Schedule of Benefits

Employer: **Cornell University**

ASC: 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* Once family **deductible** is met, all family members will be considered as having met their **deductible** for the remainder of the Calendar Year	None	$800

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

The Maximum Out of Pocket Limit includes plan **deductible.**

The Maximum Out of Pocket Limit excludes **precertification** penalties, **copayments,** expenses paid at 50%, 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 new comprehensive health plan that encourages and facilitates 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 Express Scripts/Medco.*	Lower so you pay more out of pocket: $400 deductible 80% thereafter *Pharmacy is administered by Express Scripts/Medco.*
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 1and 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 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 Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

Covered Expenses That Are Subject To The Calendar Year Deductible Are Noted In The Schedule Below.

** The In-Network benefit level includes medically necessary care provided out of the country.*

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK*	OUT-OF-NETWORK
Wellness Benefit			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% including lab and x-ray	100% including lab and x-ray	80% per exam after Calendar Year **deductible**
Maximum Exams per Calendar Year			
Adults age 18 and over	1 exam plus 3 follow up preventive visits	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% including lab and x-ray	100% including lab and x-ray	80% per exam after Calendar Year **deductible**
Maximum Exams			
Under age 3			
first 12 months of life	7 exams	7 exams	7 exams
13th – 24th months of life	4 exams	3 exams	3 exams
25th – 36th months of life	4 exams	3 exams	3 exams
For age 3 to 18	4 exams	1 exam	1 exam
Immunizations when not part of the physical exam	Same as In-Network	100%	80% per visit after Calendar Year **deductible**
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit	100% per visit	80% per visit after Calendar Year **deductible**
Nutritional Counseling other than Screening & Counseling Services for Obesity	100% per visit	$20 per visit **copay** then the plan pays 100% in an office setting; otherwise 90%	80% per visit after Calendar Year **deductible**

Obesity Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 18 and 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 cardiovascular and diet-related chronic disease**
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
Nutritional Counseling other than for Obesity Maximum Visits per Calendar Year	Unlimited	Based on **Medical Necessity**	Based on **Medical Necessity**
Use of Tobacco Products Maximum Visits per Calendar Year	Unlimited	8 visits*	8 visits*
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	Unlimited	5 visits*	5 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings			
Routine Mammography	Same as In-Network	100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per test	100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test	1 test

Routine Digital Rectal Exam For covered males age 40 and over.	100% per test	100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test	1 test
Fecal Occult Blood Test	Same as In-Network	100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test	1 test
Sigmoidoscopy Age 50 and over	Same as In-Network	100%	80% per test after Calendar Year **deductible**
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	Same as In-Network	100%	80% per test after Calendar Year **deductible**
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Colonoscopy age 50 and over	1 test	100%	80% per test after Calendar Year **deductible**
Maximum Tests per 10 consecutive year period	1 test	1 test	1 test

All Other Routine Exams and Screenings	Same as In-Network	100%	80% per test after Calendar Year **deductible**
Maximum per Calendar Year	Subject to any age and visit limits provide for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration *For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Same	Same

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Well Woman Preventive Visits			
Routine Gynecological Exam (Including Routine Pap Smears)	Same as In-Network	100%	80% per exam / test after Calendar Year **deductible**
Maximum per Calendar Year	1 exam	1 exam	1 exam
Prenatal Visits	Same as In-Network	100%	80% per exam after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Lactation Support and Counseling Services			
Lactation Consultation	Same as In-Network	100% for the first 6 visits per year. $20 **copay** thereafter	80% per visit after Calendar Year **deductible**
Breast Pump and Supplies Electric Breast Pump 1 service maximum in 36 months	Same as In-Network	100%	80% after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services			
Family Planning Services: Contraception, Voluntary Sterilization and Abortion	Same as In-Network	90% Vasectomy and Abortion. 100% for Tubal Ligation; includes associated ancillary services and contraceptive services	80% after Calendar Year **deductible.** Includes Voluntary Sterilization, Voluntary Abortion and contraceptive services.

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Vision Care			
Eye Examinations	Same as In-network	$20 exam **copay** then the plan pays 100%	80% per exam after Calendar Year **deductible**
Maximum Benefit per every two calendar years	1 exam	1 exam	1 exam

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Hearing Care			
Routine Hearing Exam	Same as In-network	$20 exam **copay** then the plan pays 100%; 100% for hearing exam performed by PCP	80% per exam after Calendar Year **deductible**
Maximum exams per every two calendar years	Same as In-network	1 exam	1 exam
Hearing aids child age 12 and under once every two calendar years adults and children age 13 once every four calendar years $1,500 max per aid per ear Excludes batteries and repairs	Same as In-network	90%	80% after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Physician Services			
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Specialist Office Visits	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	Same as In-Network	$$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	Same as In-Network	90% per procedure	80% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	Same as In-Network	$20 exam **copay** then the plan pays 100%	80% per exam after Calendar Year **deductible**
Allergy Injections	Same as In-Network	90% per procedure	80% per procedure after Calendar Year **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	90% per visit
Non-Emergency Care in a Hospital Emergency Room	Same as In-Network	50% per visit	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%	80% after Calendar Year **deductible**
Non-Urgent Use of Urgent Care Provider *(at a non-hospital free standing facility)*	Not covered	Not covered	Not covered

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-rays (except complex imaging services)	Same as In-Network	90% per procedure	80% per procedure after Calendar Year **deductible**
Complex Imaging Services			
Complex Imaging	Same as In-Network	90% per test	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	Same as In-Network	90% per procedure	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgery			
Performed in a Physician's 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**
Performed at a Hospital Outpatient Facility	Same as In-Network	90% per visit/surgical procedure	80% per visit/surgical procedure after Calendar Year **deductible**
Performed at any other Facility	Same as In-Network	90% per visit/surgical procedure	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	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	Same as In-Network	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	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits	120 visits
Private Duty Nursing (Outpatient)	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Maximum Visit Limit per *Calendar Year*	Same as In-Network	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.
Hospice Benefits			
Hospice Care - Facility Expenses (Room & Board)	Same as In-Network	100% per admission	80% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	Same as In-Network	100% per admission	80% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited	Unlimited	Unlimited
Hospice Outpatient Visits	Same as In-Network	100% per visit	80% per visit after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited	Unlimited	Unlimited

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	$20 per visit / test **copay** then the plan pays 100% in office setting; otherwise 90%	80% per visit / test after Calendar Year **deductible**
Advanced Reproductive Technology (ART) Expenses or Artificially Assisted Fertilization	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
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.	$20,000	$20,000	$20,000

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	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Physician Services	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	Same as In-Network .	90% per visit	80% per visit after Calendar Year **deductible**

Outpatient Treatment Of Mental Disorders			
Outpatient Services	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**CPHL ENHANCED WELLNESS**	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Alcoholism and Substance Abuse			
Hospital Facility Expenses			
Room and Board	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Other than Room and Board	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Physician Services	Same as In Network	90% per admission	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible** .
Inpatient Residential Treatment Facility Expenses Physician Services	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse			
Outpatient Treatment	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical and Non Surgical			
Outpatient Obesity Treatment (non surgical)	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	Same as In-Network	90% per admission	80% per admission after Calendar Year **deductible**
Related Outpatient Morbid Obesity Surgery Services	Same as In-Network	90% per service	80% per service after Calendar Year **deductible**

Autism Spectrum Disorder
Please 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_699/0648.html.

PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
Office Visits	Same as In-Network	$20 per visit **copay** then the plan pays 100%	80% per visit after Calendar Year **deductible**.
Outpatient Treatment of Mental Disorders (includes applied behavioral analysis and behavioral therapy)	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

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

Transplant Services Facility and Non-Facility Expenses

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Facility Expenses	90% per admission	90% per admission	80% per admission after Calendar Year **deductible**
Physician (including office visits)	90% per admission	90% per admission	80% per admission after Calendar Year **deductible**

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%	90%
Durable Medical and Surgical Equipment	Same as In-Network	90% per item	80% per item after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	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**
Prosthetic Devices	Same as In-Network	$20 **copay** per item then the plan pays 100% in office setting; otherwise 90%	80% 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	80% per visit after Calendar Year **deductible**
Infusion Therapy (Performed in a Physicians 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	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	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 Therapy only	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Autism Outpatient Physical and Occupational Therapy only	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Speech Therapy only	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**
Autism Speech Therapy only	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**

Speech Therapy Maximum visits per Calendar Year combined	Same as In-Network	50 visits	50 visits
Autism Behavioral Therapy	Same as In-Network	90% per visit	80% per visit after Calendar Year **deductible**

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%	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

Out-of-Network Calendar Year Deductible

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

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**.

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;
- Expenses incurred for outpatient **prescription drugs**.
- Non-covered expenses;
- 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**.
- Any covered expenses which are payable by **Aetna** at 50%.

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.

Plan Features for Prescription Drug

Prescription Drug Services

Express Scripts (ES) Three-Tier Prescription Drug Plan for Endowed Faculty and Staff Effective January 1, 2014

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

Plan Features	In-Network Coverage (Preferred Benefit Level)	Out-of-Network Coverage (Non-Preferred Benefit Level)
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5; Tier 2: $30; Tier 3: $50. Up to 30 day supply	Reimbursed 100% of the ES negotiated rate, less the applicable copay
ES Home Delivery	Tier 1: $10; Tier 2: $60; Tier 3: $90. Up to 90 day supply renewable up to a year for home delivery	Not covered

Prescription Contraceptives	CPHL In-Network	CPHL Out of Network	Aetna PPO, Aetna HSA, Aetna 80/20 In-Network	Aetna PPO, Aetna HSA, Aetna 80/20 Out of Network
Barrier methods (i.e. diaphragm)	$0 copay for generic or single source brand*+	Reimbursed 100% of the ES negotiated rate, less applicable copay*+	Refer to the above ES Tier Schedule	Refer to the above ES Tier Schedule
Oral contraceptives	$0 copay for generic or single source brand*+	Reimbursed 100% of the ES negotiated rate, less applicable copay*+	Refer to the above ES Tier Schedule	Refer to the above ES Tier Schedule
Over the Counter Contraceptives: Female condom, sponge, spermicide, Plan B and ella (Prescription required)	$0 copay for generic or single source brand*+	Reimbursed 100% of the ES negotiated rate, less applicable copay*+	Not Covered	Not Covered

*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, the visit is covered at 100% in-network.

Please note:

- **Certain medications require prior authorization or are subject to quantity limits. Call ES's Member Services at (800) 230-0508 or log on to www.express-scripts.com. If you are a first-time user, you will need to register and provide your member ID number listed on your ES ID card.**

To access the ES Formulary on the ES Website:

1. **Visit: www.express-scripts.com and log in.**
2. **Select "Clients" (on the left side of the screen)**
3. **Scroll to the bottom and click on "interactive Preferred Prescriptions Formulary Tool"**
4. **Enter medication name (minimum of four (4) letters required, then click on "Search"**
5. **The drug name, available dosage, formulary status and whether the drug is generic or brand name will be provided.**
6. **Contact ES at (800) 230-0508 with questions.**

Grandfathered Health Plan Notice

Plan Sponsor Name: Cornell University

Cornell University considers your plan a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer or Aetna member services using the phone number on your member id card.

Your plan is governed by ERISA, so you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.