## Key Medical Plan Features (What You Pay)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>PennCare/Personal Choice PPO*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PennCare Preferred Providers</td>
</tr>
<tr>
<td>Deductible**</td>
<td>$150 individual/$450 family</td>
</tr>
<tr>
<td>HSA Seed</td>
<td>N/A</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum**</td>
<td></td>
</tr>
<tr>
<td>Copay, coinsurance, and deductible</td>
<td>$1,000 individual/$3,000 family</td>
</tr>
<tr>
<td>Maximum Lifetime Benefit**</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### Doctor's Office Visits

- **Primary care**: $20 copay / $25 copay / 40% after deductible
- **Specialist**: $30 copay / $40 copay / 40% after deductible
- **Retail Clinic**: N/A / $30 copay / 40% after deductible
- **Urgent Care Center**: N/A / $50 copay / 40% after deductible

### Preventive Screenings

- **Routine physicals**: $0 copay / $0 copay / 40% no deductible
- **Routine eye exams**: N/A / N/A / N/A
- **Routine hearing screenings**: $0 copay / $0 copay / 40% no deductible
- **Pediatric immunizations**: $0 copay for children under 18 / $0 copay for children under 18 / 40% no deductible for children under 18
- **Annual GYN exam/Pap smear**: $0 copay / $0 copay / 40% no deductible
- **Mammography**: $0 copay / $0 copay / 40% no deductible

### Maternity

- **First OB visit**: $30 copay / $40 copay / 40% after deductible
- **Prenatal care**: $0 copay / $0 copay / 40% after deductible
- **Delivery and hospital inpatient services**: 10% after deductible / 20% after deductible / 40% after deductible
- **Laboratory/pathology**: $0 copay / $0 copay / 40% after deductible
- **X-rays/radiology**: 10% after deductible / 20% after deductible / 40% after deductible
- **In vitro fertilization** (limit two cycles per family per lifetime at HUP only)*: $30 copay for first visit; then 10% after deductible / Not covered / Not covered

### Outpatient Services

- **Surgery**: 10% after deductible / 20% after deductible / 40% after deductible
- **Laboratory/pathology**: $0 copay / $0 copay / 40% after deductible
- **X-rays/radiology**: 10% after deductible / 20% after deductible / 40% after deductible

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* Pre-certification needed for certain services

** Covers medical and behavioral health/substance abuse
## Definitions

**Coinsurance:** After you meet the deductible, your health plan pays a specified percentage of the charges for covered services. You pay the remaining charges, called coinsurance.

**Copayment/Copay:** A flat per-service charge that you pay for services such as doctor visits or prescriptions.

**Deductible:** The dollar amount you must pay each year before your medical and/or dental plan begins to pay benefits for certain covered expenses. The amount of the deductible depends upon the plan you select. Each covered individual will not be charged more than the individual deductible. If multiple dependents are covered, the aggregate total of the deductibles charged for all covered members will not exceed the family deductible.

**Health Maintenance Organization (HMO):** A network of health care providers offering relatively low out-of-pocket costs. HMOs generally operate in particular geographic regions and require a Primary Care Physician to coordinate care.

**Health Savings Account (HSA):** Available only to those enrolled in the High Deductible Health Plan (HDHP), HSAs provide a pre-tax way to save for future medical expenses, including those that will occur in retirement. There is no “use it or lose it” rule with the HSA—your unused funds roll over from year to year, until you are ready to use them.

**High Deductible Health Plan (HDHP):** HDHPs offer lower premiums but require you to pay for the full cost of care until you meet an annual deductible. If you're in the HDHP, you can use a Health Savings Account (HSA) to pay for your medical expenses with pre-tax paycheck deductions.

### Plan Name

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<td>PennCare Preferred Providers</td>
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<tr>
<td>Hospitalization (semi-private room, board, surgery** and anesthesia, specialists’ care and diagnostic testing)</td>
<td>10% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 copay (waived if admitted)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$0 copay for emergency; 10% after deductible for non-emergency</td>
</tr>
<tr>
<td>Therapy Services*** (physical, speech and occupational; 60 visits per year)</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Spinal Manipulation*** (60 visits per year)</td>
<td>Not available</td>
</tr>
<tr>
<td>Home Health Care***</td>
<td>10% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Provider not currently available</td>
</tr>
</tbody>
</table>

### Behavioral Health and Substance Abuse

- **Providers**
  - In-Network (Penn Behavioral Health Staff)
  - In-Network (Penn Behavioral Health Regional Network)
  - Out-of-Network

- **Outpatient**
  - $20 copay per visit; unlimited visits if medically necessary
  - $20 copay per visit; unlimited visits if medically necessary
  - 40% after deductible; unlimited visits if medically necessary

- **Inpatient**
  - 10% after $150 individual/$450 family deductible; unlimited days if medically necessary
  - 10% after $150 individual/$450 family deductible; unlimited days if medically necessary
  - 40% after $500 individual/$1,500 family deductible; unlimited days if medically necessary

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* Pre-certification needed for certain services
** Sexual reassignment surgery is not covered under this plan but is covered only in the Aetna POS II plan
*** Visit maximums are a combination of in-network and out-of-network services
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Aetna Choice POS II*</th>
<th>Keystone/AmeriHealth HMO*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network (based on reasonable and customary fees)</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$300 individual/$900 family</td>
<td>$800 individual/$2,400 family</td>
</tr>
<tr>
<td>HSA Seed</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Copay, coinsurance, and deductible</td>
<td>$1,200 individual/$3,600 family</td>
<td>$2,400 individual/$7,200 family</td>
</tr>
<tr>
<td><strong>Maximum Lifetime Benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**Doctor’s Office Visits**

| | In-Network | Out-of-Network | In-Network |
| • Primary care | $30 copay | 40% after deductible | $25 copay |
| • Specialist | $40 copay | 40% after deductible | $35 copay with referral |
| Retail Clinic | $40 copay | 40% after deductible | $35 copay |
| Urgent Care Center | $50 copay | 40% after deductible | $50 copay |

**Preventive Screenings**

| | In-Network | Out-of-Network | In-Network |
| • Routine physicals | $0 copay | 40% after deductible | $0 copay |
| • Routine eye exams | $0 copay | 40% after deductible | $35 copay*** |
| • Routine hearing screenings | $0 copay | 40% after deductible | $0 copay for hearing screenings |
| • Pediatric immunizations | $0 copay | 40% after deductible | $0 copay |
| • Annual GYN exam/Pap smear | $0 copay | 40% after deductible | $0 copay |
| • Mammography | $0 copay | 40% after deductible | $0 copay |

**Maternity**

| | In-Network | Out-of-Network | In-Network |
| • First OB prenatal visit | $0 copay | 40% after deductible | $25 copay |
| • Prenatal Care | $0 copay | 40% after deductible | $0 copay |
| • Delivery and hospital inpatient services | 20% after deductible | 40% after deductible | 10% after deductible |
| • In vitro fertilization (limit two cycles per family per lifetime at HUP only)* | $40 copay for first visit; then 20% after deductible | N/A | $35 copay for first visit; then 10% after deductible |
| • Laboratory/pathology | $30 copay | 40% after deductible | $0 copay |
| • X-rays/radiology | $40 (routine¹) or $100 (complex²) | 40% after deductible | $40 (routine¹) or $100 (complex²) copay with referral |

**Outpatient Services**

| | In-Network | Out-of-Network | In-Network |
| • Surgery | 20% after deductible | 40% after deductible | 10% after deductible |
| • Laboratory/pathology | $30 copay | 40% after deductible | $0 copay |
| • X-rays/radiology | $40 (routine¹) or $100 (complex²) copay with referral | 40% after deductible | $40 (routine¹) or $100 (complex²) copay with referral |

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* Pre-certification needed for certain services and medical devices
** Covers medical and behavioral health/substance abuse
*** $35 allowed for contacts or prescription eyeglasses every two years (Keystone); see member handbook for vision exam benefit schedule
¹ Routine radiology procedures are those that do not require prior authorization (e.g., chest x-ray)
² Complex radiology procedures are those that require prior authorization (e.g., MRI, CT scan, PET scan)
Definitions

Out-of-Pocket Maximum: The most you have to pay out of your own pocket during the benefit year in copays and coinsurances after you meet your deductible, as long as your providers accept your plan's usual, customary, and reasonable fees (UCR). Once you reach the out-of-pocket maximum, the plan pays 100% of UCR. Out-of-pocket maximums stated by plans are based on your use of providers who accept the plan's UCR. Each covered individual will not pay more than the individual out-of-pocket maximum. If multiple dependents are covered, the aggregate total of the out-of-pocket costs paid by all covered members will not exceed the family maximum.

Preventive Care: Routine screenings to detect or prevent possible medical conditions. This includes, but is not limited to, flu shots, mammograms, and cholesterol testing.

Primary Care Physician (PCP): In an HMO, your PCP is the doctor who provides your routine care and referrals to specialists.

UCR or R&C: UCR or R&C refers to the usual, customary, and reasonable fees that providers, health care facilities or other health care professionals in the same geographical area charge for similar services. Plans that pay 100% of UCR or R&C pay 100% of the usual, customary, and reasonable fees for that service. If providers have an affiliation with the plan, they are obligated to accept the plan's UCR or R&C as payment in full. However, if providers are not affiliated with the plan, they are not obligated to accept the UCR or R&C, and you may have to pay any charges in excess of the payment made by the plan.

Referral: Authorization from a provider (typically a Primary Care Physician in an HMO) for the insured person to consult a medical specialist.

Reimbursements: Medical plans offered do NOT guarantee that all covered services will be available through preferred or in-network providers. If a preferred or in-network provider is not available, the service will be processed as an out-of-network expense. Be aware that in-network providers might refer you to providers who are outside the network. When you use an out-of-network provider, services will be processed accordingly (non-preferred or self-referred). You should always verify if the provider is in-network by calling the number on the back of your ID card.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Aetna Choice POS II*</th>
<th>Keystone/AmeriHealth HMO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization (semi-private room, board, surgery** and anesthesia, specialists’ care and diagnostic testing)</td>
<td>20% after deductible</td>
<td>10% after deductible with referral; no limit if medically necessary</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 copay (waived if admitted)</td>
<td>$150 copay (waived if admitted)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>20% after deductible</td>
<td>$0 copay for emergencies; 10% after deductible for non-emergencies</td>
</tr>
<tr>
<td>Therapy Services*** (physical, speech and occupational; 60 visits per year)</td>
<td>$40 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Spinal Manipulation*** (60 visits per year)</td>
<td>$40 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Home Health Care***</td>
<td>20% after deductible</td>
<td>10% after deductible with coordination by patient management department</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% after deductible</td>
<td>10% after deductible when medically necessary; pre-approval required</td>
</tr>
</tbody>
</table>

Behavioral Health and Substance Abuse

- Providers
  - In-Network (Penn Behavioral Health Regional Network)
  - Out-of-Network
  - Keystone HMO providers

- Outpatient
  - $30 copay per visit; unlimited visits if medically necessary
  - 40% after deductible; unlimited visits if medically necessary
  - $25 copay per visit; unlimited visits if medically necessary

- Inpatient
  - 20% after deductible; unlimited days if medically necessary
  - 40% after deductible; unlimited days if medically necessary
  - 10% after deductible per admission with referral; unlimited days if medically necessary

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* Pre-certification needed for certain services
** Sexual reassignment surgery coverage available only in the Aetna POS II plan
*** Visit maximums are a combination of in-network and out-of-network services
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Aetna High Deductible Health Plan with HSA*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>In-Network</strong> $1,500 individual/$3,000 family**</td>
</tr>
<tr>
<td><strong>HSA Seed</strong></td>
<td>$500 employee/$1,000 family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td><strong>In-Network</strong> N/A <strong>Out-of-Network</strong> N/A</td>
</tr>
<tr>
<td>• Copay</td>
<td>N/A</td>
</tr>
<tr>
<td>• Coinsurance and deductible</td>
<td>$3,000 individual/$6,000 family</td>
</tr>
<tr>
<td><strong>Maximum Lifetime Benefit</strong></td>
<td><strong>Unlimited</strong></td>
</tr>
<tr>
<td><strong>Doctor’s Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary care</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td>• Specialist</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Center/Retail Clinic</strong></td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Screenings</strong></td>
<td></td>
</tr>
<tr>
<td>• Routine physicals</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Routine eye exams</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Routine hearing screenings</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Pediatric immunizations</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Annual GYN exam/Pap smear</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Mammography</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
</tr>
<tr>
<td>• First OB prenatal visit and prenatal care</td>
<td>$0 copay 40% after deductible</td>
</tr>
<tr>
<td>• Delivery and hospital inpatient services</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td>• In vitro fertilization (limit two cycles per family per lifetime at HUP only)</td>
<td>10% after deductible N/A</td>
</tr>
<tr>
<td>• Laboratory/pathology</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td>• X-rays/radiology</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Surgery</td>
<td>10% after deductible 40% after deductible</td>
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<td>• Laboratory/pathology</td>
<td>10% after deductible 40% after deductible</td>
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<td><strong>Emergency Room</strong></td>
<td>10% after deductible 10% after deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Therapy Services† (physical, speech and occupational; 60 visits per year)</strong></td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Spinal Manipulation† (60 visits per year)</strong></td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Home Health Care‡</strong></td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>10% after deductible 40% after deductible</td>
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<tr>
<td><strong>Behavioral Health and Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>• Providers</td>
<td>Aetna network Out-of-Network</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>10% after deductible 40% after deductible</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>10% after deductible 40% after deductible</td>
</tr>
</tbody>
</table>

* Pre-certification needed for certain services
** Covers medical, behavioral health/substance abuse and prescription drug
*** Covers medical and behavioral health/substance abuse
**** Sexual reassignment surgery is not covered under this plan but is covered only in the Aetna POS II plan
† Visit maximums are a combination of in-network and out-of-network services