

Highlights of your Health Care Coverage

VIGILANT MANUFACTURERS TRUST

Effective Date: 10/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		
	PPO 50% PLAN 1000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$1,000	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	50%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$5,500	Shared with In-Network
Office Visit Cost Share	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Dep Child up to Age 18 Covered In Full; Members 18 & over Out of Network Deductible, Coinsurance
Health Education (HE) (Unlimited)	Covered In full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max

MEDICAL PLAN		
PPO 50% PLAN 1000		
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Prevention	Excluded	Excluded
Diabetes Management	Excluded	Excluded
Hypertension Management	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		
Professional Office Visit	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Other Professional Diagnostic Imaging	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Professional Diagnostic Major Imaging	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service

MEDICAL PLAN		PPO 50% PLAN 1000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
FACILITY CARE OPTIONS			
Inpatient Facility	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Inpatient Professional Services	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Outpatient Surgery Facility	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
MEDICAL TRANSPORTATION BENEFITS			
Transplant Travel & Lodging (\$7,500 per transplant)	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$1,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,500 Out of Pocket Maximum	\$200 Copay then \$1,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,500 Out of Pocket Maximum	
Emergency Room Physician	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	

MEDICAL PLAN		
	PPO 50% PLAN 1000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Urgent Care Center	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 visits PCY combined limit for outpatient services)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

MEDICAL PLAN		PPO 50% PLAN 1000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Transplants (Unlimited)	Covered as any other service	Not Covered	
SUPPLEMENTAL BENEFITS			
Routine Hearing Exam (1 every 36 months)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Hearing Hardware (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full	
ANNUAL PLAN MAXIMUM			
Annual Plan Maximum	Unlimited	Unlimited	

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

VIGILANT MANUFACTURERS TRUST

Effective Date: 10/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PPO 50% PLAN 1000 - RX	
PRESCRIPTION DRUGS	
Drug List	A1
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	Shared with Medical Deductible
Family Deductible PCY	Family Deductible 2x Individual
Out of Network (Non-participating retail pharmacies)	Same as In-Network
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	50%
Mail Cost Shares	50%
Day Supply	Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

