



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please access the plan coverage booklets from the [Penn State Employee Benefits](#) online content, or the medical plan administrator, Highmark Blue Shield at 1 (844) 945-5509, or the prescription plan administrator, CVS Caremark at 1 (833) 298-7175. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$250 individual/\$375 family <u>network</u> . \$500 individual/\$500 family out-of- <u>network</u> .	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , and <u>habilitation services</u> are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,000 individual/\$1,500 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$10,600 individual/\$21,200 family. \$2,000 individual/\$2,000 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they must meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

What is not included in the <u>out-of-pocket limit</u>?	<p><u>Network</u>: <u>Premiums</u>, balance-billed charges, and health care this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket.</p> <p><u>Out-of-network</u>: <u>Premiums</u>, balance-billed charges, <u>prescription drug</u> expenses, and health care this <u>plan</u> doesn't cover.</p>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See myhighmark.com or call 1 (844) 945-5509 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive</u> schedule for additional information.
	Telemedicine	\$0 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> for pathology and lab performed at Quest or LabCorp, otherwise 30% coinsurance for other providers.	30% <u>coinsurance</u> 50% <u>coinsurance</u> for Pathology/Lab	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
If you need drugs to treat your illness or condition, pharmacy coverage is through CVS Caremark beginning January 1, 2026. More information about <u>prescription drug coverage</u> is available online During the 2026 Annual Benefits Open Enrollment Period here; https://hr.psu.edu/2026-pharmacy-update . During the 2026 plan year within Penn State Employee Benefits Prescription Coverage or through CVS Caremark and mobile app beginning January 1, 2026.	ACA Preventive Drugs	0% coinsurance	Not covered	Prescription drug out-of-pocket maximum: \$2,000 individual/\$8,000 family.
	CVS Preventive Drugs	10% generic 20% brand preferred 40% brand non-preferred	Not covered	
	Retail Pharmacy (30-day supply or less)	50% generic 50% brand preferred 70% brand non-preferred	Not covered	Network prescription drugs are not subject to deductible. Select specialty drugs are available at a lower cost after enrollment with PrudentRx.
	Retail 90 Pharmacy (83-day supply or less)	50% generic 50% brand preferred 70% brand non-preferred	Not covered	
	Retail 90 Pharmacy (84-day supply up to 90-day supply)	20% generic 20% brand preferred 70% brand non-preferred	Not covered	
	CVS Mail Order (84-day supply up to 90-day supply)	20% generic 20% brand preferred 70% brand non-preferred	Not covered	
	CVS Specialty	50% generic, \$50 max 50% brand preferred, \$50 max 70% brand non-preferred, \$100 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$100 <u>copay</u> /visit <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Out-of-network: Subject to network deductible.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><u>Network</u>: The first visit to determine pregnancy is covered at no charge. Please refer to the Women’s Health <u>Preventive Schedule</u> for additional information. Precertification may be required.</p>
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 120 visits per benefit period, combined with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : rehabilitation and habilitation services.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : Medical review required for visit after 25 per therapy. Limit does not apply to services for the treatment of a mental health or substance abuse diagnosis. Precertification may be required.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 100 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification may be required.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	-----none----- --

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	-----none----- --

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care • Non-emergency care when traveling outside the U.S. See http://www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,200

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is \$1,510

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$1,800

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is \$2,170

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$550

Note: There is no wellness program that affects cost sharing or other benefits of the medical plan.

The plan would be responsible for the other costs of these EXAMPLE covered services.