PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES

<table>
<thead>
<tr>
<th>IN-NETWORK DESIGNATED PROVIDERS</th>
<th>OUT OF NETWORK/NON DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong> (per calendar year)</td>
<td></td>
</tr>
<tr>
<td>$500 Individual</td>
<td>$1,500 Individual</td>
</tr>
<tr>
<td>$1,000 Family</td>
<td>$3,000 Family</td>
</tr>
</tbody>
</table>

All covered expenses accumulate separately toward the preferred or non-preferred Deductible.

Unless otherwise indicated, the deductible must be met prior to benefits being payable.

Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.

Pharmacy expenses do not apply towards the Deductible.

The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.

**Member Coinsurance**

10% 30%

Applies to all expenses unless otherwise stated.

**Payment Limit** (per calendar year)

$2,500 Individual $5,500 Individual

$5,000 Family $11,000 Family

All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit.

Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses apply towards the Payment Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit.

The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.

**Lifetime Maximum**

Unlimited except where otherwise indicated.

**Payment for Non-Preferred Care**

Not Applicable

Professional: 105% of Medicare
Facility: 140% of Medicare

**Primary Care Physician Selection**

Not Applicable

Not Applicable

**Certification Requirements**

Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.

**Referral Requirement**

None

None

**Network Designations**

In order to be covered at the preferred in-network benefit level; you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.

**PREVENTIVE CARE**

<table>
<thead>
<tr>
<th>IN-NETWORK DESIGNATED PROVIDERS</th>
<th>OUT OF NETWORK/NON DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Adult Physical Exams/ Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td><strong>Routine Well Child Exams/Immunizations</strong></td>
<td></td>
</tr>
<tr>
<td>7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.</td>
<td>30%; deductible waived</td>
</tr>
<tr>
<td><strong>Routine Gynecological Care Exams</strong></td>
<td></td>
</tr>
<tr>
<td>Includes routine tests and related lab fees.</td>
<td>30%; deductible waived</td>
</tr>
</tbody>
</table>

Prepared: 10/26/2015
**Routine Mammograms**  
Covered 100%; deductible waived  
30%; after deductible

**Women's Health**  
Covered 100%; deductible waived  
30%; after deductible

Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.  
Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.

**Routine Digital Rectal Exam**  
Covered 100%; deductible waived  
30%; after deductible

**Prostate-specific Antigen Test**  
Covered 100%; deductible waived  
30%; after deductible

**Colorectal Cancer Screening**  
Recommended: For all members age 50 and over.

**Routine Eye Exams**  
1 routine exam per 24 months.  
Covered 100%; deductible waived  
30%; after deductible

**Routine Hearing Screening**  
Covered 100%; deductible waived  
30%; after deductible

**Office Visits to non-Specialist**  
$20 office visit copay; deductible waived  
30%; after deductible

Includes services of an internist, general physician, family practitioner or pediatrician.

**Specialist Office Visits**  
$30 office visit copay; deductible waived  
30%; after deductible

**Audiometric Hearing Exam**  
$30 copay; deductible waived  
30%; after deductible

1 routine exam per 24 months.

**Pre-Natal Maternity**  
Covered 100%; deductible waived  
Covered according to standard claim practice.

**Walk-in Clinics**  
$20 office visit copay; deductible waived  
30%; after deductible

Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.

**Allergy Testing**  
Member cost sharing is based on the type of service performed and the place of service where it is rendered

**Allergy Injections**  
Member cost sharing is based on the type of service performed and the place of service where it is rendered

**Diagnostic Procedures**  
Covered under Routine Adult Exams

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**DIAGNOSTIC PROCEDURES**

**Diagnostic X-ray**  
10%; after deductible  
30%; after deductible

If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.

**Diagnostic Laboratory**  
10%; after deductible  
30%; after deductible

If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.
### PLAN DESIGN & BENEFITS

**MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Designated Providers</th>
<th>Out of Network/Non Designated Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Outpatient Complex Imaging</strong></td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td><strong>EMERGENCY MEDICAL CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Provider</td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Non-Urgent Use of Urgent Care Provider</td>
<td>50%; after deductible</td>
<td>50%; after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 copay; deductible waived</td>
<td>Same as in-network care</td>
</tr>
<tr>
<td>No-Emergency Care in an Emergency Room</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Use of Ambulance</td>
<td>10%; after deductible</td>
<td>Same as in-network care</td>
</tr>
<tr>
<td>Non-Emergency Use of Ambulance</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>HOSPITAL CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Coverage</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Maternity Coverage</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Expenses</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery - Freestanding Facility</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALCOHOL/DRUG ABUSE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay; deductible waived</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convalescent Facility</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Limited to 100 days per calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>10%; after deductible</td>
<td>30%; after deductible</td>
</tr>
<tr>
<td>Limited to 90 visits per calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prepared: 10/26/2015
### Hospice Care - Inpatient
- Cost sharing: 10%; after deductible
- The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

### Hospice Care - Outpatient
- Cost sharing: 10%; after deductible
- The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

### Private Duty Nursing - Outpatient
- Cost sharing: 10%; after deductible
- Limited to 30 eight hour shifts per calendar year.
- Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

### Outpatient Physical Therapy
- Cost sharing: 10%; after deductible
- Limited to 12 visits per calendar year combined.

### Spinal Manipulation Therapy
- Cost sharing: $30 copay; deductible waived
- Limited to 6 visits per calendar year.

### Autism Behavioral Therapy
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Outpatient Mental Health benefit.

### Autism Applied Behavior Analysis
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.

### Autism Physical Therapy
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Mental Health benefit.

### Autism Occupational Therapy
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Mental Health benefit.

### Autism Speech Therapy
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Mental Health benefit.

### Autism Applied Behavior Analysis
- Cost sharing: $30 copay; deductible waived
- Covered same as any other Mental Health benefit.

### Diabetic Supplies -- (if not covered under Pharmacy benefit)
- Covered same as any other medical expense.

### Generic FDA-approved Women's Contraceptives
- Covered 100%; deductible waived
- Covered same as any other medical expense.

### Hearing Aids
- Cost sharing: 10%; after deductible
- $1,000 per 36 months

### Transplants
- Cost sharing: 10%; after deductible
- Preferred coverage is provided at an IOE contracted facility only.
- Non-Preferred coverage is provided at a Non-IOE facility.

### Bariatric Surgery
- Cost sharing: 10%; after deductible
- The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

### Other Health Care
- Cost sharing: 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".

## FAMILY PLANNING

<table>
<thead>
<tr>
<th>IN-NETWORK DESIGNATED PROVIDERS</th>
<th>OUT OF NETWORK/NON DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td>Member cost sharing is based on the type of service performed and the place of service where it is rendered.</td>
</tr>
<tr>
<td>Diagnosis and treatment of the underlying medical condition.</td>
<td>Member cost sharing is based on the type of service performed and the place of service where it is rendered.</td>
</tr>
<tr>
<td><strong>Comprehensive Infertility Services</strong></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.</td>
<td></td>
</tr>
</tbody>
</table>
**Advanced Reproductive Technology (ART)**

<table>
<thead>
<tr>
<th>Covered Status</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Covered</td>
<td>Member cost sharing is based on the type of service performed and the place of service where it is rendered</td>
</tr>
</tbody>
</table>

**Vasectomy**

Member cost sharing is based on the type of service performed and the place of service where it is rendered.

**Tubal Ligation**

Covered 100%; deductible waived

30%; after deductible

### PHARMACY

#### IN-NETWORK

- **Pharmacy Plan Type**: Aetna Value Plus Open Formulary

#### OUT-OF-NETWORK

- **Pharmacy Plan Type**: Aetna Value Plus Open Formulary

#### Retail

- **Cost Sharing for 31-90 day supply at participating pharmacies.**
  - Percentage copays will not be doubled.
  - $10 copay for formulary generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.

#### Mail Order

- **Cost Sharing for Up to a 31-90 day supply from Aetna Rx Home Delivery®.**
  - $20 copay for formulary generic drugs, $80 copay for formulary brand-name drugs, and $140 copay for non-formulary brand-name and generic drugs.

#### Aetna Value Plus Specialty Drugs

- **Cost Sharing for Up to a 31-90 day supply at participating pharmacies.**
  - $10 copay for formulary generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name and generic drugs.

**Value Plus Specialty Drug List**

Choose Generics with Dispense as Written (DAW) override - the member pays the applicable copay. If the physician requires brand, member would pay brand name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

**Plan Includes:**
- Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
- A limited list of over-the-counter medications are covered when filled with a prescription.
- Performance Enhancement Drugs (6 tablets per month)
- Value Plus Pre-certification included
- Value Plus Step Therapy included
- One transition fill allowed within 90 days of member’s effective date
- Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

### GENERAL PROVISIONS

**Dependents Eligibility**

Spouse, children from birth to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.**
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval.
• Durable medical Equipment
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-982-3862.

Translation of the material into another language may be available. Please call Member Services at 1-888-982-3862.
Gettysburg College, Inc.
Proposed Effective Date: 01-01-2016
Open Choice® (PPO) – Pennsylvania
Aetna Whole Health – Pinnacle/Wellspan

PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al 1-888-982-3862.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to www.aetna.com.

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