# Summary of Lion Traditional Benefits

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.

**The Pennsylvania State University – Faculty & Staff**
**Effective: 01/01/2023**

| Benefit | | | Network | Out-of-Network |
|---|---|---|---|---|
| **General Provisions** | | | | |
| **Benefit Period** (1) | | | Calendar | |
| **Deductible** (per benefit period; excludes copays and prescription drug) | | | | |
| Salary Range | | | | |
| | < $45,000 | Individual | $250 | $500 |
| | | Family | $500 | $1,000 |
| | $45,001-$60,000 | Individual | $375 | $750 |
| | | Family | $750 | $1,500 |
| | $60,001- $90,000 | Individual | $500 | $1,000 |
| | | Family | $1,000 | $2,000 |
| | $90,000 | Individual | $625 | $1,250 |
| | | Family | $1,250 | $2,500 |
| Once any one family member reaches the individual deductible, then that person moves into the coinsurance portion of the plan. No one family member will exceed the individual deductible level and no family will exceed the family level in deductible expenses. | | | | |
| **Plan Pays –** payment based on the plan allowance | | | 90% after deductible | 70% after deductible |
| **Coinsurance Maximum** (excludes deductible, copays, and prescription drug) Employee pays 10% of allowance | | | | |
| | | Individual | $1,250 | $2,500 |
| | | Family | $2,500 | $5,000 |
| **Out of Pocket Maximums (**Deductible + coinsurance) Once met, plan pays 100% for the rest of the benefit period; excludes deductible (2) | | | | |
| Salary Range | | | | |
| | < $45,000 | Individual | $1,500 | $3,000 |
| | | Family | $3,000 | $6,000 |
| | $45,001-$60,000 | Individual | $1,625 | $3,250 |
| | | Family | $3,250 | $6,500 |
| | $60,001- $90,000 | Individual | $1,750 | $3,500 |
| | | Family | $3,500 | $7,000 |
| | $90,000 | Individual | $1,875 | $3,750 |
| | | Family | $3,750 | $7,500 |
| **Office/Clinic/Urgent Care Visits** | | | | |
| **Retail Clinic Visits** | | | 100% after $20 copayment | 70% after deductible |
| **Primary Care Provider Office Visits** | | | 100% after $20 copayment | 70% after deductible |
| **Specialist Office Visits** | | | 100% after $30 copayment | 70% after deductible |
| **Urgent Care Center Visits** | | | 100% after $30 copayment | 70% after deductible |
| **Telemedicine** (3) | | | 100% after $20 copayment | Not Covered |
| **Preventive Care** | | | | |
| **Routine Adult** | | | | |
| Physical exams | | | 100% (deductible does not apply) | 70% after deductible |
| Adult immunizations | | | 100% (deductible does not apply) | 70% after deductible |

| Benefit | Network | Out-of-Network |
|---|---|---|
| Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult) | 100% (deductible does not apply) | 70% after deductible |
| Routine gynecological exams, including a Pap Test | 100% (deductible does not apply) | 70% after deductible |
| Mammograms, annual routine | 100% (deductible does not apply) | 70% (deductible does not apply) |
| 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% after deductible |
| Diagnostic services and procedures | 100% (deductible does not apply) | 70% after deductible |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | |
| **Hospital Inpatient** | 90% after deductible | 70% after deductible |
| **Hospital Outpatient** | 90% after deductible | 70% after deductible |
| **Maternity** (non-preventive facility & professional services) | 90% after deductible | 70% after deductible |
| **Medical/Surgical** (except office visits) | 90% after deductible | 70% after deductible |
| **Emergency Services** | | |
| **Emergency Room Services** (includes emergency medical and emergency accident) | 100% after $100 copayment (waived if admitted) | |
| **Ambulance** | 90% after deductible | 90% after in-network deductible |
| **Therapy and Rehabilitation Services** | | |
| **Physical Medicine/ Occupational Therapy** | 100% after $30 copayment | 70% after deductible |
| | Medical Review required for more than 24 visits | |
| **Speech Therapy** | 100% after $30 copayment | 70% after deductible |
| | Medical Review required for more than 24 visits | |
| **Spinal Manipulations** | 100% after $30 copayment | 70% after deductible |
| | Medical Review required for more than 24 visits | |
| **Other Therapy Services** (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory 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 $20 copayment | 70% after deductible |
| **Autism Services** | 90% after deductible | 70% after deductible |
| **Other Services** | | |
| **Allergy Injections and Extracts** | 90% after deductible | 70% after deductible |
| **Assisted Fertilization Procedures** | 90% after deductible | 70% after deductible |
| | Limit: $7,500 lifetime maximum combined with infertility | |
| **Bariatric Surgery** | 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, allergy testing) | 90% after deductible | 70% after deductible |
| *Pathology/Lab* | 90% after deductible if performed at Quest or LabCorp, emergency room, or inpatient Otherwise, 70% after deductible | 50% after deductible |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 90% after deductible | 70% after deductible |
| **Wigs-** Cancer diagnosis only | Limit: $300 lifetime maximum | |
| **Hearing Aids** | 90% after deductible | 70% after deductible |
| | Limit: $700 per ear, per 36 months for the purchase of a hearing aid device and audiometric testing per ear (includes parts, fitting, accessories, attachments, adjustments) | |
| **Home Health Care/Visiting Nurse** | 90% after deductible | 70% after deductible |
| | Limit: 120 visit per benefit period | |
| **Hospice** | 90% after deductible | 70% after deductible |
| **Infertility Counseling, Testing and Treatment** (4) | 90% after deductible | 70% after deductible |
| | Limit: $7,500 lifetime maximum combined with assisted fertilization | |
| **Private Duty Nursing** | 90% after deductible | 70% after deductible |
| | Limit: 70 visits per benefit period | |
| **Skilled Nursing Facility Care** | 90% after deductible | 70% after deductible |
| | Limit:100 days per benefit period | |
| **Transplant Services** | 90% after deductible | 70% after deductible |
| **Precertification Requirements** (5) | Yes | |

| Prescription Drug – After Deductible | |
|---|---|
| **Prescription Drug Program** (6)<br>Mandatory Generic<br>*Defined by the National Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* | **Retail Drug (30-day Supply)**<br>Generic Drugs - 50% coinsurance<br>Preferred Brand Drugs - 50% coinsurance<br>Non-Preferred Brand Drugs - 70% coinsurance<br>**Specialty**<br>Preferred Brand Drugs - 50% coinsurance, $50 maximum<br>Non-Preferred Brand - 70% coinsurance, $100 maximum<br>**Mail Order Drug (90-day Supply)**<br>Generic Drugs - 20% coinsurance<br>Preferred Brand Drugs - 20% coinsurance<br>Non-Preferred Brand Drugs - 70% coinsurance<br>**Specialty**<br>Preferred Brand Drugs - 50% coinsurance, $50 maximum<br>Non-Preferred Brand - 70% coinsurance, $100 maximum |
| **Prescription Drug OOP** (plan will pay 100% coverage once the out of pocket is reached) | $2,000 individual<br>$8,000 family |

(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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. For plan year 2023 the in-network Individual TMOOP amount is $9,100 and the in- network Family TMOOP amount is $18,200.
(3) Services must be performed by a BS approved telemedicine provider.
(4) 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.
(5) BS 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.
(6) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available, and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.