

Schedule of Benefits

Employer: Cornell University
ASA: 397366
Issue Date: December 21, 2015
Effective Date: January 1, 2016
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	CPHLENHANCED WELLNESS AND IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	None	\$400
Family Deductible*	None	\$800
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.		
Plan Maximum Out of Pocket Limit includes plan deductible and copayments .		
Plan Maximum Out of Pocket Limit excludes precertification penalties, non-covered expenses and charges over the Recognized charge .		
Individual Maximum Out of Pocket Limit:		
<ul style="list-style-type: none"> For network expenses: \$2,000. For out-of-network expenses: \$3,500. 		
Family Maximum Out of Pocket Limit:		
<ul style="list-style-type: none"> For network expenses: \$4,000. For out-of-network expenses: \$7,000. 		
<i>Lifetime Maximum Benefit per Person</i>	Unlimited	Unlimited

How the Cornell Program for Healthy Living Works

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

Highlights of the Medical Plan (Choice POSID)

	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 <i>Pharmacy is administered by Optum RX</i>	Lower so you pay more out of pocket: \$400 deductible 80% thereafter <i>Pharmacy is administered by Optum RX</i>
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 <i>(the amount billed by your provider that is over the insurance company's allowed amount)</i>	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.*

<p>Step 1 To Receive an Enhanced Wellness Exam Select a PCP</p>	<p>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.</p>
<p>Step 2 Schedule Physical Exam and Lab Work</p>	<p>You and your enrolled adult family members (spouse, domestic partner and children ages 1 and over) schedule annual comprehensive physical exam(s) and lab work with your Enhanced Wellness PCP unless otherwise directed by your PCP. Your comprehensive exam and routine preventive lab work are covered at 100%.</p>
<p>Step 3 Complete a Sustainable Health Questionnaire SHQ/HRA</p>	<p>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.</p>
<p>Step 4 Comprehensive Exam and Wellness Report</p>	<p>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.</p>
<p>Step 5 The Healthy Living Wellness Resources</p>	<p>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</p> <ul style="list-style-type: none"> ➤ 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 <p>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.</p>
<p>Step 6 Follow-up Visits</p>	<p>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.</p> <p>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.</p>

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	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Preventive Care Benefits</i>			
<i>Routine Physical Exams</i>			
<i>Office Visits</i>	100% per visit No copay or deductible applies.	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	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. <i>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.</i>	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. <i>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.</i>	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. <i>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.</i>
<i>Covered Persons ages 3 to 19: Maximum Visits per Calendar Year</i>	4 visits	1 visit	1 visit
<i>Covered Persons age 19 and over: Maximum Visits per Calendar Year</i>	4 visits	1 visit	1 visit

Preventive Care Immunizations

*Performed in a facility or
physician's office*

100% per visit

100% per visit

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

No **copay** or **deductible**
applies.

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.

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**Screening & Counseling
Services -
Office Visits
Obesity and/or
Healthy Diet**

100% per visit

100% per visit

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

No **copay** or **deductible**
applies.

No **copay** or **deductible**
applies.

**Misuse of Alcohol
and/or Drugs & Use
of Tobacco Products**

**Sexually Transmitted
Infections**

**Genetic Risk for
Breast and Ovarian
Cancer**

Obesity and/or Healthy Diet

Maximum Visits per
Calendar Year

Unlimited

26 visits (*however, of these
only 10 visits will be allowed
under the Plan for healthy diet
counseling provided in
connection with Hyperlipidemia
(high cholesterol) and other
known risk factors for
cardiovascular and diet-related
chronic disease*)*

26 visits (*however, of these
only 10 visits will be allowed
under the Plan for healthy diet
counseling provided in
connection with Hyperlipidemia
(high cholesterol) and other
known risk factors for cardio
cardiovascular and diet-related
chronic disease*)*

*(This maximum applies only
to Covered Persons ages 22 &
older.)*

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

*Misuse of Alcohol and/or
Drugs*

Maximum Visits per Calendar Year	Same as In-Network	5 visits*	5 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Use of Tobacco Products

Maximum Visits per Calendar Year	Same as In-Network	8 visits*	8 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Sexually Transmitted
Infections Benefit Maximums*

Maximum Visits per Calendar Year	Same as In-Network	2 visits*	2 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Lung Cancer Screening
Maximum*

Same as In-Network	One screening every 12 months*	One screening every 12 months*
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****Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.**

***Routine Cancer Screenings
Outpatient***

Same as In-Network	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible
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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.

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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.

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Well Woman Preventive Visits

Office Visits	Same as In-Network	100% per visit	80% per visit after Calendar Year deductible
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations		No Calendar Year deductible applies.	

Well Woman Preventive Visits

Maximum Visits per Calendar Year	Same as In-Network	1 visit	1 visit
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Prenatal Care

Office Visits	Same as In-Network	100% per visit	80% per visit after Calendar Year deductible
		No deductible applies.	

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Lactation Counseling Services - Facility or Office Visits	Same as In-Network	100% per visit	80% per visit after Calendar Year deductible
		No deductible applies.	

Lactation Counseling Services Maximum Visits either in a group or individual setting	Same as In-Network	6* visits per Calendar Year	Not Applicable
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***Important Note:** Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies	Same as In-Network	100% per item. No copay or deductible applies.	80% per item after Calendar Year deductible
<i>Electric Breast Pump limited to 1 per 36 months</i>			

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.

Family Planning Services

Female Contraceptive Counseling Services - Office Visits.	Same as In-Network	100% per visit	80% per visit after Calendar Year deductible
		No Calendar Year deductible applies.	

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	Same as In-Network	2* visits per 12 months	Not Applicable
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*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives

Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed by a Physician during an-Office Visit.	Same as In-Network	100% per item No copay or deductible applies.	80% per visit after Calendar Year deductible
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Family Planning Services - Other
Voluntary Termination of Pregnancy

Outpatient	Same as In-Network	90% per visit No Calendar Year deductible.	80% per visit after Calendar Year deductible.
Voluntary Sterilization for Males			
Outpatient	Same as In-Network	90% per visit No Calendar Year deductible.	80% per visit after Calendar Year deductible.

Family Planning Services - Female Voluntary Sterilization

<i>Inpatient</i>	Same as In-Network	100%per visit. No copay or deductible applies.	80%per visit after Calendar Year deductible.
<i>Outpatient</i>	Same as In-Network	100% per visit. No copay or deductible applies.	80%per visit after Calendar Year deductible..

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

<i>Hearing Exam</i>	Same as In-Network	\$20 per exam copay then the plan pays 100%	80% per visit after Calendar Year deductible
		No Calendar deductible applies.	
<i>Children under 19 when exam performed by the PCP</i>		100% per exam	80% per visit after Calendar Year deductible .
		No Calendar Year deductible applies	

Maximum Exams per 2 Calendar Years		1 exam	1 exam
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<i>Hearing Aids</i>	Same as In-Network	90% per item	80% per visit after Calendar Year deductible
child age 12 and under once every two Calendar Years		No Calendar deductible applies.	
adults and children age 13 and over once every four Calendar Years			
\$1,500 max per aid per ear Excludes batteries and repairs.			

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

***Walk-In Clinic Visit
(Non-Emergency)***

***Preventive Care
Services****

Immunizations	Same as In-Network	100% per visit No copay or deductible applies For details, contact your physician , log onto the Aetna website www.aetna.com , or call the number on the back of your ID card.	80% per visit after Calendar Year deductible
Individual Screening and Counseling Services for Tobacco Use	Same as In-Network	100% per visit No copay or deductible applies	80% per visit after Calendar Year deductible
Maximum Benefit per visit - individual Screening and Counseling Services for Tobacco Use	Same as In-Network	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that apply to these types of services
<i>Individual Screening and Counseling Services for Obesity</i>	Same as In-Network	100% per visit No copay or deductible applies	80% per visit after Calendar Year deductible
<i>Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity</i>	Same as In-Network	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that apply to these types of services

***Important Note:**

Not all preventive care services are available at all **Walk-In Clinics**. The type of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

<i>All Other Services</i>	Same as In-Network	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies.	80% per visit after Calendar Year deductible .
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<i>Physician Services for Inpatient Facility and Hospital Visits</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	Same as in-Network	90% per procedure No Calendar Year deductible applies.	80% per procedure after Calendar deductible
<i>Allergy Testing and Treatment</i>	Same as In-Network	\$20 exam copay then the plan pays 100% No Calendar Year deductible applies.	80% per visit after Calendar deductible
<i>Allergy Injections</i>	Same as In-Network	90% per visit No Calendar Year deductible applies.	80% per visit after Calendar deductible
PLAN FEATURES	CPHL ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility and Physician</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	Paid the same as the Network level of benefits. See Important Note Below
<p>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.</p>			
<i>Non-Emergency Care in a Hospital Emergency Room</i>	Same as In-Network	50% per visit No Calendar Year deductible	50% per visit after Calendar Year deductible

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

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

PLAN FEATURES	CPHLENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>			
<i>Birthing Center</i>	Same as In-Network	90% per admission	80 per admission after Calendar. Year deductible

<i>Hospital Facility Expenses</i>			
Room and Board (including maternity)	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
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Maximum Days per Calendar Year		90 days	90 days
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PLAN FEATURES	CPHLENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar deductible

Maximum Visits per Calendar Year	Same as In-Network	120 visits	120 visits
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<i>Skilled Nursing Care (Outpatient)</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per admission after Calendar Year deductible
<i>Private Duty Nursing (Outpatient)</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Maximum Visit Limit <i>per Calendar Year</i>	Same as In-Network	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
<i>Hospice Benefits</i>			
<i>Hospice Care – Facility Expenses (Room & Board)</i>	Same as In-Network	100% per admission No Calendar Year deductible applies	80% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	Same as In-Network	100% per admission No Calendar Year deductible applies	80% per admission after the Calendar Year deductible
Maximum Benefit per lifetime	Same as In-Network	Unlimited days	Unlimited days
<i>Hospice Outpatient Visits</i>	Same as In-Network	100% per visit No Calendar Year deductible applies	80% per visit after the Calendar Year deductible
PLAN FEATURES	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Same as In-Network	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

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

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

PLAN FEATURES	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
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Inpatient Treatment of Mental Disorders

MENTAL DISORDERS

Hospital Facility Expenses

Room and Board	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Physician Services	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

Inpatient Residential Treatment Facility Expenses

Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
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Inpatient Residential Treatment Facility Expenses Physician Services

Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
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Outpatient Treatment Of Mental Disorders

Outpatient Services

Same as In-Network	\$20 per visit copay then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible
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PLAN FEATURES	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>			
<i>Hospital Facility Expense</i>			
Room and Board	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Other than Room and Board	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Physician Services	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>			
	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>			
	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per admission after Calendar Year deductible

<i>Outpatient Treatment of Substance Abuse</i>			
<i>Outpatient Treatment</i>			
<i>Office Visits</i>	Same as In-Network	\$20 per visit then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible

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

PLAN FEATURES	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>			
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	Same as In-Network	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

<i>Outpatient Morbid Obesity Surgery</i>	Same as In-Network	90% per service No Calendar Year deductible applies	80% per service after Calendar Year deductible
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Same as In-Network	Unlimited	Unlimited
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i>			
<i>Transplant Facility Expenses</i>	90% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

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

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Performed in a Physician's Office or Home Care	Same as In-Network	\$20 per visit copay then the plan pays 100%	80% per visit after Calendar Year deductible
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible

<i>Prosthetic Devices</i>	Same as In-Network	90% per item No Calendar Year deductible applies	90% per item after Calendar Year deductible
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PLAN FEATURES	CPH ENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
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Outpatient Therapies

<i>Chemotherapy</i> Performed in a Physician's Office or Home Care	Same as In-Network	\$20 per visit copay then the plan pays 100%	80% per visit after Calendar Year deductible
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible

<i>Infusion Therapy</i> (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
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Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
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<i>Radiation Therapy</i> 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
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Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
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PLAN FEATURES	CPHLENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical and Occupational combined</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
PLAN FEATURES	CPHLENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Speech Therapy Only</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
Speech Therapy Maximum visits per Calendar Year combined	Same as In-Network	50 visits	50 visits
PLAN FEATURES	CPHLENHANCED WELLNESS	IN-NETWORK	OUT-OF-NETWORK
<i>Autism Spectrum Disorder</i>			
<i>Autism - Physical Therapy, Occupational Therapy, and Speech Therapy</i>	Same as In-Network	90% per visit No Calendar Year deductible applies	80% per visit after Calendar Year deductible
<i>Autism - Behavioral Therapy</i>	Same as In-Network	\$20 per visit copay then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible
<i>Autism - Applied Behavior Analysis</i>	Same as In-Network	\$20 per visit copay then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible
Autism Speech Therapy Maximum visits per Calendar Year combined	Same as In-Network	50 visits	50 visits

Transgender Reassignment (Sex Change) Surgery

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

You can also refer to Aetna's Clinical Policy Bulletin for a more complete list of covered services and any applicable exclusions: http://www.aetna.com/cpb/medical/data/600_699/0615.html.

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

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

Expense Provisions

The following provisions apply to your health expense plan.

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

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

Out-of-Network Provider Calendar Year Deductible

Individual

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

Family Deductible Limit

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

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

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

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

Copayments and Benefit Deductible Provisions

Copayment, Copay

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

Payment Provisions

Payment Percentage

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

Maximum Out-of-Pocket Limit

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

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

Network Provider Maximum Out-of-Pocket Limit

Individual

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

Family Maximum Out-of-Pocket Limit

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

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

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

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

Individual

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

Family Maximum Out-of-Pocket Limit

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

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

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

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

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

Precertification Benefit Reduction

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

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

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

General

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

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

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

Plan Features	In-Network Coverage (Preferred Benefit Level)*	Out-of-Network Coverage (Non-Preferred Benefit Level)
Retail Pharmacy (including insulin)	Tier 1: \$5; Tier 2: \$30; Tier 3: \$50. Up to 30 day supply	Contracted rate less the applicable copay Up to 30 day supply
Home Delivery – NEW two choices: - Gannett Health Center Pharmacy on Cornell campus for safe and secure delivery, Or - Delivery to your home	Tier 1: \$10; Tier 2: \$60; Tier 3: \$90. Up to 90 day supply renewable up to a year for maintenance/specialty meds.	Not covered

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

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

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

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

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

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

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

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

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

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

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