aetna®

GETTYSBURG COLLEGE:
Open Choice®

Coverage Period: 08/1/2023-07/31/2024

Coverage for: Individual + Family | Plan Type: PPO

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, https://www.aetnastudenthealth.com/or by calling 877-626-2308. 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 866-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $100. Out-of-Network: Individual $350.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $5,000 / Family $7,000. Out-of-Network: Individual $10,000 / Family NONE.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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. See www.aetna.com/docfind or call 877-626-2308 for a list of in-network providers.	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 a referral.

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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance after $25 copay/visit, deductible doesn't apply	20% coinsurance	None
	Specialist visit	10% coinsurance after $25 copay/visit, deductible doesn't apply	20% coinsurance	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-	Generic drugs	Copay/prescription, deductible doesn't apply: $15 (retail & mail order)	Not covered	Covers 30 day supply (retail), 90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $40 (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $75 (retail & mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
insurance/individuals-families	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.
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	10% coinsurance after $100 copay/visit, deductible doesn't apply	10% coinsurance after $100 copay/visit, deductible doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network emergency use paid the same as in-network.
	Urgent care	10% coinsurance after $50 copay/visit, deductible doesn't apply	20% coinsurance after $50 copay/visit, deductible doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 10% coinsurance after $25 copay/visit, deductible doesn't apply; other outpatient services: 10% coinsurance	Office: 20% coinsurance; other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	services described elsewhere in the SBC (i.e., ultrasound). Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	None
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes Physical, Occupational & Speech Therapy.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	10% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	1 routine eye exam/plan year to age 19.
	Children's glasses	No charge	20% coinsurance	1 pair of glasses or lenses/plan year.
	Children's dental check-up	No charge	20% coinsurance	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Chiropractic care
- Infertility treatment .
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Pennsylvania Department of Insurance, Bureau of Consumer Services, Phone: 877-881-6388, TTY/TDD: 717-783-3898, http://www.insurance.pa.gov/Consumers.

- For more information on your rights to continue coverage, contact the plan at 877-626-2308.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 877-626-2308.
- Pennsylvania Department of Insurance, Bureau of Consumer Services, Phone: 877-881-6388, TTY/TDD: 717-783-3898, http://www.insurance.pa.gov/Consumers.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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	**$100**
Specialist copayment	**$25**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,270**

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

The plan's overall deductible	**$100**
Specialist copayment	**$25**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,330**

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

The plan's overall deductible	**$100**
Specialist copayment	**$25**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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 866-393-0002.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 866-480-4161.

Albanian - Për shërbime përkthimi falas për ju, telefononi 866-480-4161.

Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 866-480-4161 ይደውሉ።

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 866-480-4161

Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 866-480-4161 հեռախոսահամարով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 866-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z’indimi atakiguzi, hamagara 866-480-4161.

Bengali-Bangala - আপনাকে বিনামূকযে ভাষা পবিকিষা পপকে হকয এই নম্বকি পেবযক ান েরুন: 866-480-4161

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 866-480-4161.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မွဳမ်ား ရရွိႏုိင္ရန္ 866-480-4161 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 866-480-4161.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 866-480-4161.

Cherokee - ᏀᎩᏍᏗ ᏚᏫᏂᎯᏍᏗ ᏅᏳᎾᏓᏡᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᏁᏗ ᏱᎩ, ᏫᏥᎯᏏᏔᏡᏏ 866-480-4161.

Chinese - 如欲使用免費語言服務，請致電 866-480-4161.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 866-480-4161.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 866-480-4161.

Dutch - Voor gratis toegang tot taaldiensten, bell 866-480-4161.

French - Afin d'accéder aux services langagiers sans frais, composez le 866-480-4161.

French Creole - Pou jwenn sèvis lang gratis, rele 866-480-4161.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 866-480-4161 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 866-480-4161.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોંર્ માટે, કોલ કરો866-480-4161.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 866-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,866-480-4161 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 866-480-4161.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 866-480-4161
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 866-480-4161.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 866-480-4161.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 866-480-4161.
Japanese -	言語サービスを無料でご利用いただくには、866-480-4161 までお電話ください。
Karen -	လၢတၢ်ကမၤနှၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖာ်လၢတအိာ်ဒီးအပှၤလၢကဘာ်ဟ့ာ်အီၤအဂီၢ်ဘာ်နှာ် ကိး 866-480-4161 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 866-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 866-480-4161
Kurdish -	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 866-480-4161
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ866-480-4161
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 866-480-4161 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 866-480-4161.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 866-480-4161.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877- 626-2308។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ 866-480-4161.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 866-480-4161 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛëï de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 866-480-4161.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 866-480-4161.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 866-480-4161.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 866-480-4161 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 866-480-4161.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 866-480-4161.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 866-480-4161 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 866-480-4161.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 866-480-4161.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 866-480-4161.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 866-480-4161.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 866-480-4161.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 866-480-4161.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 866-480-4161.

Syriac - ܟܝ ܡܣܒܩܐ ܗ̄ܘܝ ܟ̣ܠ ܝܠܦ̈ܢܐ ܕܡܬܪ̈ܓܡܢܐ ܒܠܫ̈ܢܐ ܡ̈ܓܢܐܝܬ، ܡܙܡܪ̈ܘܢ: 866-480-4161

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 866-480-4161.

Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 866-480-4161 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 866-480-4161.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 866-480-4161.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 866-480-4161.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 866-480-4161 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 866-480-4161.

Urdu - بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 866-480-4161.

Yiddish - צו צוטריט שפּראַך בּאַדינונגען אין קיין פּרייַז צו איר, רופן 866-480-4161

Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 866-480-4161.