

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 HSA \$3300/20%/\$5500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$3,300 PCY	Shared with In-Network	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/40% Participating	Hospital & Professional: 50% Non-Participating	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$5,500 PCY	\$45,000 PCY	
Office Visit Cost Share	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
APP-BASED VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	INN Deductible, then 20%	Not Covered	

MEDICAL PLAN		2025 HSA \$3300/20%/\$5500	
	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 & Professional: 50% Non-Participating	
Diagnostic Laboratory	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Basic Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Major Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Supplemental Breast Exam	Covered in Full	Covered as any other service	
FACILITY CARE			
Inpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Inpatient Professional Services	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Outpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Skilled Nursing Facility (120 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Hospice Care (Home Health and Respite) (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	

MEDICAL PLAN		2025 HSA \$3300/20%/\$5500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Home Health Visits (120 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
MEDICAL CARE COORDINATION AND TRAVEL SERVICES			
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	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 (2 round trips PCY paid at highest benefit level (INN ded/Coin))	2 round trips PCY paid at highest benefit level (INN ded/Coin)	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%	
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)	\$3,300 PCY Deductible, then 0%	\$3,300 PCY Deductible, then 0%	
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service	
EMERGENCY CARE			
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Urgent Care Center	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
ALTERNATIVE CARE			
Acupuncture (Acupuncure; Manipulations (Spinal & Other); & MT; Limited to 25 visits PCY all combinted)	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	

MEDICAL PLAN		2025 HSA \$3300/20%/\$5500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Manipulations (Spinal and other) (Acupuncture; Manipulations (Spinal & Other); & MT; Limited to 25 visits PCY all combined)	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
PHARMACY			
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers	
Enhanced Preventive Drug List (PV Core)	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20% Preferred	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20% Preferred	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
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)	In Network Deductible, then 20% Preferred/40% Participatingbefore	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
OTHER SERVICES			
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 50% Non-Participating	
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	

MEDICAL PLAN		2025 HSA \$3300/20%/\$5500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Routine Hearing Exam (1 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%	
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%	
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.