Highlights of your Health Care Coverage

MainVue Homes, LLC
Group Number: 4024205

Effective Date: 10/01/2022

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	PREMERA PREFERRED CHOICE: PPO - $1,000/20%/50%/$5,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$1,000	$2,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000	Unlimited
Office Visit Cost Share	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
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		
Professional Office Visit	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $5,000 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

MEDICAL PLAN	PREMERA PREFERRED CHOICE: PPO - $1,000/20%/50%/$5,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Waive Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Covered in Full	Covered as any other service
Centers of Excellence for Radiology (Member Outreach Included)	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS		

MEDICAL PLAN	PREMERA PREFERRED CHOICE: PPO - $1,000/20%/50%/$5,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Covered in Full
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $5,000 Out of Pocket Maximum	$150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $5,000 Out of Pocket Maximum
Emergency Room Physician	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum
Urgent Care Center	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$30 Copay, applies to the $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	Covered in Full	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,000 Out of Pocket Maximum	$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered

MEDICAL PLAN	PREMERA PREFERRED CHOICE: PPO - $1,000/20%/50%/$5,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	$25 Copay
Vision Hardware ($150 every 2 consecutive calendar years)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PCY under age 19)	$25 Copay, applies to the $5,000 Out of Pocket Maximum	$25 Copay, applies to the $5,000 Out of Pocket Maximum
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Health Care Coverage

MainVue Homes, LLC
Group Number: 4024205

Effective Date: 10/01/2022

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	**PREMERA PREFERRED CHOICE: AGG HSA - $1,500/20%/50%/$4,000/DED.COINS (MAC) HERITAGE**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$1,500/$3,000	$3,000/$6,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,000	Unlimited
Office Visit Cost Share	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
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		
Professional Office Visit	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $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

MEDICAL PLAN	PREMERA PREFERRED CHOICE: AGG HSA - $1,500/20%/50%/$4,000/DED.COINS (MAC) HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		

MEDICAL PLAN	PREMERA PREFERRED CHOICE: AGG HSA - $1,500/20%/50%/$4,000/DED.COINS (MAC) HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Contraceptive Management Services (Unlimited)	Covered in Full	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductibles, then 0% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	$1,500/$3,000 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum	Covered as any other service
Centers of Excellence for Radiology (Member Outreach Included)	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS		
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	$1,500/$3,000 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum	$1,500/$3,000 Deductible, 0% Coinsurance, applies to $4,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum
Emergency Room Physician	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum
Urgent Care Center	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		

MEDICAL PLAN	PREMERA PREFERRED CHOICE: AGG HSA - $1,500/20%/50%/$4,000/DED.COINS (MAC) HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to $4,000 Out of Pocket Maximum	$3,000/$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
PHARMACY		
Prescription Drugs - Retail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to the $4,000 Out of Pocket Maximum	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to the $4,000 Out of Pocket Maximum
Prescription Drugs - Mail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to the $4,000 Out of Pocket Maximum	Not Covered
Drug List	Open A1 No Tiers	Open A1 No Tiers

MEDICAL PLAN	PREMERA PREFERRED CHOICE: AGG HSA - $1,500/20%/50%/$4,000/DED.COINS (MAC) HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Specialty Pharmacy (Mandatory - Exclusive)	$1,500/$3,000 Deductible, then 20% Coinsurance, applies to the $4,000 Out of Pocket Maximum	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	$25 Copay
Vision Hardware ($150 every 2 consecutive calendar years)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PCY under age 19)	$25 Copay, applies to the $4,000 Out of Pocket Maximum	$25 Copay, applies to the $4,000 Out of Pocket Maximum
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Health Care Coverage

MainVue Homes, LLC

Group Number: 4024205

Effective Date: 10/01/2022

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	**PREMERA PREFERRED CHOICE: PHARMACY (MAC) - $10/$25/$45**
PRESCRIPTION DRUGS	
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Retail Cost Shares	$10/$25/$45
Mail Cost Shares	$25/$62/$112
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

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Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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