### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,600 individual/$3,200 family – In-network $3,200 individual/$6,400 family – Out-of-network</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive services.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$3,575 individual/$7,150 family – In-network $7,150 individual/$14,300 family – Out-of-network</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, and health care this plan does not cover do not apply to your total out of pocket limit.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. For a list of in-network providers, visit Aetna’s DocFind at <a href="http://ohr.psu.edu/benefits">http://ohr.psu.edu/benefits</a> or the public DocFind at <a href="http://www.aetna.com">www.aetna.com</a>. You can also call the Penn State Aetna Concierge Team at 1-855-878-4197.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>

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**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

#### The Pennsylvania State University: PPO Savings (Technical Services)

**Coverage Period:** 01/01/2018 – 12/31/2018

**Coverage for:** Individual & Family | **Plan Type:** HDHP

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**Summary of Benefits and Coverage:**

- **What this Plan Covers & What You Pay For Covered Services**

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**Network Provider (You will pay the least)**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Preventive care/screening/immunization</td>
<td>No Charge for preventive services</td>
<td>30% coinsurance for preventive services</td>
<td></td>
<td>One routine physical per calendar year. Please refer to your preventive schedule for additional information.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td>Requires pre-approval by the plan.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1- Typically Generic drugs</td>
<td>Retail- 10% coinsurance</td>
<td>Not covered</td>
<td></td>
<td>Retail covers up to a 31 day supply</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>Retail- 20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td>Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are included in the deductible. Dispense as written penalties apply when the member request no substitution.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 40% coinsurance</td>
<td>Not covered</td>
<td></td>
<td>Retail covers up to a 31 day supply</td>
</tr>
</tbody>
</table>

**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits)
### Summary of Benefits and Coverage:

**What this Plan Covers & What You Pay For Covered Services**

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**The Pennsylvania State University: PPO Savings (Technical Services)**

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**Coverage Period:** 01/01/2018 – 12/31/2018

**Coverage for:** Individual & Family | **Plan Type:** HDHP

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<table>
<thead>
<tr>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Preferred- 20% coinsurance with a $65 minimum Non-Preferred- 40% coinsurance with a $100 minimum</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

- **Services You May Need**
  - Habilitation services
  - Skilled nursing care
  - Durable medical equipment
  - Hospice services

- **Services Your Plan Generally Does NOT Cover**
  - Acupuncture
  - Cosmetic Surgery

- **Other Covered Services**
  - Bariatric Surgery (requires pre-approval)
  - Chiropractic Care

- **Excluded Services & Other Covered Services**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 100 days per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined network and out-of-network: $300 maximum for wigs (cancer diagnosis only) per lifetime.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
</tbody>
</table>

#### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric Surgery (requires pre-approval)
- Hearing aids
- Non-emergency care when traveling outside of the U.S. (subject to deductible/coinsurance and balance billing)
- Infertility treatment (requires pre-approval)
- Private-duty nursing
- Coverage provided outside the United States

#### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Aetna at 1-855-878-4197. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

#### Questions:

Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
The Pennsylvania State University: PPO Savings (Technical Services)

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Individual & Family | Plan Type: HDHP

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-855-878-4197. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ The plan’s overall deductible $1600</td>
<td>■ The plan’s overall deductible $1600</td>
<td>■ The plan’s overall deductible $1600</td>
</tr>
<tr>
<td>■ Specialist coinsurance 10%</td>
<td>■ Specialist coinsurance 10%</td>
<td>■ Specialist coinsurance 10%</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance 10%</td>
<td>■ Hospital (facility) coinsurance 10%</td>
<td>■ Hospital (facility) coinsurance 10%</td>
</tr>
<tr>
<td>■ Other coinsurance 10%</td>
<td>■ Other coinsurance 10%</td>
<td>■ Other coinsurance 10%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Example Cost $12,600</td>
<td>Total Example Cost $7,000</td>
<td>Total Example Cost $1,800</td>
</tr>
<tr>
<td>In this example, Peg would pay:</td>
<td>In this example, Joe would pay:</td>
<td>In this example, Mia would pay:</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>Cost Sharing</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td>Deductibles $1,600</td>
<td>Deductibles $1,600</td>
<td>Deductibles $1,600</td>
</tr>
<tr>
<td>Copayments $0</td>
<td>Copayments $0</td>
<td>Copayments $0</td>
</tr>
<tr>
<td>Coinsurance $1,300</td>
<td>Coinsurance $30</td>
<td>Coinsurance $20</td>
</tr>
<tr>
<td>What isn’t covered $100</td>
<td>What isn’t covered $4,300</td>
<td>What isn’t covered $0</td>
</tr>
<tr>
<td>The total Peg would pay $3,00</td>
<td>The total Joe would pay $6,00</td>
<td>The total Mia would pay $1,800</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The plan would be responsible for the other costs of these EXAMPLE covered services.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4525.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HMO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).


Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjihën shqipe telefononi falas në 1-800-370-4526.
Amharic - ያስቃወ ክቡር ከ የተረጠ እን ከተጠ ከ 1-800-370-4526 ገጥፋ ፋርወ ሰው እላክ ቤት
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - Լուծանորեն գուրգական բաներին (համաձայն) կարգի 1-800-370-4526 կարգի գնով;
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba uronera urugufasha mu Kirundi, twakwwe ku yì no mëro 1-800-370-4526 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনিমূল্য 1-800-370-4526-তে করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - အာလိုအားလိုမော်သည့် တွေငါးသော 1-800-370-4526 နှင့် အတူ လိုက်ပြောပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), âgang 1-800-370-4526 sin gâstu.
Cherokee - ᓯᏰᎳᎴ ᎦᏓᎳ ᎨᏓᏳᎷ ᎨᏓᏳ giác ᎪᏓᏴ 1-800-370-4526 ᎨᏓ Ᏸ ᎨᎬᏲ ᎨᏓᏱ ᎨᏓᏱ ᏰᏱᏲ. ᏰᏱᏲ. ᏰᏱᏲ.
Chinese - 想取得繁體中文語言協助, 請撥打 1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi' paya hina 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuu fakkokoksaa bilbila 1-800-370-4526 irratti bilisan bilbila.
Dutch - Bel voor tolk- en vertaalhulp in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn assistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય માંડો ક્લીન્યા પણા પરસ્પર પરા 1-800-370-4526 પર કોન્ટેક્ટ કરો.
No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole ia kēia kōkua nei.

Hindi - हलिदै में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lu Hmoob lu dawb tau rau 1-800-370-4526.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwo ọ bula

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - ლათური - 1-800-370-4526 დარჩენილი ფორმატების ქართული.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.

Kru-Bassa - Be’m ké gbo-kpá-kpá dyé pidyi dé Basoo-wuñiñ wéé, dà 1-800-370-4526

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خوزستانی پیامگیری کنید.

Laotian - ពេញ្កយ៌ស៊ីប្រជាពលរដ្ឋាភិបាលដែលប្រអប់ជាមួយផ្លាស់ប្តូរ 1-800-370-4526 ដូចជាការបង្ហាញអំពី។

Marathi - तीलावा (मराठी) सहायतासाठी 1-800-370-4526 क्षमाकाळाच्या कृपालूंच्या खर्चाचालकांला.

Marshallese - Nan bōk jipa ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjcol wōnān.

Micronesian - Ohng palien sawas en souv kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer - ប្រចាំព្រះប្រពៃន្ធតាមាធាចារ្យនៃភាសាខ្មែរ 1-800-370-4526 ដើម្បីបានការណ៍បានទេ

Cambodian - T’áá shi shizaad k’ehjì bee shiká a’doowol nínźingo Diné k’ehjì koji t’áá jìjì’ek’holné 1-800-370-4526

Navajo - (Navajo) 三角語 資訊, 電話, 接通 1-800-370-4526 來找我們。

Nepali - Nepali मा निर्देशित भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन कर्नुहोस् ।

Nilotic-Dinka - Tên kuony ê thok ê Thuonjâñ col 1-800-370-4526 kecin ayôc.

Norwegian - For språkassistance på norsk, ring 1-800-370-4526 kostnadsfritt.

Parjabi - پنجابی دیں مپارسی ماہرین نے, 1-800-370-4526 ’ع معا کار ہے۔

Pennsylvania Dutch - For Helle in Deitsch, ruf 1-800-370-4526 aa. Es Aaruf koschett nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.