aetna®

CVS caremark®

The Pennsylvania State University – Technical Service PPO Plan 2018

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) **Individual** (employee only) **Parent/Child(ren)** (employee + child(ren)) **Family** (employee + spouse + child(ren))	 $250 $375 $500	 $500 $1,000 $1,000
Coinsurance Maximums (Excludes deductible) Employee pays 10% of plan allowance **Individual** **Parent/Child(ren)** **Family**	 $1,000 $1,500 $2,000	 $2,000 $4,000 $4,000
Out-of-Pocket (Deductible + Coinsurance) Maximum Once met, plan pays 100% (excluding applicable copayments and prescriptions) for the rest of the per calendar year **Individual** **Parent/Child(ren)** **Family**	 $1,250 $1,875 $2,500	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.
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Total Maximum Out-of-Pocket Amount (TMOOP)	See note at the end of the grid	See note at the end of the grid
All Salary Levels		
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copayment	70% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copayment	70% after deductible
Urgent Care Center Visits	100% after $20 copayment	70% after deductible
Walk-In Clinic Visits	100% after $20 copayment	70% after deductible
Telemedicine Services	100% after $10 copayment	Not Applicable
Preventive Care(3) **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	100% (deductible does not apply)	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	100% after $100 copayment (waived if admitted)	
Ambulance	Emergency and Non-emergency: 90% after deductible	Emergency: 90% after deductible Non-emergency: 70% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	100% after $20 copayment	70% after deductible
	Limit: 24 visits per calendar year	
Respiratory Therapy	90% after deductible	70% after deductible
Spinal Manipulations	100% after $20 copayment	70% after deductible
	Limit: 24 visits per calendar year	
Speech & Occupational Therapy	100% after $20 copayment	70% after deductible

Benefit	Network	Out-of-Network
	Limit: 24 visits per therapy per calendar year	
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	100% after $10 copayment	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders(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
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	
Home Health Care	90% after deductible	70% after deductible
	Limit: 120 visits calendar year	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(5)	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	90% after deductible	
Cancer diagnosis only	Limit: $300 maximum/Lifetime	
Precertification Requirements	Yes	
Prescription Drugs(7) **– CVS/Caremark**		
Prescription Drug Deductible	None	
Total Prescription Drug Out-of-Pocket Maximum		
Individual	$1,000	
Family	$6,000	
Retail		
Generic Drugs	50% coinsurance	
Preferred Brand Drugs	50% coinsurance	
Non-Preferred Brand Drugs	70% coinsurance	
***Retail includes University Health Services Pharmacy*		
Mail Order		
Generic Drugs	20% coinsurance	
Preferred Brand Drugs	20% coinsurance	
Non-Preferred Brand Drugs	70% coinsurance	
***** *Mail Order includes University Health Services Pharmacy*		
Specialty		
Preferred Brand Drugs	50% coinsurance, $50 maximum	
Non-Preferred Brand Drugs	70% 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, 2018, 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.*