

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2020

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 3500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Aggregate Family Deductible \$6,500)	\$3,500 / \$6,500	Shared with In-Network	
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)	\$6,500 / \$13,000	Unlimited	
Office Visit Cost Share	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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 (Includes Telemedicine)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		HSA 3500
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Inpatient Professional Services	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE - ON DEMAND		
Virtual Care - General Medical/ Dermatology (Voice/Video)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Not Applicable
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		

MEDICAL PLAN		HSA 3500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	\$3,500 / \$6,500 Deductible, 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Covered as any other service	
Travel and Care Coordination (Limited to IRS Guidelines)	\$3,500 / \$6,500 Deductible, 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Not Covered	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
Emergency Room Physician	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
Urgent Care Center	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Telemedicine - Mental Health	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Applicable	
Chemical Dependency Inpatient Facility Care (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		HSA 3500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Rehab Inpatient Facility (30 Days PCY combined limit for inpatient services)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (15 Visits PCY combined limit for outpatient services)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Home Health Visits (130 visits PCY)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service	
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered	
Drug List	Open A1 No Tiers	Open A1 No Tiers	
Prescription Drugs - Retail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to the \$6,500 / \$13,000 Out of Pocket Maximum	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to the \$6,500 / \$13,000 Out of Pocket Maximum	
Prescription Drugs - Mail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to the \$6,500 / \$13,000 Out of Pocket Maximum	Not Covered	
Specialty Pharmacy (Mandatory - Exclusive)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to the \$6,500 / \$13,000 Out of Pocket Maximum	Not covered	
ALTERNATIVE CARE			
Manipulations (Spinal and other) (12 visits PCY)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		HSA 3500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Acupuncture (12 visits PCY)	\$3,500 / \$6,500 Deductible, then 20% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited 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 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.

