



## The Pennsylvania State University – Technical Service PPO 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>	<b>Contract Year</b>	
<b>Deductible</b> (per calendar year)		
<b>Individual</b> (employee only)	\$250	\$500
<b>Parent/Child(ren)</b> (employee + child(ren))	\$375	\$1,000
<b>Family</b> (employee + spouse + child(ren))	\$500	\$1,000
<b>Coinsurance Maximums</b> (Excludes deductible) Employee pays 10% of plan allowance		
<b>Individual</b>	\$1,000	\$2,000
<b>Parent/Child(ren)</b>	\$1,500	\$4,000
<b>Family</b>	\$2,000	\$4,000
<b>Out-of-Pocket (Deductible + Coinsurance) Maximum</b> Once met, plan pays 100% (excluding applicable copayments and prescriptions) for the rest of the per calendar year		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.
<b>Individual</b>	\$1,250	
<b>Parent/Child(ren)</b>	\$1,875	
<b>Family</b>	\$2,500	
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	70% after deductible
<b>Total Maximum Out-of-Pocket Amount (TMOOP)</b>	See note at the end of the grid	See note above regarding out-of-pocket maximum and note at the end of the grid
Individual	\$7,150	
Two or More Persons	\$14,300	
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	100% after \$10 copayment	70% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	100% after \$20 copayment	70% after deductible
<b>Urgent Care Center Visits</b>	100% after \$20 copayment	70% after deductible
<b>Walk-In Clinic Visits</b>	100% after \$20 copayment	70% after deductible
<b>Telemedicine Services</b>	100% after \$10 copayment	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	100% (deductible does not apply)	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>	100% after \$100 copayment (waived if admitted)	
<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>	100% after \$20 copayment	70% after deductible
	Limit: 24 visits per calendar year	
<b>Respiratory Therapy</b>	90% after deductible	70% after deductible
<b>Spinal Manipulations</b>	100% after \$20 copayment	70% after deductible
	Limit: 24 visits per calendar year	
<b>Speech &amp; Occupational Therapy</b>	100% after \$20 copayment	70% after deductible

Benefit	Network	Out-of-Network
	Limit: 24 visits per therapy per calendar year	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	90% after deductible	70% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient</b>	100% after \$10 copayment	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 Disorders</b>	90% after deductible	70% after deductible
<b>Assisted Fertilization Procedures</b> Artificial Insemination Only	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</i> (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	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>Hearing Care Services</b>	90% after deductible Limit: \$700 per ear, per 36 months for the purchase of a hearing aid device and audiometric testing per ear	
<b>Home Health Care</b>	90% after deductible	70% after deductible
	Limit: 120 visits calendar year	
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment(5)</b>	90% after deductible	70% after deductible
<b>Private Duty Nursing</b>	90% after deductible	70% after deductible
	Limit: 70 eight-hour shifts	
<b>Skilled Nursing Facility Care</b>	90% after deductible	70% after deductible
	Limit: 100 days per calendar year	
<b>Transplant Services</b>	90% after deductible	Not covered
<b>Wigs</b>	90% after deductible	
Cancer diagnosis only	Limit: \$300 maximum/Lifetime	
<b>Precertification Requirements</b>	Yes	
<b>Prescription Drugs – CVS Caremark</b>		
<b>Prescription Drug Deductible</b>	None	
<b>Total Prescription Drug Out-of-Pocket Maximum</b>		
Individual	\$1,000	
Family	\$6,000	
<b>Retail</b>		
Generic Drugs	50% coinsurance	
Preferred Brand Drugs	50% coinsurance	
Non-Preferred Brand Drugs	70% coinsurance	
<i>*Retail includes University Health Services Pharmacy</i>		
<b>Mail Order</b>		
Generic Drugs	20% coinsurance	
Preferred Brand Drugs	20% coinsurance	
Non-Preferred Brand Drugs	70% coinsurance	
<i>* Mail Order includes University Health Services Pharmacy</i>		
<b>Specialty</b>		
Preferred Brand Drugs	50% coinsurance, \$50 maximum	
Non-Preferred Brand Drugs	70% coinsurance, \$100 maximum	
<b>*NEW* Preventive Prescription Drugs – CVS Caremark</b>		
<b>*LOWER GENERIC COINSURANCE*</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 as TMOOP is set at \$7,150 for an individual and \$14,300 for plans with two or more persons.