PREMERA HMO

Highlights of your Health Care Coverage

VIGILANT MANUFACTURERS TRUST

Effective Date: 10/01/2023

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	**2023 HMO 2000**	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$2,000	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,000	Not Covered
Office Visit Cost Share	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum; $60 Copay Specialist, applies to the $4,000 Out of Pocket Maximum	Not Covered
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		

MEDICAL PLAN	2023 HMO 2000	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Professional Office Visit	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum; $60 Copay Specialist, applies to the $4,000 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - Specialist	$60 Copay Specialist, applies to the $4,000 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$5 Copay PCP, applies to the $4,000 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	Not Covered
Other Professional Diagnostic Imaging	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Professional Diagnostic Major Imaging	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Other Professional Diagnostic Laboratory/Pathology	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Diagnostic Mammography	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
FACILITY CARE OPTIONS		
Inpatient Facility	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered

MEDICAL PLAN	2023 HMO 2000	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
Sterilization - Female (Unlimited)	Covered in Full	Not Covered
Sterilization - Male (Unlimited)	Covered in Full	Not Covered
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence for Knee & Hip Total Joint Replacement (Not Including Partial & Revisions) (Excluded)	Not Applicable, no eligible Centers of Excellence providers	Not Applicable, no eligible Centers of Excellence providers
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions) (Excluded)	Excluded	Excluded
Centers of Excellence for Radiology (Member Outreach Excluded)	Covered as any other service	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$2,000 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum	$2,000 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$300 Copay then $2,000 Deductible and 20% Coinsurance; all cost shares apply to the $4,000 Out of Pocket Maximum	$300 Copay then $2,000 Deductible and 20% Coinsurance; all cost shares apply to the $4,000 Out of Pocket Maximum
Emergency Room Physician	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $4,000 Out of Pocket Maximum	$25 Copay, applies to the $4,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	$5 Copay PCP, applies to the $4,000 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		

MEDICAL PLAN	2023 HMO 2000	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 visits PCY combined limit for outpatient services)	$60 Copay Specialist, applies to the $4,000 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$60 Copay Specialist, applies to the $4,000 Out of Pocket Maximum	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	$2,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	Not Covered
Transplants (Unlimited)	Covered as any other service	Not Covered
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 HMO. Members are responsible for amounts more than 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: 10/01/2023

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List at www.premera.com.

PHARMACY PLAN	**2023 HMO 2000 - PHARMACY $10/$40/$70/$150**
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	NO RX DEDUCTIBLE
Family Deductible PCY	NO FAMILY DEDUCTIBLE
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	$10/$40/$70/$150
Mail Cost Shares	$25/$100/$70/$375.
Day Supply	Retail: 30 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 HMO. Members are responsible for amounts more than 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.

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera HMO provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-722-4661 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-722-4661（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.

058940 (09-01-2022)