December 2025 Open Enrollment

Dear Fellow Associates:

Star Buick GMC & Star Buick GMC Cadillac is pleased to announce Healthcare Enrollment 2025 is now open until December 20, 2024.

Employees making changes to their health insurance plan or supplemental benefits, such as life insurance, long term disability, short term disability, health savings account, or who have a change in their benefits usage status, must submit the appropriate forms by the 12/20/2024, deadline; NO forms will be accepted after that date for open enrollment purposes.

A $25,000 Prudential Life Insurance Policy is now available as a full-time employee benefit. For the HDHP4000 plan, a Health Savings Account will now offer a tax-free opportunity to set aside funds to pay deductibles and co-pays as hey arise. For updated information, please refer to the open enrollment page at **www.starcarhr.com**.

All employees are requested to return the selection form either selecting a health plan or declining coverage. You may deliver forms to the Main Office in Quakertown – or the Human Resources Office in Easton.

To assist Star employees in understanding the benefits offered to them and options to save money through employee benefits, we have enlisted the help of Jennifer Kinley of American Fidelity. Employees may contact her at (800)654-8489 ext 2495 or e-mailing Jennifer.kinley@americanfidelity.com.

Questions or concerns? Please feel free to contact me by calling (610)844-4323 or e-mailing robg@starcar.com.

Sincerely,

Rob Grow
StarCarHR

Easton & Quakertown
CIRCLE YOUR WORK LOCATION

star

Star Premium Benefits Coverage
1/1/2025-12/31/2025
(See Benefit Plan Summary for details.)

Employee Name: _____ Employee#_____ Hire Date ____/____/___

NON-SMOKER AGREEMENT: I will not smoke or vape while at work. Initial: _____

Circle Your Selection	Employee	Employee & Spouse	Employee & Child/Children	Employee & Family
LV Flex Blue HSA 4000	**$99.95**	$395.95	$407.95	$641.95
LV Flex Blue PPO 2000	**$152.95**	$481.95	$493.95	$703.95
LV Flex Blue PPO 1000	**$188.95**	$522.95	$570.95	$753.95
Dental Plan until 06/30/25:	$10.64	$35.30	$35.30	$35.30
Vision Plan until 06/30/25:	$1.67	$4.98	$4.98	$4.98

I choose to be enrolled in the above circled plan offered by the Star Dealerships: _____

***Add a Health Savings Account (HSA) in the amount of $_____ per bi-weekly pay.**

I decline HighMark Blue Shield medical & drug coverage: _____ **Date**_____

I wish to enroll in the Prudential Life Insurance benefit offered by Star _____

Spousal Employment Affirmation

If you are married and your spouse is employed full time and has Medical/Rx coverage available to him/her. I understand that my spouse is not considered an eligible dependent under my Medical/RX coverage. Initial _____

401K: You have the option to enroll in a 401K Retirement plan after 1 year of employment. Please let HR know of your intent to enroll or waive your 401K plan.

_____**I wish to enroll in the 401(k) Retirement Plan.**

_____ I am **declining** participation in the 401(k) Retirement Plan.

IMFORMATION ABOUT THE ACA GOVERNMENT HEALTHCARE MARKETPLACE CAN BE FOUND AT: www.healthcare.gov

Employee Signature: _____ **Date:** _____

Employee Print Name: _____

*HSA4000 only

Easton & Quakertown
CIRCLE YOUR WORK LOCATION

star

Star Standard Benefits Coverage
1/1/2025-12/31/2025
(See Benefit Plan Summary for details.)

Employee Name: _____ Employee# _____ Hire Date ____/____/___

Circle Your Selection	Employee	Employee & Spouse	Employee & Child/Children	Employee & Family
LV Flex Blue HSA 4000	**$115.95**	$409.95	$419.95	$661.95
LV Flex Blue PPO 2000	**$169.95**	$499.95	$499.95	$719.95
LV Flex Blue PPO 1000	**$199.95**	$535.95	$590.95	$768.95
Dental Plan until 06/30/25:	**$10.64**	$35.30	$35.30	$35.30
Vision Plan until 06/30/25:	**$1.67**	$4.98	$4.98	$4.98

I choose to be enrolled in the above circled plan offered by the Star Dealerships: _____

***Add a Health Savings Account (HSA) in the amount of $_____ per bi-weekly pay.**

I decline HighMark Blue Shield medical & drug coverage: _____ **Date**_____

I wish to enroll in the Prudential Life Insurance benefit offered by Star _____

Spousal Employment Affirmation

If you are married and your spouse is employed full time and has Medical/Rx coverage available to him/her. I understand that my spouse is not considered an eligible dependent under my Medical/RX coverage. Initial _____

401K: You have the option to enroll in a 401K Retirement plan after 1 year of employment. Please let HR know of your intent to enroll or waive your 401K plan.

_____ **I wish to enroll in the 401(k) Retirement Plan.**

_____ I am **declining** participation in the 401(k) Retirement Plan.

IMFORMATION ABOUT THE ACA GOVERNMENT HEALTHCARE MARKETPLACE CAN BE FOUND AT: www.healthcare.gov

Employee Signature: _____ **Date:** _____

Employee Print Name: _____

*HSA4000 only

Provided by: star

PROTECTING WHAT MATTERS MOST TO YOU

Secure your future with Prudential

Effective January 1, 2025, Star Auto Group will be providing a new **employer-paid benefit** to all full-time employees: a **$25,000 Prudential Life and AD&D policy**.

New Benefit Includes:

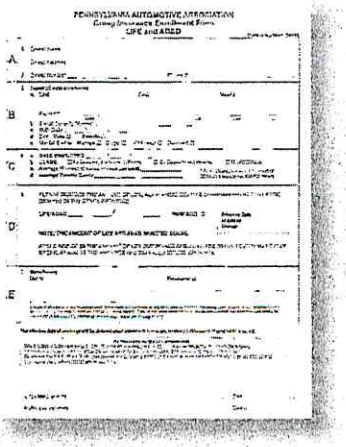
- $25,000 for loss of life.
- $50,000 for loss of life - in the event of an accidental death.
- Dismemberment benefit - financial reimbursement for losing sight, a limb, fingers, etc.

Please reference the Certificate of Coverage booklet for additional details on your benefit.

How to Enroll

Please complete a Prudential Life enrollment form and document your desired beneficiary(s).

ENROLLMENT FORM →



QUESTIONS? 1-800-222-8712

PAA

PENNSYLVANIA AUTOMOTIVE ASSOCIATION
Group Insurance Enrollment Form
LIFE and AD&D

Control Number: 08450

A

1. Dealer Name _____

Dealer Address _____

2. Dealer Number _____ Phone # _____

B

3. **Name of new employee**
   a. Last First Middle

   _____

   Address: _____
   Street City State Zip
   b. Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___
   c. Birth Date ___ ___ / ___ ___ / ___ ___
   d. Sex: Male ☐ Female ☐
   e. Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

C

4. a. **DATE EMPLOYED** ___ ___ / ___ ___ / ___ ___
   b. **CLASS:** ☐ I - Owners, Partners, Officers ☐ II - Department Heads ☐ III - All Others
   c. Average Number of hours worked per week _____.
   d. Average Weekly Salary _____

* An employee must work a minimum of 20 hours a week to maintain this benefit.

D

5. PLEASE INDICATE THE AMOUNT OF LIFE, ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE DESIRED IN THE SPACE PROVIDED.

LIFE/AD&D _____ / _____ **NEW ADD** ☐

Effective Date of Add or Change _____

NOTE: THE AMOUNT OF LIFE AND AD&D MUST BE EQUAL.

AT THE AGE OF 65 THE AMOUNT OF LIFE INSURANCE AND AD&D ARE REDUCED AUTOMATICALLY BY 25%. AT AGE 70 THE AMOUNTS ARE REDUCED BY LIKE AMOUNTS.

E

6. **Beneficiary**
   Name Social Security Number Relationship

   _____

   _____

If more than I beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Policy.

The effective date of coverage will be delayed when enrollment forms are received subsequent to your waiting period.

Pennsylvania Notice of Compensation

Why this Notice is Being Provided - Title 40 of the PA Statutes, Section 532.7c. requires Prudential to provide the following information to those enrolling in group life insurance under a contract issued in Pennsylvania to this Contract Holder:
Be advised that the Contract Holder may receive and/or retain a portion of the contributions paid under the plan to be used for general purposes of the Contract Holder and/or members.

Employee Signature _____ Date _____

Authorized Signature _____ Date _____

Veris - Star Buick GMC 2025
Lehigh Valley Flex Blue PPO $1000
Group numbers: 025651-30; 33, 36, 39, 43, 46

HIGHMARK.

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, 2024		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) (All in-network services are credited to both enhanced and standard deductibles.) Individual Family	 $1,000 $2,000	 $3,000 $6,000	 $6,000 $12,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $3,000 $6,000	 $6,000 $12,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $9,100 $18,200		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	100% after $60 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $50 copay	100% after $75 copay	50% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse		
Telemedicine Services (3)	100% after $15 copay	100% after $15 copay	not covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Emergency Services			
Emergency Room Services (5)	100% after $175 copay (waived if admitted)		

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Ambulance - Emergency (6)	100% after deductible	100% after enhanced in-network deductible	100% after enhanced in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	100% after enhanced in-network deductible	50% after program deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $30 copay	100% after $60 copay	50% 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	70% after deductible	50% after deductible
Speech Therapy	100% after $30 copay	100% after $60 copay	50% 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	50% 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		
Spinal Manipulations	100% after $30 copay	100% after $60 copay	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after deductible	100% after enhanced in-network deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	100% after enhanced in-network deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $30 copay	100% after $30 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $30 copay	100% after $30 copay	50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered	not covered
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse		
Hospice	100% after deductible	100% after enhanced in-network deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	100% after enhanced in-network deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	100% after enhanced in-network deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes	Yes

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (10) Hard Mandatory Generic 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 generic 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 generic 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.

(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 (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) 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 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. 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.

Veris Star Buick GMC - 2025
Lehigh Valley Flex Blue HDHP $4000
Group numbers: 025651-32; 35, 38, 41, 45, 48

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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, 2024		
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 $24,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and prescription drug cost sharing. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $500 $1,000	 $1,000 $2,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,500 $15,000		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after deductible	80% after deductible	60% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after deductible	80% after deductible	60% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	80% after deductible	60% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible	60% after deductible
Telemedicine Services (3)	100% after enhanced in-network 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
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)		60% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)		60% after deductible
Mammograms, Medically Necessary	100% after enhanced in-network deductible		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 deductible	100% after enhanced in-network deductible	100% after enhanced in-network deductible
Ambulance - Emergency (6)	100% after deductible	100% after enhanced in-network deductible	100% after enhanced in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	100% after enhanced in-network deductible	60% after program deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)			
Hospital Inpatient	100% after deductible	80% after deductible	60% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	60% after deductible

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible	60% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after deductible	80% after deductible	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
Speech Therapy	100% after deductible	80% after deductible	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 deductible	80% after deductible	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		
Spinal Manipulations	100% after deductible	80% after deductible	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 enhanced in-network deductible		60% after deductible
Outpatient Substance Abuse Services	100% after enhanced in-network deductible		60% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	80% after deductible	60% after deductible
Assisted Fertilization Procedures	not covered		not covered
Dental Services Related to Accidental Injury	not covered		not covered
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
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible	60% after deductible
Home Health Care	100% after deductible	80% after deductible	60% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse		
Hospice		100% after enhanced in-network deductible	60% after deductible
Infertility Counseling, Testing and Treatment (8)	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		
Transplant Services	100% after enhanced in-network deductible		60% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes	Yes
Prescription Drugs			
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible		
Prescription Drug Program (10) 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 Open Benefit Design	**Retail Drugs (31/60/90-day Supply)** Plan Pays 100% after enhanced in-network deductible **Maintenance Drugs through Mail Order (90-day Supply)** Plan Pays 100% after enhanced in-network 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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.

(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. If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. In addition, with your embedded out-of-pocket limit, once an individual family member's out-of-pocket limit is satisfied, additional claims reimbursement begins for that person. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family TMOOP amount is met.
(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 (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. 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. This formulary covers all FDA-approved generic and brand-name drugs. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details.

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.