** or **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*	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Applicable

***Important Note**: Visits in excess of the Lactation Counseling Services 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*	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 for limitations on breast pumps and supplies.

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits	100% per visit. No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	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 Visits.	100% per item. No **copay** or **deductible** applies.	80% per item after Calendar Year **deductible**

Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males Outpatient	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**
Outpatient	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction	$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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Specialist Office Visits	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery	$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	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	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	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	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	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services

***Important Note**:
Not all preventive care services are available at all **Walk-In Clinics**. The types 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	$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	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**.
Allergy Injections	90% per visit after Calendar Year **deductible**.	80% per visit after Calendar Year **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	90% per visit after the Calendar Year **deductible**	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	50% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	90% per visit after Calendar Year **deductible**	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.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	90% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Hospital Facility Expenses Room and Board (including maternity)	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits

Skilled Nursing Care (Outpatient)	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Private Duty Nursing (Outpatient)	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Maximum Visit Limit per Calendar Year	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)	100% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**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.	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible**.	80% per visit after Calendar Year **deductible**
Comprehensive Infertility Expenses	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible**.	80% per visit after Calendar Year **deductible**
Advanced Reproductive Technology (ART) Expenses	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible**.	80% per visit after Calendar Year **deductible**
Maximum per lifetime	$20,000	$20,000

The Artificially Assisted Fertilization 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 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	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery	90% per service after Calendar Year **deductible**	80% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	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 after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Ground, Air or Water Ambulance Emergency use	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**
Ground, Air or Water Ambulance Non-Emergency use	50% after Calendar Year deductible	50% after Calendar Year deductible
Durable Medical and Surgical Equipment	90% per item after the Calendar Year **deductible**	80% per item after the Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Routine Patient Costs	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Prosthetic Devices	90% per item after the Calendar Year **deductible**	80% per item after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Transgender Reassignment 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		
Inpatient Hospital Transgender Reassignment Surgery	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Office Visits (includes surgery performed in the office)	$20 per visit / surgical procedure **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit / surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Infusion Therapy	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**
Radiation Therapy	$20 per visit **copay** then the plan pays 100% in office setting; otherwise 90% after Calendar Year **deductible.**	80% per service after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Speech Therapy Maximum visits per Calendar Year (combined with Autism Speech Therapy)	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Autism - Physical Therapy, Occupational Therapy, Speech Therapy	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Autism - Behavioral Therapy	$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	$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 with Speech Therapy)	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$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

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits.*

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**.

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 a **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 a **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.

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, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

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.

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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**;
- Non-covered expenses;
- 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, 2017

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 **New: Fill up to 90 days exclusively at Gannett Pharmacy on Cornell Campus (pay $10/$60/$90 Home Delivery copay)**	Contracted rate less the applicable copay Up to 30 day supply
Home Delivery – **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, WCM-PPO, H S A** **In-Network**	**CPHL, WCM-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 OptumRx 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, WCM-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, 2017, you can find more information at https://www.optumrx.com/public/landing

If you have questions about your prescription drug coverage, contact OptumRx Member Services at 866-533-6977.