The Pennsylvania State University – PPO Savings 2017

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.**

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible per benefit period (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 benefit period. **Individual** **Family**	 $3,575 $7,150	 Not Applicable
Total Maximum Out-of-Pocket Amount (TMOOP) – 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
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Retail Clinic Visits & Virtual Visits	90% after deductible	70% after deductible
Telemedicine Services(2)	90% after deductible	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	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 Medicine	90% after deductible	70% after deductible
	Limit: 24 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Speech & Occupational Therapy	90% after deductible	70% after deductible

Benefit	Network	Out-of-Network
	Limit: 24 visits per therapy/benefit period	
Spinal Manipulations	90% after deductible	70% after deductible
	Limit: 24 visits/benefit period	
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/benefit period	
Hearing Care Services	90% after deductible	
	Limit: $700 per 36 months for the purchase of a hearing aid device and audiometric testing	
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: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services	90% after deductible	Not Covered
Wigs *Cancer diagnosis only*	90% after deductible	
	Limit: $300 maximum/lifetime	
Precertification Requirements(6)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program(7) *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.* ***Retail and Mail Service Pharmacy includes University Health Services Pharmacy*	**Retail Drugs (31-day Supply)*** Plan pays 90% **after deductible** per generic Plan pays 80% **after deductible** per formulary brand Plan pays 60% **after deductible** per non-formulary brand **Maintenance Drugs through Mail Order (90-day Supply)*** Plan pays 90% **after deductible** per generic Plan pays 80% **after deductible** per formulary brand Plan pays 60% **after deductible** per non-formulary brand	
	Specialty Medications Walgreens Specialty Pharmacy Only **Retail Drugs (31-day Supply)** Plan pays 80% with a $65 minimum **after deductible** per generic Plan pays 80% with a $65 minimum **after deductible** per formulary brand Plan pays 60% with a $100 minimum **after deductible** per non-formulary brand	

Note: The Network Total Maximum Out-of-Pocket (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, 2017, TMOOP cannot be more than $6,550 for self only coverage, $7,150 for an Individual in a family and $14,300 for plans with two or more persons. Your Plan satisfies this requirement.*

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral health visits provided by a Highmark approved telemedicine provider are eligible under Outpatient Mental Health/Substance Abuse benefit.
(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(4) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

(6) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(7) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.