



The Pennsylvania State University – Faculty, Staff, and Technical Service PPO Savings Plan 2020

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
<b>General Provisions</b>		
<b>Calendar Year</b>	Contract Year	
<b>Deductible per calendar year</b> (Applies to Medical and Prescription Drug benefits)		
<b>Individual</b> (employee only)	\$1,600	\$3,200
<b>Family</b> (employee + spouse and/or child(ren))	\$3,200	\$6,400
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	70% after deductible
<b>Coinsurance Maximums</b> (Excludes deductible) Includes coinsurance, prescription drug cost sharing and prescription drug copayments.		
<b>Individual</b>	\$1,975	\$3,950
<b>Family</b>	\$3,950	\$7,900
<b>Maximum Out-of-Pocket Limit (Deductible and Coinsurance)</b> (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.	See note at the end of the grid.	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 the Maximum Out-of-Pocket Limit. See note at the end of the grid.
<b>Individual</b>	\$3,575	
<b>Family</b>	\$7,150	
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	90% after deductible	70% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	90% after deductible	70% after deductible
<b>Urgent Care Center Visits</b>	90% after deductible	70% after deductible
<b>Walk-In Clinic Visits</b>	90% after deductible	70% after deductible
<b>Telemedicine Services</b>	90% after deductible	Not Applicable
<b>Preventive Care</b>		
<b>Deductible does NOT apply to IN-NETWORK Preventive Care</b>		
<b>Routine Adult</b>		
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
<b>Routine Pediatric</b>		
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
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	90% after deductible	70% after deductible
<b>Hospital Outpatient</b>		
<b>Maternity</b> (non-preventive facility & professional services)		
<b>Medical/Surgical</b> (except office visits)		
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	90% after deductible	
<b>Ambulance</b>	Emergency and Non-emergency: 90% after deductible	Emergency: 90% after deductible Non-emergency: 70% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Therapy</b>	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	
<b>Respiratory Therapy</b>	90% after deductible	70% after deductible
<b>Speech &amp; Occupational Therapy</b>	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	
<b>Spinal Manipulations</b>	90% after deductible	70% after deductible
	Limit: 24 visits per calendar year	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible

Benefit	Network	Out-of-Network
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	90% after deductible	70% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient</b>	90% after deductible	70% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	90% after deductible	70% after deductible
<b>Applied Behavior Analysis for Autism Spectrum Disorder</b>	90% after deductible	70% after deductible
<b>Assisted Fertilization Procedures</b> <i>Artificial Insemination Only</i>	90% after deductible	70% after deductible
<b>Dental Services Related to Accidental Injury</b>	90% after deductible	70% after deductible
<b>Diagnostic Services</b> <i>Advanced Imaging (MRI, CAT, PET scan, etc.)</i>	90% after deductible	70% after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	90% after deductible	70% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	90% after deductible	70% after deductible
<b>Gastric Bypass/Bariatric Surgery</b>	90% after deductible	Not Covered
<b>Gender Reassignment Surgery/Transgender Services –</b>	90% after deductible	70% after deductible
<b>Home Health Care</b>	90% after deductible	70% after deductible
<b>Hearing Care Services</b>	Limit: 120 visits per calendar year	
	90% after deductible	
	Limit: \$700 per ear, per 36 months for the purchase of a hearing aid device and audiometric testing per ear	
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment</b>	90% after deductible	70% after deductible
<b>Private Duty Nursing</b>	90% after deductible	70% after deductible
<b>Skilled Nursing Facility Care</b>	Limit: 70 eight-hour shifts	
	90% after deductible	70% after deductible
	Limit: 100 days per calendar year	
<b>Transplant Services</b>	90% after deductible	Not Covered
<b>Wigs</b> <i>Cancer diagnosis only</i>	90% after deductible	
	Limit: \$300 maximum/lifetime	
<b>Precertification Requirements</b>	Yes	
<b>Prescription Drugs – CVS Caremark</b>		
<b>Prescription Drug Deductible</b> Individual Family	Integrated with medical deductible Integrated with medical deductible	
<b>Retail</b> Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs <i>*Retail includes University Health Services Pharmacy</i>	10% coinsurance 20% coinsurance 40% coinsurance	
<b>Mail Order</b> Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs <i>* Mail Order includes University Health Services Pharmacy</i>	10% coinsurance 20% coinsurance 40% coinsurance	
<b>Specialty</b> Preferred Brand Drugs Non-Preferred Brand Drugs	20% coinsurance, \$65 minimum 40% coinsurance, \$100 minimum	
<b>*NEW* Preventive Prescription Drugs – CVS Caremark</b> <b>*NO DEDUCTIBLE – COINSURANCE ONLY*</b>		
<b>Generic</b>	10% coinsurance	
<b>Preferred Brand</b>	20% coinsurance	
<b>Non-Preferred Brand</b>	40% coinsurance	

**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, 2020, TMOOP cannot be more than \$8,150 for an individual and \$16,300 for plans with two or more persons. Your plan satisfies this requirement.