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The Pennsylvania State University – Faculty, Staff, and Technical Service PPO Savings Plan 2019

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Calendar Year	Contract Year	
Deductible per calendar year (Applies to Medical and Prescription Drug benefits) **Individual** (employee only) **Family** (employee + spouse and/or child(ren))	 $1,600 $3,200	 $3,200 $6,400
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Coinsurance Maximums (Excludes deductible) Includes coinsurance, prescription drug cost sharing and prescription drug copayments. **Individual** **Family**	 $1,975 $3,950	 $3,950 $7,900
Out-of-Pocket (Deductible and Coinsurance) Maximum (Includes deductible, coinsurance, prescription drug cost sharing and prescription drug copayments and other qualified medical expenses - Network only) Once met, the plan pays 100% of covered services for the rest of the calendar year. **Individual** **Family**	 $3,575 $7,150	Penn State limits are outlined above. These limits do not negate that utilization of an out-of-network provider may result in balance billing of the non-covered amount. Balance billed amounts are not applicable to TMOOP.
Total Maximum Out-of-Pocket Amount (TMOOP)	See note at the end of the grid	See note at the end of the grid
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	90% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Walk-In Clinic Visits	90% after deductible	70% after deductible
Telemedicine Services	90% after deductible	Not Applicable
Preventive Care **Deductible does NOT apply to IN-NETWORK Preventive Care**		
Routine Adult		
Physical exams	100% (deductible does not apply)	70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 90% after deductible	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	90% after deductible	
Ambulance	Emergency and Non-emergency: 90% after deductible	Emergency: 90% after deductible Non-emergency: 70% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	
Respiratory Therapy	90% after deductible	70% after deductible
Speech & Occupational Therapy	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	
Spinal Manipulations	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder(4)	90% after deductible	70% after deductible
Assisted Fertilization Procedures *Artificial Insemination Only*	90% after deductible	70% after deductible
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Gastric Bypass/Bariatric Surgery	90% after deductible	Not Covered
Gender Reassignment Surgery/Transgender Services –	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 120 visits per calendar year	
Hearing Care Services	90% after deductible	
	Limit: $700 per ear, per 36 months for the purchase of a hearing aid device and audiometric testing per ear	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 70 eight-hour shifts	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days per calendar year	
Transplant Services	90% after deductible	Not Covered
Wigs *Cancer diagnosis only*	90% after deductible	
	Limit: $300 maximum/lifetime	
Precertification Requirements	Yes	
Prescription Drugs – CVS/Caremark		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Retail Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs ***Retail includes University Health Services Pharmacy*	 10% coinsurance 20% coinsurance 40% coinsurance	
Mail Order Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs *** Mail Order includes University Health Services Pharmacy*	 10% coinsurance 20% coinsurance 40% coinsurance	
Specialty Preferred Brand Drugs Non-Preferred Brand Drugs	 20% coinsurance, $65 maximum 40% coinsurance, $100 maximum	

Note: Total Maximum Out-of-Pocket Maximum *(TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. With plan years beginning on or after January 1, 2019, TMOOP cannot be more than $7,150 for an individual and $14,300 for plans with two or more persons. Your plan satisfies this requirement.*