

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 70% PLAN 4000	
	IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$4,000	Shared with In-Network	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$7,000 PCY	Shared with In-Network	
Office Visit Cost Share	\$40 Copay, applies to the \$7,000 PCY 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 70% PLAN 4000	
	IN-NETWORK	OUT-OF-NETWORK	
Diabetes Management Plus	Included	Not Applicable	
PROFESSIONAL CARE			
Professional Office Visit	\$40 Copay, applies to the \$7,000 PCY 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	\$40 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)	\$40 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	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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 70% PLAN 4000	
	IN-NETWORK	OUT-OF-NETWORK	
Inpatient Professional Services	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$4,000 Deductible, 0% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	\$4,000 Deductible, 0% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,000 PCY Out of Pocket Maximum	\$200 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,000 PCY Out of Pocket Maximum	
Emergency Room Physician	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	
Urgent Care Center	\$40 Copay, applies to the \$7,000 PCY 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 70% PLAN 4000	
	IN-NETWORK	OUT-OF-NETWORK	
Ambulance Transportation (Unlimited)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$40 Copay, applies to the \$7,000 PCY 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)	\$40 Copay, applies to the \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$40 Copay, applies to the \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$40 Copay, applies to the \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$40 Copay, applies to the \$7,000 PCY 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	\$40 Copay, applies to the \$7,000 PCY 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	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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)	\$4,000 Deductible, then 30% Coinsurance, applies to \$7,000 PCY 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	

MEDICAL PLAN	PPO 70% PLAN 4000	
	IN-NETWORK	OUT-OF-NETWORK
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	\$40 Copay; Test: Covered in Full	OON Deductible, then OON Coinsurance
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 70% PLAN 4000 - 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/\$50/\$80/\$250
Mail Cost Shares	\$30/\$150/\$240/\$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.

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.

