Star Buick GMC | Lehigh Valley Flex Blue PPO $4,000 Plan

Group: Star GMC

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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 Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) (All in-network services are credited to both enhanced and standard deductibles.) Individual Family	 $4,000 $8,000	 $6,000 $12,000	 $12,000 $32,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 None None	 $2,500 $5,000	 $5,000 $10,000
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	 $10,150 $20,300		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	60% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	100% after $60 copay	60% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $50 copay	100% after $75 copay	60% after deductible
	copay does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse		
On-Demand Telemedicine Services (3) Includes Virtual Health Enhanced	100% after $15 copay		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% (deductible does not apply)
Breast Cancer Screenings	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% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)		60% after deductible
Emergency Services			
Emergency Room Services (5)	100% after $175 copay (waived if admitted)		
Ambulance - Emergency (6)	100% after enhanced in-network deductible		
Ambulance - Non-Emergency (6)	100% after enhanced in-network deductible		60% after deductible
Hospital and Medical / Surgical Expenses (5)			
Hospital Inpatient (including maternity)	100% after deductible	80% after deductible	60% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	60% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible	60% after deductible
Surgical Services (professional)	100% after deductible	80% after deductible	60% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible	60% after deductible

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Therapy Services			
Physical Medicine	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Speech Therapy	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Occupational Therapy	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Respiratory Therapy	100% after deductible	80% after deductible	60% after deductible
Spinal Manipulations	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible	60% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after enhanced in-network deductible		60% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced in-network deductible		60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $30 copay		60% after deductible
Outpatient Substance Abuse Services	100% after $30 copay		60% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	80% after deductible	60% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible	60% after deductible
Assisted Fertilization Procedures	not covered	not covered	not covered
Dental Services Related to Accidental Injury (10)	not covered	not covered	not covered
Diabetes Treatment			
Equipment and Supplies	100% after deductible	80% after deductible	60% after deductible
Diabetes Education Program	100% after deductible	80% after deductible	60% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)		60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible	60% after deductible
Enteral Foods	100% (deductible does not apply)		60% (deductible does not apply)
Home Health Care	100% after deductible	80% after deductible	60% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse		
Home Infusion and Suite Infusion Therapy	100% after deductible	80% after deductible	60% after deductible
Hospice	100% after enhanced in-network deductible		60% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	100% after deductible	80% after deductible	60% after deductible
Private Duty Nursing	100% after enhanced in-network deductible		60% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	80% after deductible	60% after deductible
	limit: 100 days/benefit period		
Therapeutic Injections	100% after deductible	80% after deductible	60% after deductible
Transplant Services (10)	100% after enhanced in-network deductible		60% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes	Yes
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (11) SensibleRx Complete Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31/60/90-day Supply)** $10 / $20 / $30 Generic copay $55 / $110 / $165 Formulary brand copay $80 / $160 / $240 Non-Formulary brand copay 30% for Specialty drugs $250 Maximum per Prescription **Maintenance Drugs through Mail Order (90-day Supply)** $20 Generic copay $110 Formulary brand copay $160 Non-Formulary brand copay 30% for Specialty drugs $500 Maximum per Prescription		

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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.

Signature of Client Representative	Title	Date

(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 any medical and prescription drug deductibles, coinsurance, and copays. If you are enrolled in a "Family plan", with your aggregate deductible, once an individual's deductible is satisfied, claim reimbursement for covered services will begin for that member. Once the family deductible is satisfied collectively by covered family members, claim reimbursement will begin for all covered family members. With your aggregate out-of-pocket limit, once an individual's out-of-pocket is satisfied, claim reimbursement for covered services will increase to 100% that member. Once the family out-of-pocket is satisfied collectively by covered family members, then 100% claim reimbursement for covered services will begin for all covered family members. With your aggregate TMOOP, once an individual's TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family TMOOP amount is satisfied collectively.
(3) On-Demand 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 (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) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(8) 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.
(9) 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.
(10) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).
(11) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved 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 SensibleRx Complete, 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. This program utilizes the Copay Armor Plus drug list.