PREMERA | BLUE CROSS

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 2500**	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$2,500	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)	$6,000	Shared with In-Network
Office Visit Cost Share	$30 Copay, applies to the $6,000 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 2500	
	IN-NETWORK	**OUT-OF-NETWORK**
Diabetes Management Plus	Included	Not Applicable
PROFESSIONAL CARE		
Professional Office Visit	$30 Copay, applies to the $6,000 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	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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 80% PLAN 2500	
	IN-NETWORK	**OUT-OF-NETWORK**
Inpatient Professional Services	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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)	$2,500 Deductible, 0% Coinsurance, applies to $6,000 Out of Pocket Maximum	$2,500 Deductible, 0% Coinsurance, applies to $6,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay then $2,500 Deductible and 20% Coinsurance; all cost shares apply to the $6,000 Out of Pocket Maximum	$200 Copay then $2,500 Deductible and 20% Coinsurance; all cost shares apply to the $6,000 Out of Pocket Maximum
Emergency Room Physician	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum
Urgent Care Center	$30 Copay, applies to the $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum
ALTERNATIVE CARE		

MEDICAL PLAN	PPO 80% PLAN 2500	
	IN-NETWORK	**OUT-OF-NETWORK**
Acupuncture (12 visits PCY)	$30 Copay, applies to the $6,000 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 $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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 $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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 $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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 $6,000 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 $6,000 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	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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)	$2,500 Deductible, then 20% Coinsurance, applies to $6,000 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

Effective Date: 10/01/2025

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 2500 - 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

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Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທຫາເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອເຊດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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