Schedule of Benefits

Employer: **Cornell University**

ASC: 397366

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For: Choice POS II High Deductible Health Plan with a Health Savings Account

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*		
Employee Only Coverage:		
Individual Deductible*	$1,150	$2,300
Employee and Family Coverage:		
Family Deductible*	$2,300	$4,600

*Unless otherwise indicated, any applicable Individual and or Family Plan **deductible** must be met before benefits are paid.

****-Subject to Recognized Charge**

Out-of-Pocket Maximum		
Employee Only Coverage:	$2,500	$3,500
Employee and Family Coverage:	$4,500	$6,500

Out-of-Pocket Maximum includes plan **deductible and copayments** but excludes **precertification** penalties.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

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.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	$12 exam **copay** then the plan pays 100%	80% per exam after Calendar Year **deductible**
Maximum Exams every 2 calendar years		
Adults age 19 to 65	1 exam	1 exam
Maximum Exams per every calendar year		
Adults age 65 and over	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	$12 exam copay then the plan pays 100%	80% per exam after Calendar Year **deductible**
Maximum Exams		
Under age 2		
first 12 months of life	7 exams	7 exams
13th-24th months of life	2 exams	2 exams
Maximum Exams per calendar year		
For age 2 to 19	1 exam	1 exam
Routine Gynecological Exam	$12 exam **copay** then the plan pays 100%	80% per exam after Calendar Year **deductible**
Maximum exams per Calendar Year	1 exam	1 exam

Routine Hearing Exam 1 exam every 24 months	$12 exam **copay** then the plan pays 100%	80% per exam after Calendar Year **deductible**
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	90% after Calendar Year deductible	80% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography For covered females over.	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears Including Related Lab Fees	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test

Fecal Occult Blood Test	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Sigmoidoscopy Age 50 and over	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum Tests per 5 consecutive year period	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum Tests per 5 consecutive year period	1 test	1 test
Colonoscopy age 50 and over	$12 test **copay** then the plan pays 100%	80% per test after Calendar Year **deductible**
Maximum Tests per 10 consecutive year period	1 test	1 test

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care		
Eye Examinations including refraction	$12 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

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits to non-specialist	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Specialist Office Visits *All Specialists except those specifically listed in this schedule.*	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery	90% per visit after Calendar Year **deductible**	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	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Allergy Injections	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Immunizations when not part of the physical exam	90% per procedure after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Prenatal Visits	90% per procedure after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility	90% per procedure after Calendar Year **deductible**	90% per procedure after Calendar Year **deductible**
Non-Emergency Care in a Hospital Emergency Room	50% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	90% per procedure after Calendar Year **deductible**	**8**0% per procedure after Calendar Year **deductible**
Non-Urgent Use of Urgent Care Provider *(at a non-hospital free standing facility)*	Not covered	Not covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing (except complex imaging services)	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
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)		
Performed at a Hospital Outpatient Facility	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 procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility Expenses		
Birthing Center	90% per procedure after Calendar Year **deductible**	80% per procedure 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
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. 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)	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	Unlimited
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited	Unlimited

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.	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Advanced Reproductive Technology (ART) Expenses or Artificially Assisted Fertilization	90% per visit after Calendar Year **deductible**	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
Mental Disorders	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**
Maximum Benefit per Calendar Year	45 days	45 days
Outpatient Treatment Of Mental Disorders		
Mental Disorders	90% per visit after the Calendar Year **deductible**	70% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Alcoholism and Substance Abuse		
Inpatient Treatment	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**
Maximum Days per Calendar Year	45 days	45 days
Outpatient Treatment	90% per visit after the Calendar Year **deductible**	70% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	50 visits	50 visits

Important Notice:
Both **network** and **out of network** alcoholism and substance abuse and mental illness treatment expenses accumulate toward any maximum shown above for alcoholism and substance abuse and mental illness treatment expenses.

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

Transplant Services Facility and Non-Facility Expenses			
Your coverage will be considered network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.			
PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Facility Expenses	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician (including office visits)	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Other Covered Health Expenses		
Acupuncture in-lieu of anesthesia	90% after Calendar Year **deductible**	80% per item after the Calendar Year **deductible**
Ground, Air or Water Ambulance	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**
Non Emergency Ambulance		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**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	90% per item after the Calendar Year **deductible**	80% per item after the 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
Outpatient Therapies		
Chemotherapy	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Infusion Therapy	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Radiation Therapy	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		
Outpatient Physical, Occupational and Speech Therapy combined	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	90% per visit after the Calendar Year **deductible**	80% per visit after the 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

The **deductible** is the portion of covered expenses you pay each year before the plan starts to pay benefits.

Individual Deductible
The individual **deductible** applies separately to you. Once your covered expenses reach the individual **deductible** amount in a calendar year, the plan will begin to pay benefits.

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

Network Deductible
This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. After **covered expenses** reach the **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Deductible
This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. 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.

Payment Provisions

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

Out-of-Pocket Maximum
The **Out-of-Pocket Maximum** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you meet the **Out-of-Pocket Maximum**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

This plan has an Individual and Family **Maximum Out-of-Pocket Maximum**.

For purposes of the provision, the **Individual Out-of-Pocket Maximum** applies to a person enrolled for employee only coverage (with no dependent coverage). Once the amount of eligible expenses you have paid during the Calendar Year meets the individual **Out-of-Pocket Maximum**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year.

The **Family Out-of-Pocket Maximum** applies to a person enrolled with one or more dependents. Once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the Family **Out-of-Pocket Maximum**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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**;
- Non-covered expenses;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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

Plan Features	In-Network Coverage	Out-of-Network Coverage
	Managed by Medco	**Managed by Medco**
Local Participating Pharmacies (including insulin; generics required when available)	Tier 1: $5 Tier 2: $20 Tier 3: $40 Up to a 30 day supply Deductible waived for preventative medications.	Deductible then reimbursed 100% of the Medco Health negotiated rate, less the applicable copay. Deductible waived for preventative medications.
Home Delivery	Tier 1: $10 Tier 2: $40 Tier 3: $60 Up to a 90 day supply Deductible waived for preventative medications	Not covered

Preventative medications are not subject to the deductible. Please refer to Medco's Preventative Medication List for examples of your plan's preventative medications by drug category. This list includes both medications that are always prescribed for prevention and medications that are sometimes prescribed for prevention but may also be prescribed for treatment of an existing condition.

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

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

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