Werner Enterprises, Inc. $1,500 with Copays Plan

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.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	01/01/2026	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $1,500 $3,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and deductible) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 $3,500 $7,000	 $7,000 $14,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $3,500 $7,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $40 copay	60% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $40 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $50 copay; $40 copay for physician assistants; $40 copay for nurse practitioners	60% after deductible
Urgent Care Center Visits	100% after $40 copay	60% after deductible
Telemedicine Services (3)	100% (deductible does not apply)	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	60% after deductible
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% after deductible
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	60% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services (5)	$250 copay (waived if admitted), then deductible and coinsurance	$250 copay (waived if admitted), then deductible and coinsurance
Ambulance - Emergency and Non-Emergency (6)	80% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Outpatient Surgery (facility)	80% after deductible	60% after deductible
Surgical Services (professional)	80% after deductible	60% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)	80% after deductible	60% after deductible
Therapy Services		
Physical Medicine	100% after $50 copay	60% after deductible
Speech Therapy	100% after $50 copay	60% after deductible
Occupational Therapy	100% after $50 copay	60% after deductible
Respiratory Therapy	100% after $50 copay	60% after deductible
Spinal Manipulations	100% after $50 copay	60% after deductible
	limit: 30 visits/benefit period	
Cardiac Rehabilitation Therapy	100% after $50 copay	60% after deductible
Infusion Therapy	100% after $50 copay	60% after deductible
Chemotherapy	80% after $50 copay	60% after deductible
Radiation Therapy	100% after $50 copay	60% after deductible
Dialysis	100% after $50 copay	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $40 copay for services done in a providers office; 80% after deductible for all other services not done in office setting	60% after deductible
Outpatient Substance Abuse Services	100% after $40 copay for services done in a providers office; 80% after deductible for all other services not done in office setting	60% after deductible
Other Services		
Acupuncture	100% after $50 copay	60% after deductible
Allergy Extracts and Injections	80% after deductible	60% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment		
Equipment and Supplies	80% after deductible	60% after deductible
Diabetes Education Program	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Mammograms, Medically Necessary	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Wigs	80% after deductible	60% after deductible
	Limit : $300 per benefit period	
Hearing Aids	80% after deductible	60% after deductible
	Limit: $1,000 per ear per benefit period	
Hearing Aid Exam	80% after deductible	60% after deductible
Home Health Care/Visiting Nurse	80% after deductible	60% after deductible
	limit: 120 visits/benefit period aggregate with visiting nurse	
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment (7)	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
	limit: 60 visits/benefit period	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	limit: 120 days/benefit period	
Transplant Services	100% after deductible for blue distinction center/bdc+; 80% after deductible if not bdc/bdc+	60% after deductible
Travel and Lodging (Transplant Services)	80% after deductible $10,000 Lifetime Maximum	60% after deductible $10,000 Lifetime Maximum
Precertification/Authorization Requirements (8)	Yes	Yes

Benefit	In Network	Out of Network
Prescription Drug		

Highmark Prescription Drug Program
 	
Hard Mandatory Generic – a penalty applies if choosing a brand drug if a generic drug is available.
 	
Pharmacy Network - Defined by the National Plus Pharmacy Network - Prescriptions filled at a non-network pharmacy are not covered.
 	
Formulary - Your plan uses the National Select Formulary.
 	
Specialty Medications – Outpatient specialty drugs require pre-certification through VIVIO Health. More information about specialty drug coverage is available at www.myVIVIO.com/Werner or 1-800-470-4034.
	Retail Pharmacy (up to 90-day supply)
	
	- $10 generic Copayment
	- 30% brand formulary copayment,
	  ○ Minimum $25 Copayment Maximum $50 Copayment
	- 45% brand non-formulary copayment,
	  ○ Minimum $40 Copayment
	  ○ Maximum $80 Copayment
		Not Covered

	Mail Order Pharmacy (up to 90-day supply)
	
	$25 generic Copayment
	- 30% brand formulary copayment,
	  ○ Minimum $62.50 Copayment Maximum $125 Copayment
	- 45% brand non-formulary copayment,
	  ○ Minimum $100 Copayment
	  ○ Maximum $200 Copayment
		Not Covered

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(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.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) 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.
(8) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.