

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	HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible = \$6,000 PCY)	\$5,500 PCY/\$6,000 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$6,500 PCY	Shared with In-Network
Office Visit Cost Share	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
CHRONIC CONDITION MANAGEMENT PROGRAMS		

MEDICAL PLAN		HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK	
Diabetes Management Plus	Included	Not Applicable	
PROFESSIONAL CARE			
Professional Office Visit	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Telemedicine with Traditional Providers - General Medical	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max	
Diagnostic Laboratory	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Basic Diagnostic Imaging	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Major Diagnostic Imaging	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Preventive Mammography	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Supplemental Breast Exam	Covered in Full	Covered as any other service	
FACILITY CARE			
Inpatient Facility	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

MEDICAL PLAN		HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK	
Inpatient Professional Services	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Outpatient Surgery Facility	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
MEDICAL TRANSPORTATION BENEFITS			
Transplant Travel & Lodging (\$7,500 per transplant)	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Emergency Room Physician	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Urgent Care Center	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

MEDICAL PLAN		HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK	
Ambulance Transportation (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Manipulations (Spinal and other) (12 visits PCY)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
PHARMACY			
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers	
Prescription Drugs - Retail (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
Prescription Drugs - Mail (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

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	IN-NETWORK	OUT-OF-NETWORK	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
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.

