

## 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 – Non-Medicare Eligible Retirees

Effective: 01/01/2023

Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> (1)	Calendar	
<b>Deductible</b> (per benefit period; excludes copays and prescription drug)		
Individual	\$375	\$750
Family	\$750	\$1,500
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.		
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	70% after deductible
<b>Coinsurance Maximums</b> (excludes deductible, copays, and prescription drug) Employee pays 10% of allowance		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
<b>Out-of-Pocket Maximums</b> (Deductible + coinsurance) Once met, plan pays 100% for the rest of the benefit period; excludes deductible (2)		
Individual	\$1,625	\$3,250
Family	\$3,250	\$6,500
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	100% after \$20 copayment	70% after deductible
<b>Primary Care Provider Office Visits</b>	100% after \$20 copayment	70% after deductible
<b>Specialist Office Visits</b>	100% after \$30 copayment	70% after deductible
<b>Urgent Care Center Visits</b>	100% after \$30 copayment	70% after deductible
<b>Telemedicine</b> (3)	100% after \$20 copayment	Not Covered
<b>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 (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
<b>Routine Pediatric</b>		
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
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>	90% after deductible	70% after deductible
<b>Hospital Outpatient</b>	90% after deductible	70% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	90% after deductible	70% after deductible
<b>Medical/Surgical</b> (except office visits)	90% after deductible	70% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b> (includes emergency medical and emergency accident)	100% after \$100 copayment (waived if admitted)	
<b>Ambulance</b>	90% after deductible	90% after in-network deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine/ Occupational Therapy</b>	100% after \$30 copayment	70% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
	Medical Review required for more than 24 visits	
<b>Speech Therapy</b>	100% after \$30 copayment	70% after deductible
	Medical Review required for more than 24 visits	
<b>Spinal Manipulations</b>	100% after \$30 copayment	70% after deductible
	Medical Review required for more than 24 visits	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory 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>	90% after deductible	70% after deductible
<b>Autism Services</b>	90% after deductible	70% after deductible
<b>Other Services</b>		
<b>Allergy Injections and Extracts</b>	90% after deductible	70% after deductible
<b>Assisted Fertilization Procedures</b>	90% after deductible	70% after deductible
	Limit: \$7,500 lifetime maximum combined with infertility	
<b>Bariatric Surgery</b>	90% after deductible	70% after deductible
<b>Diagnostic Services</b>	90% after deductible	70% after deductible
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, allergy testing)	90% after deductible	70% after deductible
<i>Pathology, Lab</i>	90% after deductible if performed at Quest or LabCorp, emergency room, or inpatient Otherwise, 70% after deductible	50% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	90% after deductible	70% after deductible
<b>Wigs-</b> Cancer diagnosis only	Limit: \$300 lifetime maximum	
<b>Hearing Aids</b>	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)	
<b>Home Health Care/Visiting Nurse</b>	90% after deductible	70% after deductible
	Limit: 120 visit per benefit period	
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (4)	90% after deductible	70% after deductible
	Limit: \$7,500 lifetime maximum combined with assisted fertilization	
<b>Private Duty Nursing</b>	90% after deductible	70% after deductible
	Limit: 70 visits per benefit period	
<b>Skilled Nursing Facility Care</b>	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
<b>Transplant Services</b>	90% after deductible	70% after deductible
<b>Precertification Requirements</b> (5)	Yes	

**Prescription Drug – After Deductible**

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

- (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.