The PPO Savings Plan

Faculty, Staff & Technical Service

Schedule of Benefits

Prepared exclusively for:

Employer:	The Pennsylvania State University
Contract number:	285717
Control number:	285739 – Technical Service
Control number:	285718 – Faculty & Staff Schedule of Benefits 1A
Contract effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	October 4, 2018

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from a **network provider**.
  - "Out-of-network coverage", we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles** and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums	
	In-network coverage*	**Out-of-network coverage***
Deductible		
You have to meet your Calendar Year **deductible** before this plan pays for benefits.		
Individual Only Plan	$1,600 per Calendar Year	$3,200 per Calendar Year
Family Only Plan	$3,200 per Calendar Year	$6,400 per Calendar Year
Deductible waiver		
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives		
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	$3,575 per Calendar Year	$7,150 per Calendar Year
Family	$7,150 per Calendar Year	$14,300 per Calendar Year
Preventive care and wellness		
Routine physical exams		
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care immunizations		
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
Preventive screening and counseling services		
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Obesity and/or healthy diet counseling maximums:		
Maximum visits per 12 months (This maximum applies only to covered persons 22 and older.)	26 visits (however, of these, only *10* visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only *10* visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk age factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums:		
Maximum visits per 12 months	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Use of tobacco products maximums:		
Maximum visits per 12 months	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling maximums:		
Maximum visits per 12 months	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums:		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)		
Routine cancer screenings	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines

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Eligible health services	In-network coverage*	Out-of-network coverage*
	supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
***Important note**: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**		
Preventive care services only	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits.		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% per item No **deductible** applies	70% (of the **recognized charge**) per item after deductible
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **physician** services office visits.		
Devices		
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies	70% (of the **recognized charge**) per item after deductible
Female voluntary sterilization		
Inpatient	100% per admission No **deductible** applies	70% (of the **recognized charge**) per admission after deductible
Outpatient	100% per visit No **deductible** applies	70% (of the **recognized charge**) per visit after deductible
Physicians and other health professionals		
Physicians and **specialists** office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Complex imaging services, lab work and radiological services performed during a **physician's** office visit	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Immunizations that are not considered Preventive Care		
Immunizations that are not considered Preventive Care	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Specialist		
Specialist office visits		
Office hours visits (non-surgical)	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Complex imaging services, lab work and radiological services performed during a **specialist** office visit	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Physician surgical services		
Physicians and **specialists** office visits		
Performed at a **physician's**, **PCP** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Performed at a **specialist's** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Alternatives to physician office visits		
Walk-in clinic visits		
Preventive Care Services		
Immunizations	100% per visit No **deductible** applies Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.	70% (of the **recognized charge**) per visit after deductible Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*	Out-of-network coverage*
All non-preventive care services for which cost sharing is not shown above		
All other services	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Hospital and other facility care		
Hospital care		
Inpatient **hospital**	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Alternatives to hospital stays		
Outpatient surgery and physician surgical services	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Home health care		
Outpatient	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maximum visits per Calendar Year	120	120
Hospice care		
Inpatient facility	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	90% (of the **negotiated charge**) per visit	70% (of the **recognized charge**) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maximum visits/shifts per Calendar Year	70 shifts	70 shifts
	Up to eight hours equal one shift	Up to eight hours equal one shift

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Skilled nursing facility

Inpatient facility	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Maximum days per Calendar Year	100	100

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Emergency services and urgent care		
Emergency services		
Hospital emergency room	90% (of the **negotiated charge**) per visit after deductible	Paid the same as in-network coverage 90% (of the **negotiated charge**) per visit after deductible
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered

Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder treatment	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Applied behavior analysis	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan.		
Birthing center		
Inpatient	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received – See Diabetic Supply Guidelines for full coverage details	Covered according to the type of benefit and the place where the service is received – See Diabetic Supply Guidelines for full coverage details
Family planning services		
Voluntary sterilization for males		
Outpatient	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maternity and related newborn care		
Inpatient	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Delivery services and postpartum care services		

Eligible health services	In-network coverage*	Out-of-network coverage*
Performed in a facility or at a **physician's** office	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Other prenatal care services	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Mental health treatment - inpatient		
Inpatient mental health treatment	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Mental health treatment - outpatient		
Outpatient mental health treatment visits to a **physician** or **behavioral health provider**	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Substance related disorders treatment - inpatient		
Inpatient **substance abuse** detoxification during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per admission after deductible	70% (of the **recognized charge**) per admission after deductible
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider** **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Obesity surgery		
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	90% (of the **negotiated charge**) per admission after deductible	Not covered
Outpatient obesity surgery		
	90% (of the **negotiated charge**) per visit after deductible	Not covered
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Reconstructive breast surgery		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Reconstructive surgery and supplies		
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Transplant services facility and non-facility

Eligible health services	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*
Inpatient **hospital** transplant services	90% (of the **negotiated charge**) per transplant after deductible	90% (of the **negotiated charge**) per transplant after deductible	Not Covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not Covered

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Eligible health services	In-network coverage*	Out-of-network coverage*
Basic infertility		
Basic **infertility**	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Outpatient comprehensive infertility services		
	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Specific therapies and tests		
Outpatient Diagnostic Testing		
Diagnostic complex imaging services		
	90% (of the **negotiated** charge) per visit after deductible	70% (of the **recognized** charge) per visit after deductible
Diagnostic lab work		
Performed at a Quest Lab or LabCorp Lab	90% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Performed at any other outpatient facility	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Diagnostic radiological services		
	90% of the **negotiated charge** per visit. after deductible	70% of the **recognized charge** per visit. after deductible
Chemotherapy		
	90% of the **negotiated charge** per visit. after deductible	70% of the **recognized charge** per visit. after deductible
Outpatient infusion therapy		
	90% (of the **negotiated charge**) per visit. after deductible	70% (of the **recognized charge**) per visit. after deductible
Outpatient radiation therapy		
	90% (of the **negotiated charge**) per visit. after deductible	70% (of the **recognized charge**) per visit. after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*

Short-term rehabilitation services		
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)		
	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)		
	90% (of the **negotiated charge**) per visit after deductible	70% of the **recognized charge**) per visit after deductible

Outpatient Physical and Occupational Therapies Maximum		
Maximum visits per Calendar Year	Unlimited visits; medical necessity reviewed for beyond 24 visits	Unlimited visits; medical necessity reviewed for beyond 24 visits
Outpatient Speech Therapy Maximum		
Maximum visits per Calendar Year	24 visits; medical necessity reviewed for beyond 24 visits	24 visits; medical necessity reviewed for beyond 24 visits

Ambulance service		
Ground, air or water **ambulance**	90% (of the **negotiated charge**) per trip after deductible	90% (of the **recognized charge**) per trip after deductible

Durable medical equipment (DME)		
DME	90% (of the **negotiated charge**) per item after deductible	70% (of the **recognized charge**) per item after deductible
Hearing exams		
Hearing exams	90% (of the **negotiated charge**) per visit after deductible	90% (of the **recognized charge**) per visit after deductible
	One exam in any 36 consecutive month period	
Hearing aids		
Hearing aids	90% (of the **negotiated charge**) per item after deductible	90% (of the **recognized charge**) per item. *Note: In-network deductible applies.* after deductible
Maximum one device per ear, per 36 months	$700	$700

Prosthetic devices		
Prosthetic devices	90% (of the **negotiated charge**) per item after deductible	70% (of the **recognized charge**) per item after deductible

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Eligible health services	In-network coverage*	Out-of-network coverage*
Spinal manipulation		
Spinal manipulation	90% (of the **negotiated charge**) per visit after deductible	70% (of the **recognized charge**) per visit after deductible
Maximum visits per **Calendar Year**	24 visits; medical necessity reviewed for beyond 24 visits	24 visits; medical necessity reviewed for beyond 24 visits

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Family planning services - female contraceptives	
• Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan***
Female contraceptive devices	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan***
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan***
Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies ***Prescriptions filled at CVS Caremark participating pharmacies and University Health Services pharmacy will run through the CVS Caremark prescription drug plan. All other female contraceptives will run through the Aetna medical plan.*** Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.
Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum coinsurance out-of-pocket limits**
- Total maximum out-of-pocket limits

that are listed in the first part of this schedule of benefits.

Deductible provisions

Eligible health services that are subject to the **deductible** include **prescription drug eligible health services** provided under the medical plan **prescription drug** plan.

Eligible health services applied to the out-of-network **deductibles** will not be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will not be applied to satisfy the out-of-network **deductibles**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **payment percentage** for **eligible health services** to which the **deductible** does not apply.

For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members. For purposes of the Calendar Year **deductible** provision below:

- The individual **deductible** applies to a person who is enrolled for self only coverage with no dependent coverage
- The family **deductible** applies to a person who is enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Individual
This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family
This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

Important Note:
As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment,** and **payment percentage**, as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan.

Payment percentage

The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will not be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will not be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self only coverage with no dependents coverage
- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents. The family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family.

Individual

Once the amount of the **payment percentage** and **deductibles** you have paid during the Calendar Year for **eligible health services** meet the Individual **maximum out-of-pocket limit** this plan will pay 100% of **covered benefits** that apply toward the limit for you for the remainder of the Calendar Year.

Family

Once the amount of the **payment percentage** and **deductibles** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

CVS CAREMARK 844-462-0203 PPO SAVINGS PLAN PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible – Combined with Medical	$1600 Individual $3200 Family
Total Prescription Drug Out-of-Pocket Maximum – Combined with Medical Individual Family	 $3575 $7150
Retail (30-day supply) Prescriptions filled at CVS Caremark participating pharmacies or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs *Retail includes University Health Services Pharmacy	 10% coinsurance 20% coinsurance 40% coinsurance
Mail Order (90-day supply) Prescriptions filled at CVS Caremark Mail Order or University Health Services pharmacy Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs *Mail order includes University Health Services Pharmacy	 10% coinsurance 20% coinsurance 40% coinsurance
Specialty (30-day supply) Prescriptions filled at CVS Caremark Specialty Pharmacy. Select few specialty medications also available at University Health Service pharmacy; contact them for details. Preferred Brand Drugs Non-Preferred Brand Drugs	 20% coinsurance; $65 minimum 40% coinsurance; $100 minimum
2020 Preventive Drug List No deductible, coinsurance only Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	 10% coinsurance 20% coinsurance 40% coinsurance