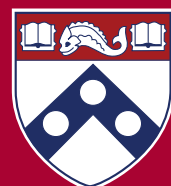


University of Pennsylvania

Benefits 2016-2017 Enrollment Guide



Penn
Human Resources

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IMPORTANT INFORMATION REGARDING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) INDIVIDUAL MANDATE

Effective January 1, 2014 under the Patient Protection and Affordable Care Act (ACA) all individuals and their family members are required to obtain health insurance or they may be subject to a tax penalty.

The health plan options listed here are provided to you, as an eligible participant in the University of Pennsylvania benefits program, and to your eligible dependents in accordance with Penn's obligation under Employer Shared Responsibility provisions of the ACA.

It is important to remember that if you waive your University coverage, you are still responsible for obtaining coverage through some other source, such as a spouse or domestic partner's plan or your parent's plan (if you are under age 26); or you can obtain coverage via the Health Insurance Marketplace.

You are required to report to the IRS that you have coverage, whether through the University or some other source. The University will provide you with the required form (1095-C) in time for your tax filing. The 1095-C form will confirm that you were offered the minimum level of coverage each month and whether you elected the coverage or waived this coverage.

More Information

You can learn more about your benefits and options from the following resources:

- Visit www.hr.upenn.edu/myhr to access plan summaries, benefit comparison charts, contribution charts, and online provider directories.
- For more specific plan questions, contact plan providers directly using the Contact Information for the Health and Welfare Plans on page 18.
- Contact the Penn Benefits Center at 1-888-PENN-BEN (1-888-736-6236), Monday–Friday, 8am–6pm EST.
- Contact Human Resources at benefits@hr.upenn.edu.

Before You Enroll

This Enrollment Guide will help you understand your benefit options so you can make informed decisions about the benefits that are right for you and your family. The information in this guide describes the benefits available to full-time faculty and staff.

Eligibility

You and your dependents are eligible for the benefits described in this enrollment guide. Eligibility for certain benefits may vary based on employment status. You will be required to provide documentation certifying the eligibility of your dependents according to Penn's plan rules. Detailed information about the documentation process can be found on the Human Resources website at www.hr.upenn.edu/myhr.

Eligible dependents include:

- Your spouse
- A same-sex domestic partner who is on your plan on or before July 1, 2016. Same-sex domestic partners enrolled in a Penn health plan prior to July 1, 2016 may remain on the plan for an additional two years, until June 30, 2018. As of July 1, 2018, same-sex domestic partners will not be eligible to remain on the plan unless a marriage certificate is submitted. Dependent children of a same-sex domestic partner may remain on the plan for two years as long as they are under age 26.
- Your biological and/or adopted children and stepchildren up to the end of the month in which they turn age 26. (Your spouse's biological and/or adopted children are eligible if they meet the age and dependent criteria.)
- Your children age 26 or older who are incapable of self-support due to a mental or physical condition that existed prior to age 26 and who were eligible for coverage as dependents prior to age 26.

How to Enroll

Simply log onto the University of Pennsylvania enrollment website at www.pennbenefits.upenn.edu. The online system will walk you through the enrollment process. To use the online enrollment system, you need your PennKey and password. If you do not have online access or are having problems enrolling online, contact the Penn Benefits Center at 1-888-PENN-BEN (1-888-736-6236), Monday–Friday, 8am–6pm EST.

New Hire Eligibility Period

When you are newly hired or become newly eligible for benefits, you have 30 days from the date your benefits become effective to enroll for health care coverage. Your healthcare coverage is effective the first day of the month following your hire date.

Changing Your Elections

Penn's plan year runs July 1–June 30. You can make changes to your elections only during the annual Open Enrollment period or when you experience a qualifying life event.

Each year, you have the opportunity to make changes to your elections during the annual Open Enrollment period. Open Enrollment generally is held in mid-April, and any changes made during this period become effective for the following plan year, beginning July 1.

The elections you make during an enrollment period stay in effect for the entire plan year unless you experience a qualifying life event change. Qualifying events include the birth or adoption of a child, marriage, domestic partnership (prior to July 1, 2016), divorce or separation, death of a dependent, and change in your dependent's eligibility for benefits. Keep in mind that the IRS limits the types of changes you can make for such events. If you experience a qualifying life event, log onto the online enrollment system at www.pennbenefits.upenn.edu to change your coverage.

Please note you must make any changes within 30 days of the event or you must wait until the next Open Enrollment period. If you have any questions, please contact the Penn Benefits Center at 1-888-PENN-BEN (1-888-736-6236), Monday–Friday, 8am–6pm EST.

Your Contributions

Your contributions for medical, dental, vision, and flexible spending accounts are made with pre-tax dollars. You pay for employee and dependent life insurance with after-tax dollars. All contributions are taken from your paycheck in the month for which your benefits are effective. Your pay must support your contributions for the benefits elected.

After You Enroll

After you've enrolled, the Penn Benefits Center will mail you a confirmation statement. Review this statement to make sure all of your information is correct. If any of your elections are listed incorrectly, call the Penn Benefits Center immediately at 1-888-PENN-BEN (1-888-736-6236).

If you elect to cover new dependents under Penn's plans, you will need to submit documentation proving that those dependents meet Penn's definition of eligibility. You will receive a personalized letter from the Penn Benefits Center with instructions on what you need to do. For more information, visit www.hr.upenn.edu/myhr/benefits/health/eligibility/verification.

You will need to submit Evidence of Insurability (EOI) information if you elected Supplemental Life Insurance exceeding \$500,000. The EOI can be completed online at www.pennbenefits.upenn.edu. Your confirmation statement will reflect the \$500,000 maximum until your EOI information has been provided.

Medical Coverage

Penn provides comprehensive medical coverage for you and your family. You may choose from four medical plan options. For more information about plan coverage details, see the Key Medical Plan Features chart beginning on page 6.

PennCare/Personal Choice PPO—This Preferred Provider Organization (PPO) plan administered by Independence Blue Cross has three components. You may receive your care through any provider you choose at any time, but your out-of-pocket costs are based on which component of the plan you're using at that time. You don't need a Primary Care Provider (PCP) or referrals for this plan.

- **PennCare Network Providers:** Use health care providers who are part of or affiliated with the University of Pennsylvania Health System (UPHS) network. Preventive care services are covered at 100%. Most other services are covered at 90% after a deductible; you pay only 10% of the covered charges.
- **Personal Choice Preferred Providers:** Use health care providers who are part of the Personal Choice network. Preventive care services are covered at 100%. Provider office visits are covered at 100% after copays. Most other services are covered at 80% after a deductible; you pay 20% of the covered charges.
- **Non-Preferred Providers:** Use health care providers who are not part of either the PennCare or Personal Choice networks. Most services, including preventive care, are covered at 60% after a deductible; you pay 40% of the covered charges.

Aetna Choice POS II—Administered by Aetna, this POS plan offers more freedom: you don't need a Primary Care Provider (PCP) or referrals for this plan, even when using in-network providers. The Aetna Choice POS II plan has two components: in-network or out-of-network. You may receive your care through any provider you choose at any time, but your out-of-pocket costs are based on which component of the plan you're using at that time.

- **In-Network Providers:** Use health care providers who are part of the Aetna Choice POS II network. Preventive care services are covered at 100%. Provider office visits are covered at 100% after copays. Most other services are covered at 80% after a deductible; you pay 20% of the covered charges.
- **Out-of-Network Providers:** Use health care providers who are not part of the Aetna Choice POS II network. Most services, including preventive care, are covered at 60% after a deductible; you pay 40% of the covered charges.

Keystone/AmeriHealth HMO—This is a managed care plan administered by Independence Blue Cross. You must select and coordinate your care through a network Primary Care Physician (PCP). You must obtain referrals from your PCP if you need to see other network providers for care. This plan does not provide coverage if you go outside the HMO network of providers. Preventive care services are covered at 100%. Office visits and most outpatient services are covered at 100% after copays. Most other services are covered at 90% after a deductible.

Aetna High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)*—This plan is designed to give you more choice and control over how you spend your health care dollars. Administered by Aetna, it has two components: in-network or out-of-network. You may receive your care through any provider you choose at any time, but your out-of-pocket costs are based on which component of the plan you're using at that time. You don't need a Primary Care Provider (PCP) or referrals for this plan.

As the name implies, this plan carries a high deductible, and you need to meet that deductible before the plan begins paying benefits. This applies to all services, including prescription drugs and office visits. However, the deductible does not apply to in-network preventive care and preventive generic prescription drugs.

This plan has an HSA: a tax savings vehicle that you can contribute to via payroll deduction and use the money to offset the cost of care. What's more, Penn will also contribute money to the HSA on your behalf—\$500 for employee-only coverage, or \$1,000 if you cover any dependents.

- **In-Network Providers:** Use health care providers who are part of the Aetna HDHP network. Preventive care services are covered at 100%. Provider office visits are covered at 100%. All services are covered at 90% after a deductible; you pay 10% of the covered charges.
- **Out-of-Network Providers:** Use health care providers who are not part of the Aetna HDHP network. Most services, including preventive care, are covered at 60% after a deductible; you pay 40% of the covered charges.

*The Aetna High Deductible Health Plan with Health Savings Account is not available to Visiting Scholars or members of Locals 54, 115 and 590.

USING UPHS PROVIDERS

No matter which medical plan you're enrolled in, most University of Pennsylvania Health System (UPHS) providers will be in-network and available for most of your health care needs. In-network providers for behavioral health may differ depending on which plan you're in, however. Please check with your providers to see if they're in-network for your plan. Go to www.pennmedicine.org/penncarenetwork for more information.

PennCare/ Personal Choice PPO	Aetna Choice POS II	Keystone/AmeriHealth HMO	Aetna High Deductible Health Plan with HSA
No PCP or referrals needed	No PCP or referrals needed	PCP and referrals required	No PCP or referrals needed
Use any provider	Use any provider	Use in-network providers only	Use any provider
Deductible must be met first for all non-preventive services. After deductible is met, out-of-pocket costs are based on whether you're using in-network or out-of-network providers.	Deductible must be met first for all non-preventive services. After deductible is met, out-of-pocket costs are based on whether you're using in-network or out-of-network providers.	Preventive office visits and most outpatient services are covered at 100% (some copays apply). Most other services are covered at 90% after a deductible.	Deductible must be met first for all non-preventive services, including non-generic prescription drugs. After deductible is met, out-of-pocket costs are based on whether you're using in-network or out-of-network providers.
Not eligible for Health Savings Account	Not eligible for Health Savings Account	Not eligible for Health Savings Account	Eligible for Health Savings Account
Eligible for Health Care Flexible Spending Account	Eligible for Health Care Flexible Spending Account	Eligible for Health Care Flexible Spending Account	Not eligible for Health Care Flexible Spending Account
Highest payroll deductions	Second highest payroll deductions	Second lowest payroll deductions	Lowest payroll deductions
Penn Behavioral Health Network	Penn Behavioral Health Network	Magellan Network	Aetna Network

BEHAVIORAL HEALTH BENEFITS

Behavioral health benefits include the categories of mental health and substance abuse benefits. The Penn behavioral health benefits allow you to maximize your mental health and substance abuse benefits by utilizing in-network providers such as psychiatrists, psychologists, psychiatric nurses or social workers, therapists or other clinicians.

Behavioral health benefits are integrated into each of the Medical Plans; however, they may not use the identical networks. See table above for the network.

Benefits allow for a range of treatment options, from individual and family counseling to substance abuse programs and inpatient treatment facilities. Coverage for Autism diagnosis and treatment is provided for all members enrolled in one of the University of Pennsylvania/Independence Blue Cross or Aetna Plans.

Benefits are based on medical necessity and are reviewed for the appropriateness of the treatment plan, which may vary due to the age of the patient. All medical and behavioral health copayments, coinsurance, deductibles, out-of-pocket maximums, and other general exclusions and limitations will apply.

WHICH MEDICAL PLAN IS RIGHT FOR YOU?

Evaluate Your Medical History and Usage

- How much and what type of health care services did you need last year?
- Will your health care needs be similar this year?
- How much do you think your out-of-pocket health care costs will be this year?

Consider Your Preferences

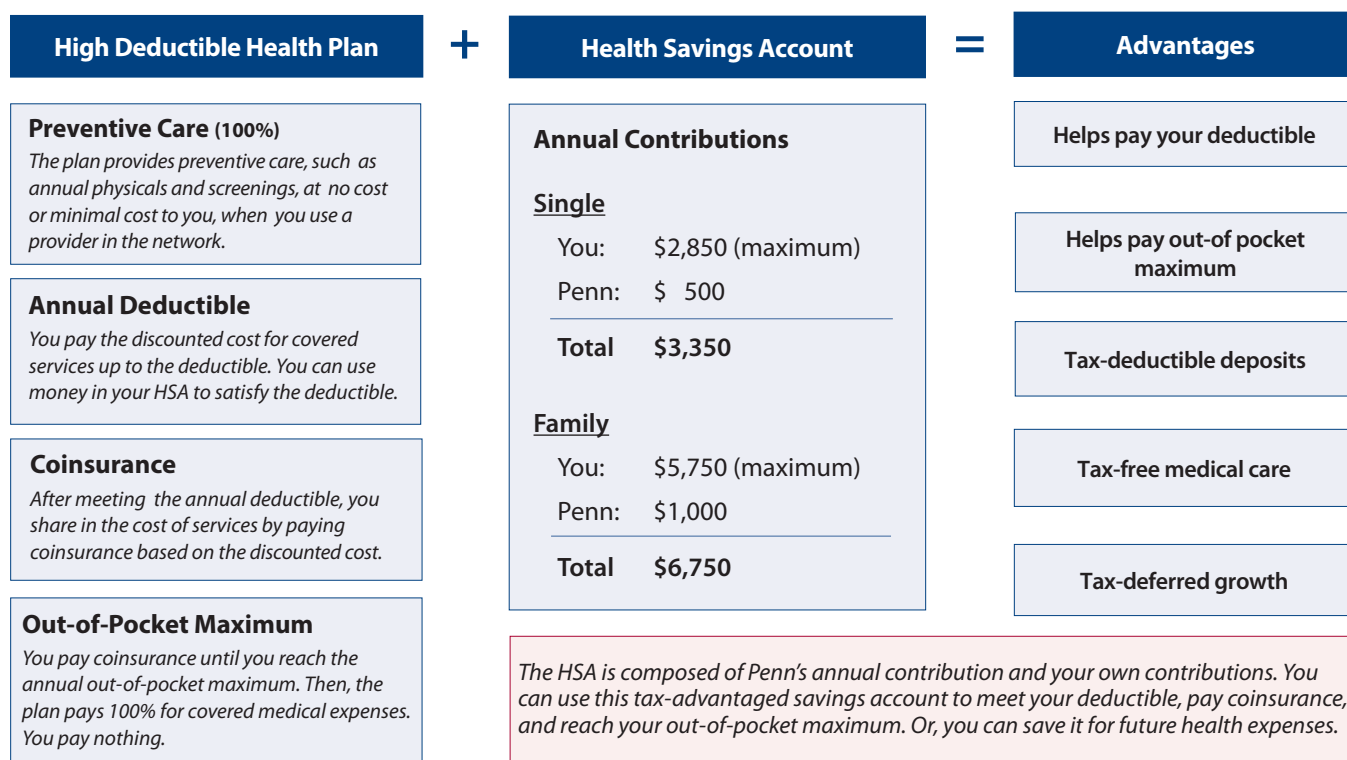
- How important is cost to you in your plan decision?
- How much of a role do you want to play in managing your health care costs?
- How much freedom and flexibility do you want when it comes to choosing providers and hospitals?
- Are you more concerned with an affordable payroll deduction, or with how much you pay when you use health care services?

Plan for the Future

- Do you have other coverage available (e.g., through your spouse's/domestic partner's employer)?
- Are you interested in receiving tax savings on money you set aside for health care expenses?
- Are you looking for a way to save for health care expenses in retirement?

How the High Deductible Health Plan with HSA Works

When you enroll in the High Deductible Health Plan, you may establish a Health Savings Account (HSA). The HSA is a pre-tax savings account you can use now to pay for eligible health care expenses for you and your eligible dependents, as well as save to pay for future health care expenses. Here's how the HDHP and the HSA work together to help protect you from big medical bills and meet your health care-related expenses.



The Health Savings Account Feature

The HSA provides a triple tax advantage: money goes in tax-free, grows tax-free and is tax-free when used to pay for eligible medical expenses. At the end of the plan year, unused money in your HSA rolls over to the next year. Once your balance reaches \$1,000, you can invest your account in a selection of investment funds through PayFlex. You can also take the money in the HSA if you leave Penn or retire. Once money is in the account, it's yours to keep or use toward eligible medical plan expenses.

Important HSA Rules

- You may not be enrolled in any other health coverage plan, including Medicare or union plans (i.e., no secondary coverage under a spouse).
- You cannot participate in the Health Care Flexible Spending Account if you elect the Aetna HDHP with HSA. Also, your spouse cannot have a health care pre-tax spending account.
- For 2016, the maximum amount you can contribute to an HSA is \$2,850 for single coverage and \$5,750 for family coverage. Penn will contribute \$500 for single coverage or \$1,000 for family coverage to your HSA.
- If you are age 55 or older, you can contribute an additional \$1,000 per year.
- Penn's contribution amount and any post-tax contributions must be counted toward the HSA limits.
- If you reach the pre-tax maximum in any year, you must stay in the Aetna HDHP for the following plan year. If you fail to do this, you'll be subject to IRS tax penalties.
- Money must be in an HSA account to receive reimbursement.
- Anyone may make post-tax contributions to your account.
- You may change your HSA pre-tax contribution amounts anytime. The 2017 contribution limits will be released later this year, and you'll be able to modify contribution levels if you like, based on revised limits.
- Please note: Expenses for domestic partners and/or children not claimed as dependents on your tax return are ineligible for reimbursement under the HSA.**

Key Medical Plan Features (What You Pay)

Plan Name	PennCare/Personal Choice PPO*		
	PennCare Preferred Providers	Personal Choice Preferred Providers	Non-Preferred Providers (based on reasonable and customary fees)
Deductible**	\$150 individual/\$450 family	\$350 individual/\$1,050 family	\$500 individual/\$1,500 family
HSA Seed	N/A	N/A	N/A
Out-of-Pocket Maximum**			
• Copay, coinsurance, and deductible	\$1,000 individual/\$3,000 family	\$2,500 individual/\$7,200 family	\$3,500 individual/\$10,500 family
Maximum Lifetime Benefit**	Unlimited	Unlimited	Unlimited
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 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

* Pre-certification needed for certain services

** Covers medical and behavioral health/substance abuse

Plan Name	PennCare/Personal Choice PPO*		
	PennCare Preferred Providers	Personal Choice Preferred Providers	Non-Preferred Providers (based on reasonable and customary fees)
Hospitalization (semi-private room, board, surgery** and anesthesia, specialists' care and diagnostic testing)	10% after deductible	20% after deductible	40% after deductible; limited to 70 days
Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Ambulance	\$0 copay for emergency; 10% after deductible for non-emergency	\$0 copay for emergency; 20% after deductible for non-emergency	\$0 copay for emergency; 40% after deductible for non-emergency
Therapy Services*** (physical, speech and occupational; 60 visits per year)	\$30 copay	\$40 copay	40% after deductible
Spinal Manipulation*** (60 visits per year)	Not available	\$40 copay	40% after deductible
Home Health Care***	10% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment	Provider not currently available	20% after deductible	40% after deductible
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

* 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

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	Aetna Choice POS II*		Keystone/AmeriHealth HMO*
	In-Network	Out-of-Network (based on reasonable and customary fees)	In-Network
Deductible**	\$300 individual/\$900 family	\$800 individual/\$2,400 family	\$100 individual/\$200 family
HSA Seed	N/A	N/A	N/A
Out-of-Pocket Maximum**			
• Copay, coinsurance, and deductible	\$1,200 individual/\$3,600 family	\$2,400 individual/\$7,200 family	\$1,200 individual/\$2,400 family
Maximum Lifetime Benefit**	Unlimited	Unlimited	Unlimited
Doctor's Office Visits			
• 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			
• 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			
• 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 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 (routine ¹) or \$100 (complex ²)	40% after deductible	\$40 (routine ¹) or \$100 (complex ²) copay with referral
Outpatient Services			
• Surgery	20% after deductible	40% after deductible	10% after deductible
• Laboratory/pathology	\$30 copay	40% after deductible	\$0 copay
• X-rays/radiology	\$40 (routine ¹) or \$100 (complex ²) copay with referral	40% after deductible	\$40 (routine ¹) or \$100 (complex ²) copay with referral

* 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)

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

* 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

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.

Plan Name	Aetna High Deductible Health Plan with HSA*	
	In-Network	Out-of-Network
Deductible**	\$1,500 individual/\$3,000 family	\$1,500 individual/\$3,000 family
HSA Seed	\$500 employee/\$1,000 family	
Out-of-Pocket Maximum**		
• Copay	N/A	N/A
• Coinsurance and deductible	\$3,000 individual/\$6,000 family	\$3,000 individual/\$6,000 family
Maximum Lifetime Benefit***	Unlimited	Unlimited
Doctor's Office Visits		
• Primary care	10% after deductible	40% after deductible
• Specialist	10% after deductible	40% after deductible
Urgent Care Center/Retail Clinic	10% after deductible	40% after deductible
Preventive Screenings		
• Routine physicals	\$0 copay	40% after deductible
• Routine eye exams	\$0 copay	40% after deductible
• Routine hearing screenings	\$0 copay	40% after deductible
• Pediatric immunizations	\$0 copay	40% after deductible
• Annual GYN exam/Pap smear	\$0 copay	40% after deductible
• Mammography	\$0 copay	40% after deductible
Maternity		
• First OB prenatal visit and prenatal care	\$0 copay	40% after deductible
• Delivery and hospital inpatient services	10% after deductible	40% after deductible
• In vitro fertilization (limit two cycles per lifetime at HUP only)	10% after deductible	N/A
• Laboratory/pathology	10% after deductible	40% after deductible
• X-rays/radiology	10% after deductible	40% after deductible
Outpatient Services		
• Surgery	10% after deductible	40% after deductible
• Laboratory/pathology	10% after deductible	40% after deductible
• X-rays/radiology	10% after deductible	40% after deductible
Hospitalization (semi-private room, board, surgery**** and anesthesia, specialists' care and diagnostic testing)	10% after deductible	40% after deductible
Emergency Room	10% after deductible	10% after deductible
Ambulance	10% after deductible	40% after deductible
Therapy Services [†] (physical, speech and occupational; 60 visits per year)	10% after deductible	40% after deductible
Spinal Manipulation [†] (60 visits per year)	10% after deductible	40% after deductible
Home Health Care [†]	10% after deductible	40% after deductible
Durable Medical Equipment	10% after deductible	40% after deductible
Behavioral Health and Substance Abuse		
• Providers	Aetna network	Out-of-Network
• Outpatient	10% after deductible	40% after deductible
• Inpatient	10% after deductible	40% after deductible

* 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

Prescription Drug Coverage (What You Pay)

The Prescription Drug Plan is administered by CVS/caremark for all medical plans. Maintenance medication and 90-day retail pick up options are available at CVS pharmacies. You may use CVS/caremark Mail Service to receive maintenance medications at your address of choice. Please note: the plan structure for prescription coverage depends on which medical plan you select.

PennCare/Personal Choice PPO, Aetna Choice POS II and Keystone/AmeriHealth HMO plans

For these three plans, the amount you pay for prescription drugs depends on how you use your coverage and the type of prescription you fill (generic, brand name with or without a generic equivalent, or a maintenance medication).

- When you purchase a prescription at a retail pharmacy, you'll pay less if you use a participating in-network pharmacy.
- If you're able to take a generic drug, you'll save money—not only will you pay a lower coinsurance amount, but that lower coinsurance is a percentage of a lower base price for the drug.
- You can use the CVS/caremark Mail Service for long-term maintenance medications. The mail order program offers several advantages including home delivery, three-month supplies, and lower minimum and maximum coinsurance amounts.

Applies to those enrolled in the PennCare/Personal Choice PPO, Aetna Choice POS II, and Keystone/AmeriHealth HMO plans				
	Generics	Brand Names With No Generic Equivalent	Brand Names With Generic Equivalent*	Specialty
Coinsurance; Minimum and Maximum Payment				
Non-Maintenance				
• 30-day supply (any network retail pharmacy)	10%; \$7.50 min/\$20 max	30%; \$15 min/\$100 max	10%+; \$15 min/\$100 max*	N/A
Maintenance				
• 30-day supply (any network retail pharmacy, up to 3 fills)**	10%; \$7.50 min/\$20 max	30%; \$15 min/\$100 max	10%+; \$15 min/\$100 max*	30%; \$15 min/\$100 max, only available at CVS pharmacy
• 30-day supply (any network retail pharmacy, after 3 fills)**	20%; \$15 min/\$40 max	60%; \$30 min/\$150 max	20%+; \$30 min/\$200 max*	N/A
• 90-day supply (CVS pharmacies or CVS Mail Service)	10%; \$15 min/\$40 max	20%; \$20 min/\$100 max	10%+; \$30 min/\$200 max*	20%; \$20 min/\$100 max
Annual Out-of-Pocket Maximum	\$2,000 individual/\$6,000 family*			

* For brand names with a generic equivalent, you pay a percentage of the brand name cost PLUS the cost difference between brand name and generic. The cost difference between brand name and generic does not count toward the minimums and maximums.

** After three 30-day fills, you will pay double the normal coinsurance amount, as well as double the minimum and maximum coinsurance payments. You can save money by ordering 90-day supplies through the CVS/caremark Mail Service program or at CVS pharmacies.

Aetna High Deductible Health Plan (HDHP) with HSA

When you enroll in the Aetna High Deductible Health Plan (HDHP), the amount you pay for prescription drugs varies only based on whether your prescription is a preventive generic drug or some other drug type. When you take generic preventive drugs, you're not subject to the deductible; for all other drugs, you must reach your deductible before the plan begins to pay benefits.

Applies to those enrolled in the Aetna High Deductible Health Plan (HDHP) with HSA	
Annual Deductible*	\$1,500 individual/\$3,000 family
Annual Out-of-Pocket Maximum*	\$3,000 individual/\$6,000 family
Preventive Generic Drugs (any retail or mail order, maintenance or non-maintenance)	10%, no deductible
Preventive Brand Name Drugs (with or without generic equivalent, any retail or mail order, maintenance or non-maintenance)	10% after deductible
Non-Preventive Drugs (generic or brand, with or without generic equivalent, any retail or mail order, maintenance or non-maintenance)	10% after deductible

* Amounts you pay toward medical and behavioral health/substance abuse also count toward the deductible and out-of-pocket maximum. After the out-of-pocket maximum is reached, all covered prescription drugs are paid at 100%.

Dental Coverage (What You Pay*)

Penn Dental Plan

The Penn Dental Plan provides coverage when you receive treatment from dentists and specialists who have appointments at any Penn Dental Family Practice location. Office locations and coverage details are available online at www.hr.upenn.edu/myhr/benefits/health/dentalandvision/dental.

MetLife Preferred Dentist Program (PDP)

The MetLife dental plan provides coverage when you receive treatment from any dentist or specialist you choose. Use MetLife preferred providers to pay less in out-of-pocket expenses because preferred providers accept the plan's negotiated fees as payment in full. MetLife dental plan coverage details are available online at www.hr.upenn.edu/myhr/benefits/health/dentalandvision/dental.

	Penn Dental Plan	MetLife Preferred Dentist Program (PDP)**	
		Preferred Provider	Non-Preferred Provider
Deductible	None	\$50 individual	\$50 individual
Diagnostic Care (e.g., exams, x-rays)*	\$0 copay	\$0 copay	\$0 copay of R&C**
Preventive Care (e.g., cleanings)	\$0 copay; limited to two visits per plan year (7/1-6/30)	\$0 copay; limited to two visits per plan year (7/1-6/30)	\$0 copay of R&C**; limited to two visits per plan year (7/1-6/30)
Restorative Care (e.g., fillings)	\$0 copay***	10% after deductible	10% of R&C** after deductible
Oral Surgery (extractions)	\$0 copay	\$0 copay after deductible	\$0 copay of R&C** after deductible
Endodontics (e.g., root canal therapy)	20%	20% after deductible	20% of R&C** after deductible
Periodontics (treatment of gums)	20%	20% after deductible	20% of R&C** after deductible
Prosthodontics**** (e.g., bridges, dentures)	40%	50% after deductible	50% of R&C** after deductible
Crowns and Restorations****	40%	50% after deductible	50% of R&C** after deductible
Implants****	50%****	50% after deductible	50% of R&C** after deductible
Orthodontics†	40% (\$2,000 individual lifetime max per child/adult)	50% (\$1,500 lifetime max per adult/child) after deductible	50% of R&C** (\$1,500 lifetime max per adult/child) after deductible
Cosmetics (e.g., veneers, microabrasion and bonding. Bleaching is excluded.)	50%	Not covered	Not covered
Plan Year Maximum (what the plan pays)	\$3,000 per individual	\$2,000 per individual	\$2,000 per individual

* Please reference the plan document for limitations and exclusions. Note that if you receive dental treatment anywhere other than a Penn Dental Plan office, no benefits will be paid unless due to an emergency that occurs outside of the Philadelphia area (outside a 100-mile radius of a Penn Dental Plan office). Reimbursement will be at the Penn Dental Plan coverage level, based on Penn Dental Plan network fees.

** Benefits at a MetLife PDP provider are based on the fee negotiated by MetLife with the provider. Your responsibility is limited to the coinsurance amounts. Non-preferred provider benefits are based on the Plan's reasonable and customary fees (R&C). Non-preferred dentists are not required to accept the plan's R&C as payment in full, so you may pay not only your coinsurance amount but also the difference between R&C and the dentist's actual charges.

*** \$35-\$55 copay applied to tooth-colored fillings on posterior teeth.

**** Coverage for a restoration (bridge, crown, removable denture or implant) of a tooth or teeth missing or extracted prior to enrollment in the Penn Dental or MetLife Plan is subject to the approval of the Clinical Director and may be denied. If the tooth was extracted or lost prior to the employment date with the University of Pennsylvania, coverage would be denied by MetLife.

† Any amounts applied to the lifetime maximums for orthodontics apply toward the annual benefit maximums as well.

Vision Coverage

You may choose between two vision coverage options: the Davis Vision plan and the VSP vision plan. Both plans provide coverage when you obtain vision care from the provider of your choice. Use in-network providers to receive higher coverage and pay less out-of-pocket. Most services are covered once every fiscal year (July 1 through June 30), although you may receive discounts for additional services provided by preferred providers. The VSP plan offers a slightly higher level of benefit and more in-network providers, but has a slightly higher payroll deduction. Coverage details are available online at www.hr.upenn.edu/myhr/benefits/health/dentalandvision/vision.

	Davis Vision Plan		
	Scheie Eye Providers	Davis Vision Providers	Out-of-Network Providers
Glasses (covered once every fiscal year)			
• Eye Exam and Refraction	\$0 copay	\$10 copay	Up to \$32 reimbursement
• Frames	Up to \$100 retail allowance or select from designer frame collection	Up to \$65 retail allowance or select from designer frame collection	Up to \$30 reimbursement
Standard Lenses			
• Single	\$0 copay	\$0 copay	Up to \$30 reimbursement
• Bifocal	\$0 copay	\$0 copay	Up to \$36 reimbursement
• Trifocal	\$0 copay	\$0 copay	Up to \$50 reimbursement
• Aphakic/Lenticular	\$0 copay	\$0 copay	Up to \$72 reimbursement
Polycarbonate Lenses			
• Single	\$0 copay if under age 19; discounted prices if age 19 and over	\$0 copay if under age 19; discounted prices if age 19 and over	Up to \$30 reimbursement
• Bifocal			Up to \$36 reimbursement
• Trifocal			Up to \$50 reimbursement
• Progressive Lenses	Discounted prices	Discounted prices	Up to \$36 reimbursement
Contact Lenses (evaluation and fitting covered once every fiscal year; contact lenses covered once every fiscal year in lieu of glasses)			
Evaluation and Fitting			
• Daily Wear	\$0 copay	\$0 copay	Up to \$20 reimbursement
• Extended Wear	\$0 copay	\$0 copay	Up to \$30 reimbursement
• Disposable	\$0 copay	\$0 copay	Up to \$75 reimbursement
Standard Contact Lenses			
• Disposable	Up to \$80 allowance	Up to \$75 allowance	Up to \$75 reimbursement
• Specialty Contact Lenses	Up to \$110 allowance	Up to \$75 allowance	Up to \$60 reimbursement
Additional Discounts (available only at the point of purchase)			
• Lens options (e.g., tints)	Discounted prices (\$0 copay for tints)	Discounted prices (\$0 copay for tints)	Not covered
• Additional Eyewear	Discounted prices	Discounted prices*	Not covered
• Laser Vision Correction**	For discounts, call Scheie Eye at 1-800-789-PENN (7366)	For discounts, call Davis Vision at 1-888-393-2583	Not covered

* Members selecting non-covered materials (e.g., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

** Laser Vision Correction is NOT a covered benefit under this vision plan. However, you are afforded discounts as noted based on whether you use a Scheie provider or a Davis provider.

	VSP Vision Plan		
	Choice Providers	Participating Scheie Locations/Providers	Out-of-Network
Glasses (covered once every fiscal year)			
• Eye Exam and Refraction	\$10 copay	\$10 copay	Up to \$45 reimbursement
• Frames	Up to \$150 retail allowance plus 20% off amount exceeding allowance (\$80 allowance at Costco)	Up to \$150 retail allowance	Up to \$70 reimbursement
Standard Lenses (covered once every fiscal year)			
• Single	\$20 copay	\$20 copay	Up to \$30 reimbursement
• Lined Bifocal			Up to \$50 reimbursement
• Lined Trifocal			Up to \$65 reimbursement
• Lined Aphakic/Lenticular			Up to \$100 reimbursement
• Polycarbonate lenses for children up to age 19	Covered in full	Covered in full	No additional reimbursement
Contact Lenses (evaluation and fitting covered once every fiscal year; contact lenses covered once every fiscal year in lieu of glasses)			
Evaluation, Fitting and Lenses			
• Daily Wear	\$20 copay for evaluation and fitting; up to \$150 allowance for contact lenses	Usual & customary fees for evaluation and fitting; up to \$150 allowance for contact lenses	Up to \$105 reimbursement (fitting, evaluation and contact lenses)
• Extended Wear			
• Disposable			
Additional Discounts (available only at the point of purchase)			
• Lens options (e.g., anti-reflective coatings and progressive lenses)	Average savings of 20-25%	Usual & customary fees	Not covered
• Additional Eyewear	20% discount; Costco pricing applies	Usual & customary fees	Not covered
• Laser Vision Correction*	For discounts, call VSP at 1-800-877-7195	For discounts, call Scheie Eye at 1-800-789-PENN (7366)	Not covered

* Laser Vision Correction is NOT a covered benefit under this vision plan. However, you are afforded discounts as noted based on whether you use a Scheie provider or a VSP provider.



Life Insurance

You are eligible for life insurance through Penn's carrier, Aetna Group Insurance. Update your life insurance beneficiary information via the benefits online enrollment system at www.pennbenefits.upenn.edu. For more information about any of the insurance offerings described below, please see the Summary Plan Description online at www.hr.upenn.edu/myhr/benefits/forms/spd.

Note: Your benefits base salary for life insurance purposes is calculated and frozen in March of each year. This amount will not change even if your salary changes during the course of the plan year.

Basic Life Insurance

Penn provides you with Basic Life Insurance of one times your benefits base salary (maximum of \$300,000) at no cost to you. If your base salary is more than \$50,000, you can choose to reduce your Basic Life Insurance to \$50,000 to avoid imputed income tax. You may increase this free insurance amount by electing supplemental coverage.

Accidental Death and Dismemberment Insurance (AD&D)

You will automatically receive Accidental Death and Dismemberment Insurance (AD&D) at no cost to you. This feature pays benefits of up to two times your benefits base salary (up to \$125,000) if you die or have other losses directly caused by an accident (some exclusions apply).

Supplemental Life Insurance

You can increase your Supplemental Life Insurance by a maximum of one times your salary. Your Basic and Supplemental coverage combined cannot exceed \$1,000,000. If your Supplemental coverage exceeds \$500,000, you must provide Evidence of Insurability (EOI) to the insurance company. You may choose to limit your Supplemental coverage to \$500,000 so you don't have to submit EOI.

Dependent Life Insurance

You may purchase life insurance for your eligible dependents in the amount of \$20,000 of coverage for your spouse/same-sex domestic partner, and/or \$10,000 of coverage for each eligible dependent child.

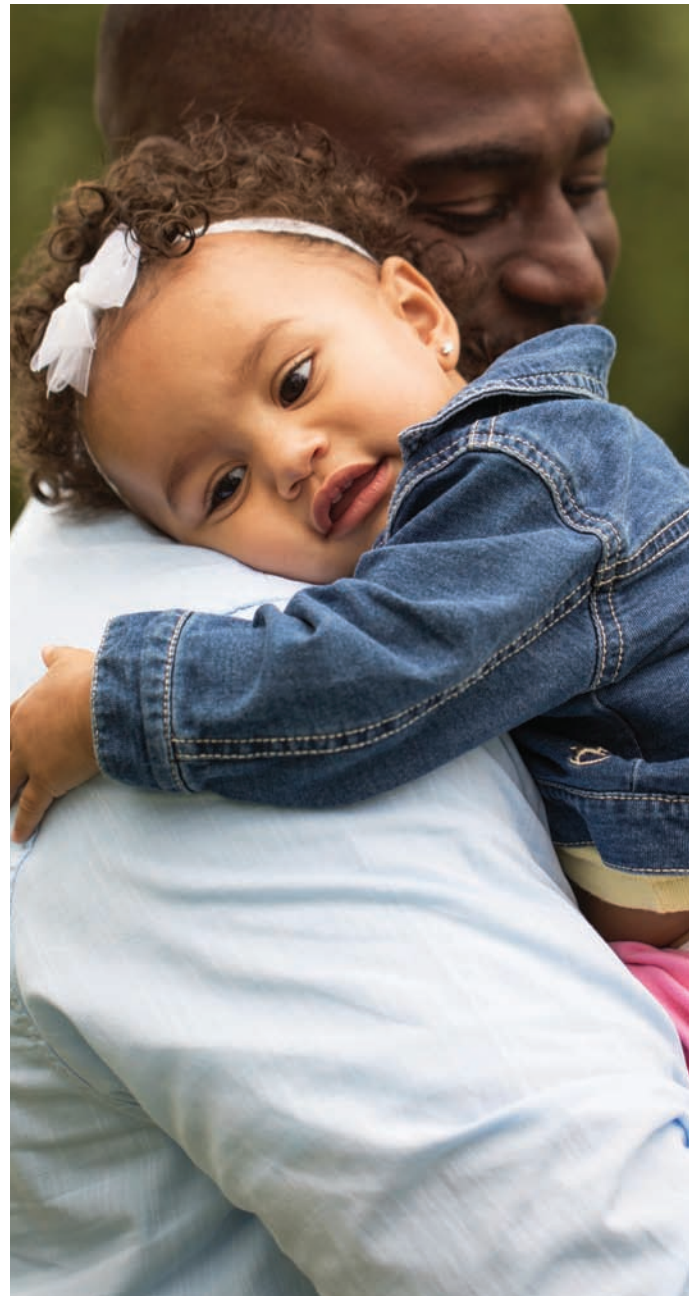
Note: Same-sex domestic partner dependent life insurance coverage will end on July 1, 2018.

Review Your Life Insurance Beneficiary

Keep your life insurance beneficiary information up to date. You may review and update your life insurance beneficiary as often as you like at www.pennbenefits.upenn.edu. After logging on, click Enrollment Opportunities, then Declare Life Event, and select Beneficiary Designation Change.

You can choose as many beneficiaries as you'd like, whether a spouse, child, other family members, or friends. You can even choose an entity like a charity, trust, or your estate as your life insurance beneficiary.

Please note that this beneficiary designation applies only to your life insurance plan.



Flexible Spending Accounts

Penn offers two types of Flexible Spending Accounts (FSA): a Health Care FSA and a Dependent Care FSA. They provide you with a way to pay for certain out-of-pocket expenses with pre-tax dollars. They're designed to save you taxes when you pay for certain eligible expenses that are not covered by other benefit plans.

When you participate, your contribution is deducted from your paycheck before federal taxes are taken, and your contributions are put into an account on your behalf. Then, when you incur eligible expenses, you submit a claim form to be reimbursed from your account. You may make contributions to a:

- **Health Care Flexible Spending Account**—For health care expenses (incurred by you and your eligible tax dependents) that are not eligible to be paid by insurance (e.g., copays, coinsurance).
- **Dependent Care Flexible Spending Account**—For dependent care (daycare, elder care) expenses that allow you to work, but **not** for dependent health care expenses.

How the Health Care FSA Works

If you enroll in the Aetna HDHP with HSA plan, you will be enrolled in a Health Savings Account. IRS regulations do not permit you to be enrolled in a Health Savings Account (HSA) and a Health Care Flexible Spending Account (FSA) at the same time. If you select the Aetna HDHP and you're currently enrolled in the Health Care Flexible Spending Account (FSA), you must exhaust your FSA dollars before your HSA account can be opened.

The maximum amount you can contribute to the Health Care FSA is \$2,550 for full-time employees and \$1,000 for part-time employees with two years of continuous service.

You are able to roll over up to \$500 of unused money in your Health Care FSA to the following plan year. You will forfeit any remaining balance over \$500.

You have until June 30 (the end of the plan year) to incur expenses, and until September 30 of the following plan year to submit eligible claims. For example, if you enroll in a Health Care FSA during the 2016-2017 plan year, you'll have until June 30, 2017 to incur expenses and until September 30, 2017 to submit eligible expenses for reimbursement. If you have any money remaining in your account at that time, up to \$500 will roll over to the following plan year's account.

You can claim eligible expenses up to your annual election amount even if you haven't yet contributed the full amount of the expenses to your account.

Expenses paid through an FSA cannot also be claimed as a tax deduction on your federal income tax return.

Health Care FSA Debit Card

This convenient card gives you immediate access to your Health Care FSA funds. You can use it to pay for eligible health care expenses without having to submit a claim for reimbursement. Just like your bank account debit card, the Health Care FSA debit card will automatically debit your FSA account. That means you don't have to pay for expenses with out-of-pocket money, and there's no need to file a paper claim. However, it's important to save your receipts since you may need to produce them for an audit. Some purchases and health care services require substantiation. Visit www.pennbenefits.upenn.edu for complete details and a list of retail merchants that accept the debit card.

How the Dependent Care FSA Works

The maximum amount you can contribute to the Dependent Care FSA depends on certain factors:

- \$5,000 if you're single and file your taxes as head of household or if you're married and file a joint tax return
- \$2,500 if you're married and file separate tax returns
- \$1,800 if you're a highly compensated employee (salary of \$120,000 or more)

You must use all available funds by the end of the plan year deadline or you will forfeit any remaining balance.

You have until September 15 of the following plan year to incur expenses, and until September 30 of the following plan year to submit eligible claims. For example, if you enroll in a Dependent Care FSA during the 2016-2017 plan year, you'll have until September 15, 2017 to incur expenses and until September 30, 2017 to submit eligible expenses for reimbursement.

Expenses paid through an FSA cannot also be claimed as a tax deduction on your federal income tax return.

Administration

If you have a Flexible Spending Account, you can access your account details securely online through Penn's online benefits enrollment site, www.pennbenefits.upenn.edu. Just log in with your PennKey and password, continue until you reach the Enrollment Options page, and click the link titled FlexDirect FSA Manager.

ADP Benefit Services (ADP) administers the Flexible Spending Accounts. ADP is also responsible for processing claims, issuing checks to plan participants, and answering questions regarding the benefit.

If you have any questions about the benefit or your account, call the Penn Benefits Center at 1-888-PENN-BEN (1-888-736-6236). To obtain reimbursement on a claim, visit our forms website to download the appropriate form and mail your claim to: ADP Spending Account, P.O. Box 34700, Louisville, KY 40232.

Additional Benefits

Supplemental Long-Term Disability

To supplement your University-provided LTD coverage, you can purchase an individual LTD policy underwritten by Standard Insurance Company. Supplemental LTD can help you protect more of your income in the case of a long-term disability, with benefits of up to 75% of base salary, less Penn and other individual LTD coverage. The maximum monthly benefit amount that can be purchased as a supplement is \$7,500 per month. This program offers the advantages of tax-free benefits, portability, and enhanced protection if you can't perform the duties of your own occupation. You must earn at least \$15,000 per year and be actively at work for six consecutive months in order to apply. Enrollment information will be mailed to newly eligible faculty and staff, who will then have 60 days to enroll after receiving the information. For more information, visit www.hr.upenn.edu/myhr/benefits/time/disability or contact the plan administrator at 1-877-321-4427, or UPenn@IncomeBenefit.com.

Long-Term Care Insurance

Long-Term Care benefits assist individuals who are unable to care for themselves. Benefits can be provided while at home, in a nursing or assisted living facility, and even in an adult day care center. You can apply for coverage for yourself and/or the following family members: spouse/qualified same-sex domestic partner, siblings/spouses of siblings, adult children, parents/parents-in-law, step-parents/step-parents-in-law, grandparents/grandparents-in-law, and step-grandparents/step-grandparents-in-law. If you enroll within 90 days of the date you become eligible for benefits at Penn, you will automatically be accepted into the plan regardless of your health status, as long as you are full-time and actively at work on your effective date of coverage. If you apply at any other time, you must show proof of good health. Your eligible family members applying at any time must show proof of good health. Penn's Long-Term Care Insurance plan is underwritten by Genworth. Please contact Genworth directly for all services, including enrolling in the plan, filing claims, and requesting information. For more information, please visit the Human Resources website at www.hr.upenn.edu/myhr/benefits/additional/ltc.



Important Information

You can find the following legal notices on our website at www.hr.upenn.edu/myhr/benefits/forms:

- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act
- Premium Assistance Through Medicaid and CHIP
- Children's Health Insurance Program (CHIP) Update to HIPAA Special Enrollment
- Notice of Privacy Practices
 - Summary of Benefits Coverage
 - Penn's Health Coverage for Health Insurance Marketplaces

If you would like a printed copy of any of these notices, please contact us at benefits@hr.upenn.edu or 215-898-3539.

University of Pennsylvania Non-Discrimination Statement

The University of Pennsylvania values diversity and seeks talented students, faculty and staff from diverse backgrounds. The University of Pennsylvania does not discriminate on the basis of race, color, sex, sexual orientation, gender identity, religion, creed, national or ethnic origin, citizenship status, age, disability, veteran status or any other legally protected class status in the administration of its admissions, financial aid, educational or athletic programs, or other University administered programs or in its employment practices. Questions or complaints regarding this policy should be directed to the Executive Director of the Office of Affirmative Action and Equal Opportunity Programs, Sansom Place East, 3600 Chestnut Street, Suite 228, Philadelphia, PA 19104-6106; or 215-898-6993 (Voice) or 215-898-7803 (TDD).

Plan Governance

The selected benefit highlights in this guide are based on Plan documents that govern the operation of the Plans. If there is any conflict between the information presented here and the information in the Plan documents, the Plan documents always govern and are the controlling legal documents. Benefits descriptions are not terms of employment, nor are they intended to establish a contract between the University and its faculty and staff. Plan documents are available for inspection in the Benefits Office. Copies are available for a small copy fee. The University reserves the right to change, amend or terminate any of its PennChoice Benefit Plans for any reason at any time.

Statement on Collective Bargaining Agreements

The provisions of applicable collective bargaining agreements govern the health and welfare benefits of employees in collective bargaining units.

Contact Information for the Health and Welfare Plans

Plan and Administrator	Group/Policy#	Contact Information	Other Information
The Penn Benefits Center	N/A	1-888-PENN-BEN (1-888-736-6236) www.pennbenefits.upenn.edu	Call for general benefit questions, life event changes (within 30 days), and claims adjudication.
Medical			
PennCare/Personal Choice PPO	10041473	1-800-ASK-BLUE (1-800-275-2583) www.ibx.com http://pennhealth.com/penncareppo/index.html	For inpatient admission (except for maternity or emergency admissions), pre-certification is required. Call 215-241-2990 or 1-800-275-2573.
Aetna Choice POS II	811778	1-888-302-8742 859-455-8650 (fax) www.aetna.com	For an emergency out of area, go to the nearest hospital. Hospital must call 1-888-632-3862.
Keystone/AmeriHealth HMO	10049781	1-800-ASK-BLUE (1-800-275-2583) www.ibx.com	Call both Primary Care Physician (PCP) and HMO within 48 hours of emergency care. For an emergency out of area, go to the nearest hospital. Hospital must call 1-800-ASK-BLUE (1-800-275-2583). Sick Care out of area: 1-800-810-BLUE.
Aetna High Deductible Health Plan with Health Savings Account	811778	1-888-302-8742 859-455-8650 (fax) www.aetna.com	For an emergency out of area, go to the nearest hospital.
Penn Behavioral Health	N/A	1-888-321-4433 www.pennbehavioralhealth.org	Behavioral Health benefits for PennCare/Personal Choice PPO and Aetna Choice POS II plans.
Prescription Drug			
CVS/caremark	RX1580	1-844-833-6390 www.caremark.com	RX Bin 004336 RX PCP: ADV
Dental			
Penn Dental Plan	N/A	215-898-PDFP (7337) Locations: Bryn Mawr, Locust Walk, University City www.mypenndentist.org	After hours, call any network office for instructions on how to reach the doctor on call. Or, call the emergency answering service at 215-952-8029. For emergency treatment outside a 100-mile radius of any office, use any dentist.
MetLife	300187	1-800-942-0854 www.metlife.com/dental	Contact your family dentist for emergencies.
Vision			
Davis Vision	10054917	1-800-ASK-BLUE (1-800-275-2583) 1-888-393-2583 (claims/benefit questions) www.ibx.com	IBC vision plan administered by Davis Vision.
VSP Plan	30031862	1-800-877-7195 www.vsp.com	
Pre-Tax Expense Accounts			
ADP FSA Services	N/A	1-888-PENN-BEN (1-888-736-6236), option 3 www.pennbenefits.upenn.edu	
Health Care-Related Issues			
Health Advocate	N/A	1-866-799-2329	Call for general health care questions (e.g., billing concerns, covered services, locating treatment facilities, etc.).



www.hr.upenn.edu/myhr
1-888-PENN-BEN (1-888-736-6236)

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