Summary of HDHP 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.

Werner Enterprises, Inc. Employee Benefits Plan **$2,000 Deductible Plan w/ HSA**

Benefit	In Network	Out of Network
General Provisions		
Effective Date	1/1/2025	
Benefit Period(1)	Calendar Year (1/1/2025 – 12/31/2025)	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% coinsurance for the rest of the benefit period; Excludes amounts over UCR) Individual Family	 $3,650 $6,800	 $7,300 $13,600
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	80% after deductible	60% after deductible
Primary Care Provider Office Visits	80% after deductible	60% after deductible
Specialist Office Visits	80% after deductible	60% after deductible
Urgent Care Center Visits	80% after deductible	60% after deductible
Telemedicine (3)	80% after deductible	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
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; barium enema; blood occult)	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% after deductible
Mammograms, Annual Routine	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 (Includes Emergency medical / Emergency Accident)	80% after deductible	80% after in-network deductible
Ambulance	80% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Medical/Surgical	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine, Massage Therapy, Occupational Therapy and Speech Therapy.	80% after deductible	60% after deductible
Spinal Manipulations (Chiropractic Services)	80% after deductible limit: 30 visits/benefit period aggregate with chiropractic services	60% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	80% after deductible	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 and Substance Abuse	80% after deductible	60% after deductible
Autism (including ABA Therapy with no limits)(5)	80% after deductible	60% after deductible

Other Services		
Acupuncture	80% after deductible	60% after deductible
	Limit: 12 visits per benefit period	
Allergy Extracts & Injections	80% after deductible	60% after deductible
Assisted Fertilization	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
TMJ	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
Durable Medical Equipment	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 year 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 per benefit period	
Hospice	80% after deductible	60% after deductible
Private Duty Nursing (Outpatient only)	80% after deductible	60% after deductible
	Limit: 60 visits per benefit period	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	Limit: 120 days per benefit period	
Transplant Services	100% after deductible if performed in a BDC/BDC+ (6) 80% after deductible if not BDC/BDC+ in-network	60% after deductible
Travel/Lodging (Transplant Services)	80% after deductible $10,000 Lifetime Maximum	60% after deductible $10,000 Lifetime Maximum
Precertification Requirements(7)	Yes	Yes

Prescription Drug	
Highmark Prescription Drug Program (8) **Hard Mandatory Generic** (9) – 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)** - Generic – 80% after deductible - Brand Formulary – 80% after deductible - Brand Non - Formulary – 80% after deductible **Mail Order Pharmacy (up to 90-day supply)** - Generic – 80% after deductible - Brand Formulary – 80% after deductible - Brand Non - Formulary – 80% after deductible

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 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.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) Blue Distinction is a designation given by Blue Cross and Blue Shield (BCBS) companies to healthcare facilities (typically hospitals) that have demonstrated expertise in delivering quality healthcare. At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care - facilities that are recognized for their distinguished care in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, and transplants.
For more information or to locate a Blue Distinction Center, please visit https://www.bcbs.com/about-uscapabilities-initiatives/quality-care-thats-right-you

(7) Highmark 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 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.

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

(9) Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, regardless of your doctor requesting that the brand drug be dispensed.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

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

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

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

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

HIGHMARK.