

Highlights of your Health Care Coverage

VIGILANT MANUFACTURERS TRUST

Effective Date: 10/01/2025

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 80% PLAN 1000 | |
|---|--|--|--|
| | IN-NETWORK | OUT-OF-NETWORK | |
| MEDICAL COST SHARES | | | |
| 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) | 20% | 50% | |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual) | \$5,000 | Shared with In-Network | |
| Office Visit Cost Share | \$30 Copay, applies to the \$5,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum | |
| 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 | |
| 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 | | | |

| MEDICAL PLAN | | PPO 80% PLAN 1000 | |
|--|---|--|--|
| | IN-NETWORK | OUT-OF-NETWORK | |
| Diabetes Management Plus | Included | Not Applicable | |
| PROFESSIONAL CARE | | | |
| Professional Office Visit | \$30 Copay, applies to the \$5,000 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 | \$30 Copay, applies to the OOP Max | 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) | \$30 Copay, applies to the OOP Max | 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 SERVICES | | | |
| Preventive Imaging and Laboratory | Covered in Full | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Diagnostic Laboratory | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Basic Diagnostic Imaging | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Major Diagnostic Imaging | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Preventive Mammography | Covered in Full | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Diagnostic Mammography | Covered in Full | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| Supplemental Breast Exam | Covered in Full | First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible, Coinsurance | |
| FACILITY CARE | | | |
| Inpatient Facility | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum | |

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|---|---|---|--|
| | IN-NETWORK | OUT-OF-NETWORK | |
| Inpatient Professional Services | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 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 20% Coinsurance, applies to \$5,000 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 20% Coinsurance, applies to \$5,000 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 20% Coinsurance, applies to \$5,000 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 20% Coinsurance, applies to \$5,000 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 \$5,000 Out of Pocket Maximum | \$1,000 Deductible, 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum | |
| EMERGENCY CARE AND TRANSPORTATION | | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$200 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum | \$200 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum | |
| Emergency Room Physician | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | |
| Urgent Care Center | \$30 Copay, applies to the \$5,000 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 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | |
| ALTERNATIVE CARE | | | |

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|---|--|--|--|
| | IN-NETWORK | OUT-OF-NETWORK | |
| Acupuncture (12 visits PCY) | \$30 Copay, applies to the \$5,000 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) | \$30 Copay, applies to the \$5,000 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 20% Coinsurance, applies to \$5,000 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) | \$30 Copay, applies to the \$5,000 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 20% Coinsurance, applies to \$5,000 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) | \$30 Copay, applies to the \$5,000 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 20% Coinsurance, applies to \$5,000 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) | \$30 Copay, applies to the \$5,000 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 | \$30 Copay, applies to the \$5,000 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 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum | |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$1,000 Deductible, then 20% Coinsurance, applies to \$5,000 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) | \$30 Copay | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum | |

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|--|-------------------|-----------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| 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

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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 80% PLAN 1000 - RX |
|---|---|
| PRESCRIPTION DRUGS | |
| Formulary Drug List | Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty |
| Annual Benefit Maximum | Unlimited |
| Individual Deductible PCY | \$0 |
| Family Deductible PCY | No Family Deductible |
| 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 | \$10/\$40/\$70/\$250 |
| Mail Cost Shares | \$30/\$120/\$210/\$250 |
| Day Supply | Retail Rx Copay = 30 Days; up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days |

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

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