Highlights of your Health Care Coverage

Silver Bay Seafoods, LLC

Group Number: 4018083 Effective Date: 06/01/2025

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	**2025 HS $1500/20-50%/$4000/$30**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$1,500 PCY	$3,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,000 PCY	$45,000 PCY
Office Visit Cost Share	$30 Non Specialist; $50 Specialist; Applies to OOPM	$30 Non Specialist; $50 Specialist; Applies to OOPM
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered In Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Included
Diabetes Prevention Plus	Excluded	Excluded
Hypertension Plus	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	$30 Non Specialist; $50 Specialist; Applies to OOPM	$30 Non Specialist; $50 Specialist; Applies to OOPM
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	Covered in Full	Not Covered

MEDICAL PLAN	2025 HS $1500/20-50%/$4000/$30	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Not Covered)	Not Covered	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Diagnostic Laboratory	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Basic Diagnostic Imaging	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Major Diagnostic Imaging	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		

MEDICAL PLAN	2025 HS $1500/20-50%/$4000/$30	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Inpatient Facility	INN ded, then 20% Preferred / 30% Participating	Out of Network Ded,then Hospital 50%; Other Facilities & Professionals: Same as INN
Inpatient Professional Services	INN Deductible, then 20%	Same as In Network
Outpatient Surgery Facility	INN deductible, then 20% Preferred / 30% Participating	OON deductible, then Hospital 50%; Other Facilities & Professionals same as INN cost
Outpatient Facility	INN deductible, then 20% Preferred / 30% Participating	Out of Network Ded,then Hospital 50%; Other Facilities & Professionals: Same as INN
Skilled Nursing Facility (120 days PCY)	INN Deductible, then 20% Preferred/20% Participating	Same as In Network
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	INN Ded then 20% preferred / 30% Participating	Ded, then Hospital 50%; all Prof same as INN, highest benefit level
Hospice Care (Home Health and Respite) (Unlimited)	INN Deductible, then 20%	Same as In Network Cost share (highest benefit level)
Home Health Visits (120 visits PCY)	Deductible then 20%	Same as In Network
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Covered In Full
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
Sterilization - Male (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 50% Non-Participating; Other Facilities and All Professionals: Same as In-Network Cost Share (highest benefit level)
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
Medical Access Transportation (INN / OON:2 round trips PCY paid at highest benefit level (INN Ded/Coin))	INN / OON:2 round trips PCY paid at highest benefit level (INN Ded/Coin)	INN / OON:2 round trips PCY paid at highest benefit level (INN Ded/Coin)
Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%

MEDICAL PLAN	2025 HS $1500/20-50%/$4000/$30	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	Covered in Full	Covered in Full
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%	$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%
Emergency Room Physician	In Network Deductible, then 20%	In Network Deductible, then 20%
Urgent Care Center	$30 Copay, applied to the OOPM	$30 Copay, applied to the OOPM
Ambulance Transportation (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 60%
ALTERNATIVE CARE		
Acupuncture (Accupuncture; Manipulations (spinal & other); & MT: Limited to 25 visits PCY all combined)	$30 Non Specialist; $50 Specialist; applies to oopm	$30 Non Specialist; $50 Specialist, applies to OOPM
Manipulations (Spinal and other) (Accupuncture; Manipulations (spinal & other); & MT: Limited to 25 visits PCY all combined)	$30 Non Specialist; $50 Specialist; applies to oopm	$30 Non Specialist; $50 Specialist, applies to OOPM
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	INN Ded, then 20% Preferred	OON Ded,then Hosp & Hosp Based CD: 50%,Other Fac & All Prof:Same as INN Cost share(highest benefit)
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Non Specialist copay	$30 Non Specialist copy
Mental Health Inpatient Facility Care (.)	INN Deductible, then 20% preferred	OON Ded,then Hosp & Hosp Based CD: 50%,Other Fac & All Prof:Same as INN Cost share(highest benefit)
Mental Health Outpatient Professional Care (Unlimited)	$30 Non Specialist	$30 Non Specialist
REHABILITATION & NEURO		
Rehab Inpatient Facility (Unlimited)	In Network Deductible, then 20% Preferred, 30% Participatin	OON ded, then Hosp & Hosp based CD program: 50%; other fac & all Prof: same as INN
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (PT/OT/ST 90 visits PCY, Cardiac & Pul Rehab 72 visits PCY combined)	$30 Non Specialist; $50 Specialist, applies to OOPM	$30 Non Specialist; $50 Specialist, applies to OOPM
OTHER SERVICES		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Allergy/Therapeutic Injections	$30 Copay, applies to OOPM	$30 Copay; applies to OOPM
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	INN Deductible, then 20%	OON ded, then Hosp & Hosp based CD program: 50%; other fac & all Prof: same as INN
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (Not Covered)	Not Covered	Not Covered
Vision Hardware (Not Covered)	Not Covered	Not Covered
Pediatric Vision Exam (Not Covered)	Not Covered	Not Covered
Pediatric Vision Hardware (Not Covered)	Not Covered	Not Covered
Routine Hearing Exam (1 every 2 calendar years)	$30 copay	$30 copay
Hearing Hardware ($3,000 every 3 calendar years)	Covered in Full	Covered In Full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
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 Blue Shield of Alaska. 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

Silver Bay Seafoods, LLC

Group Number: 4018083 — Effective Date: 06/01/2025

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 in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN	**2025 HS RX $0-$10/$25/$50**
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	INN: $10/$25/$50 OON $10/$25/$50 then 40% Coinsurance
Mail Cost Shares	INN: $20/$50/$100 OON: Not covered
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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