

Summary of Lion Traditional Medical 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, Postdoctoral Appointee

Effective: 01/01/2026

Group Numbers: 106962-

00/01/02/03/04/05/06/07/08/09/70/75/76/77/78/79/20/21/22/23/24/25/94/95/34/35/36/37/38/39/97/98/40/41/42/43/44/45/99/60

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	\$2000	\$4,000
	Family	\$4000	\$8,000
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	\$2250	\$4,500
	Family	\$4500	\$9,000
\$45,001-\$60,000	Individual	\$2,375	\$4,750
	Family	\$4,750	\$9,500
\$60,001- \$90,000	Individual	\$2,500	\$5,000
	Family	\$5,000	\$10,000
\$90,000	Individual	\$2,625	\$5,250
	Family	\$5,250	\$10,500
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$20 copayment		70% after deductible
Primary Care Provider Office Visits/Virtual Visits	100% after \$20 copayment		70% after deductible
Specialist Office Visits/Virtual Visits	100% after \$30 copayment		70% after deductible
Urgent Care Center Visits	100% after \$30 copayment		70% after deductible
Telemedicine (3) (Well360 Virtual Medicine)	100% (copayment does not apply)		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 \$150 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 Use		
Inpatient	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation		
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 treatments Does not cover fertility drugs (4)	
Bariatric Surgery	90% after deductible	70% after deductible
Diagnostic Services	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 Independent lab (including Quest or Lab Corp), 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 treatments Does not cover fertility drugs (4)	
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

Benefit	Network	Out-of-Network
	Limit:100 days per benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (5)	Yes	

- (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 2026 the in-network Individual TMOOP amount is \$10,600 and the in-network Family TMOOP amount is \$21,200.
- (3) Services must be performed by a BS approved telemedicine provider through Well360 Virtual Medicine via MyHighmark
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy such as self-injected or oral medications are not covered under the medical or prescription benefits.
- (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.

Summary of Lion Traditional Prescription Benefits

On the chart below, you'll see what your responsibility is for prescription medications. Please note that your cost may reflect deductible, coinsurance, or separate out-of-pocket maximum expenses owed based on the benefit plan design (1).

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Prescription Drug	
Prescription Drug Program	<p style="text-align: center;">ACA Preventive Drug (2) 0% coinsurance</p> <p style="text-align: center;">CVS Preventive Drug (lower coinsurance) Generic Drugs - 10% coinsurance Preferred Brand Drugs - 20% coinsurance Non-Preferred Brand Drugs - 40% coinsurance</p> <p style="text-align: center;">Retail Drug (30-day supply or less) Generic Drugs - 50% coinsurance Preferred Brand Drugs - 50% coinsurance Non-Preferred Brand Drugs - 70% coinsurance</p> <p style="text-align: center;">Retail 90 (83-day supply or less) (3) Generic Drugs - 50% coinsurance Preferred Brand Drugs - 50% coinsurance Non-Preferred Brand Drugs - 70% coinsurance</p> <p style="text-align: center;">Retail 90 (84-day supply to 90-day supply) (3) Generic Drugs - 20% coinsurance Preferred Brand Drugs - 20% coinsurance Non-Preferred Brand Drugs - 70% coinsurance</p> <p style="text-align: center;">CVS Mail Order (84-day supply to 90-day supply) (4) Generic Drugs - 20% coinsurance Preferred Brand Drugs - 20% coinsurance Non-Preferred Brand Drugs - 70% coinsurance</p> <p style="text-align: center;">Specialty Generic Drugs - 50% coinsurance, \$100 maximum Preferred Brand Drugs - 50% coinsurance, \$100 maximum Non-Preferred Brand - 70% coinsurance, \$200 maximum</p>
Prescription Drug OOP (plan will pay 100% coverage once the out of pocket is reached)	<p>\$2,000 individual \$8,000 family</p>

- (1) 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 2026 the in-network Individual TMOOP amount is \$10,600 and the in-network Family TMOOP amount is \$21,200.
- (2) Preventive medications defined by the Affordable Care Act are medications that can be offered at no cost. Examples include bowel preparation, breast cancer primary prevention, contraceptives, fluoride, HIV PrEP, low dose generic statins (age based), tobacco cessation and vaccines.
- (3) University Health Services (UHS) is a convenient home or office delivery of your medications. UHS can fill your 30-day supply at the Retail Drug coinsurance, your 83-day supply or less as Retail 90 with same coinsurance as Retail Drug, or your maintenance medications as Retail 90 with same coinsurance as mail order.
- (4) CVS Mail Order is a convenient home delivery option through CVS for members to obtain their maintenance medications.
- (5) Prescriptions are generally covered if 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 an exception request form and return it to CVS Caremark for clinical review.
- (6) Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available, and you specify 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 coinsurance or copayment.
- (7) Medical treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy such as self-injected or oral medications are not covered under the medical or prescription benefits.