The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Employee Benefits Division at 814-865-1473. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call **814-865-1473** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** individual/**$500** family – In-network **$500** individual/**$1,000** family – Out-of-network The deductible does not apply to preventive services. Coinsurance amounts do not apply toward the deductible.	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.
Are there services covered before you meet your deductible?	**Yes.** Preventive services, office visits, emergency room services, urgent care, outpatient mental health, outpatient substance abuse and rehabilitation services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No.**	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.
What is the out-of-pocket limit for this plan?	**$1,250** individual/**$2,500** family – In-network out-of-pocket limit **(excludes deductible)** up to a total out-of-pocket of **$7,150** individual / **$14,300** family**.** **$2,500** individual/**$5,000** family – Out-of-network	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, prescription drug expenses and health care this plan does not cover do not apply to your total out of pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes**. For a list of in-network providers, visit Aetna's DocFind at http://ohr.psu.edu/benefits or the public DocFind at www.aetna.com. You can also call the Penn State Aetna Concierge Team at 1-855-878-4197.	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.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	———— none ————
	Specialist visit	$30 copay/visit	30% coinsurance	———— none ————
	Preventive care/screening/ immunization	No Charge for preventive services	30% coinsurance for preventive services	One routine physical per calendar year. Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	———— none ————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Requires pre-approval by the plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by calling 844-462-0203	Tier 1- Typically Generic drugs	Retail- 50% coinsurance Mail- 20% coinsurance	Not covered	Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.
	Tier 2- Typically Preferred brand drugs	Retail- 50% coinsurance Mail- 20% coinsurance	Not covered	Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.
	Tier 3- Typically Non-preferred brand drugs	Retail- 70% coinsurance Mail- 70% coinsurance	Not covered	Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.
	Specialty drugs	Preferred- 50% coinsurance with a $50 maximum Non-Preferred- 70% coinsurance with a $100 maximum	Not covered	Specialty drugs must be purchased through CVS Caremark Specialty Pharmacy. Maximum allowed per prescription is 31 days. Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	———————— none ————————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	———————— none ————————
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copayment waived if admitted as an inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	———————— none ————————
	Urgent care	$30 copay/visit	30% coinsurance	———————— none ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	May require pre-approval by the plan.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	May require pre-approval by the plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	30% coinsurance	May require pre-approval by the plan.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	$20 copay/visit	30% coinsurance	———————— none ————————
	Childbirth/delivery	10% coinsurance	30% coinsurance	May require pre-approval by the plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	professional services			
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.
	Rehabilitation services	$30 copay/visit	30% coinsurance	May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.
	Habilitation services	Not Covered	Not Covered	———————— none ————————
	Skilled nursing care	10% coinsurance	30% coinsurance	May require pre-approval by the plan. Combined in-network and out-of-network: 100 days per calendar year.
	Durable medical equipment	10% coinsurance	30% coinsurance	May require pre-approval by the plan. Combined network and out-of-network: $300 maximum for wigs (cancer diagnosis only) per lifetime.
	Hospice services	10% coinsurance	30% coinsurance	May require pre-approval by the plan.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	———————— none ————————
	Children's glasses	Not covered	Not covered	———————— none ————————
	Children's dental check-up	Not covered	Not covered	———————— none ————————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Habilitation Services
- Long-term care
- Routine foot care
- Weight loss programs

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)
• Chiropractic Care	• 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.cciio.cms.gov.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,600**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,150**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,950**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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 1-800-370-4526.

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/HNO 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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

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

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏡᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏋᎢ (ᏣᎳᎩ) ᏫᏏᎳᏛᎢᏍ 1-800-370-4526 ᎤᎾᎢ Ꮳ ᎪᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᎨᏒᎾ.
Chinese -	欲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 I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten 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 asistans 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 ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

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

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

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla

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 - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကိးဘ် ကီး 1-800-370-4526 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘူးလၢာ်စ့ၤဘဉ်

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

Kru-Bassa - Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pìɖyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǹ wɛ́ɛ, ɖá 1-800-370-4526

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

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

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuɔŋjäŋ col 1-800-370-4526 kecïn aɣöc.

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

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet 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.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - ܐܢ ܐܢܬ ܟܐ ܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ ܟܐ ܡܫܡܫܢܘܬܐ ܗܘܐ ܠܟ ܡܓܢܐ ܩܪܝ 1-800-370-4526 ܡܓܢܐ.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భషతో సయంకొరకు ఎలాంటి ఖర్చు లేకుండ **1-800-370-4526** కు కల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-800-370-4526 ʻo ʻikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu - ا ریرک ل گ تف م رپ 1-800-370-4526 ےعل کتنو اع م ین لل ری م و در

Vietnamese - **Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.**

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.