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 – Technical Services
Effective: 01/01/2023

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period (1)	Calendar	
Deductible (per benefit period; excludes copays and prescription drug)		
Employee Only	$250	$500
Employee + 1 child/children	$250 / $375	$500 / $500
Employee + Spouse and/or Employee + Family	$250 / $500	$500 / $1,000
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 Maximums (excludes deductible, copays, and prescription drug) Employee pays 10% of allowance		
Employee Only	$750	$1,500
Employee + 1 child/children	$750 / $1,125	$1,500 / $1,500
Employee + Spouse and/or Employee + Family	$750 / $1,500	$1,500 / $3,000
Out-of-Pocket Maximums (Deductible + coinsurance) Once met, plan pays 100% for the rest of the benefit period; excludes deductible (2)		
Employee Only	$1,000	$2,000
Employee + 1 child/children	$1,000 / $1,500	$2,000 / $2,000
Employee + Spouse and/or Employee + Family	$1,000 / $2,000	$2,000 / $4,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $10 copayment	70% after deductible
Primary Care Provider Office Visits	100% after $10 copayment	70% after deductible
Specialist Office Visits	100% after $20 copayment	70% after deductible
Urgent Care Center Visits	100% after $20 copayment	70% after deductible
Telemedicine (3)	100% after $10 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
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

Benefit	Network	Out-of-Network
Therapy and Rehabilitation Services		
Physical Medicine/ Occupational Therapy	100% after $20 copayment	70% after deductible
	Medical Review required for more than 24 visits	
Speech Therapy	100% after $20 copayment	70% after deductible
	Medical Review required for more than 24 visits	
Spinal Manipulations	100% after $20 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	90% after deductible	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 **Wigs-** Cancer diagnosis only	90% after deductible Limit: $300 lifetime maximum	70% after deductible
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) Mandatory Generic *Defined by the National Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drug (30-day Supply)** Generic Drugs - 50% coinsurance Preferred Brand Drugs - 50% coinsurance Non-Preferred Brand Drugs - 70% coinsurance **Specialty** Preferred Brand Drugs - 50% coinsurance, $50 maximum Non-Preferred Brand - 70% coinsurance, $100 maximum **Mail Order Drug (90-day Supply)** Generic Drugs - 20% coinsurance Preferred Brand Drugs - 20% coinsurance Non-Preferred Brand Drugs - 70% coinsurance **Specialty** Preferred Brand Drugs - 50% coinsurance, $50 maximum Non-Preferred Brand - 70% coinsurance, $100 maximum
Prescription Drug OOP (plan will pay 100% coverage once the out of pocket is reached)	$1,000 individual $6,000 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.