

# 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	STERLING 250	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 3X Individual)	\$250	\$500
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 3X Individual)	\$3,750	Unlimited
<b>Office Visit Cost Share</b>	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Not Covered
<b>Health Education (HE)</b> (Unlimited)	Covered In Full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered In Full	Not Covered
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered In Full	Not Covered
<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit (Includes Telemedicine)</b>	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Inpatient Professional Services</b>	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Contraceptive Management Services</b> (Unlimited)	Covered In Full	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

<b>MEDICAL PLAN</b>		<b>STERLING 250</b>	
	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>VIRTUAL CARE - ON DEMAND</b>			
<b>Virtual Care - General Medical/ Dermatology (Voice/Video)</b>	Covered In Full	Not Applicable	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered In Full	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Other Professional Diagnostic Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Professional Diagnostic Major Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	Waive Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	Waive Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Hospice Inpatient Facility</b> (Unlimited; within the 6 month lifetime maximum)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>PREMERA DESIGNATED CENTERS OF EXCELLENCE</b>			
<b>Centers of Excellence Packaged Services</b> (Heritage Prime Network - No Eligible Services)	Covered as any other service	Covered as any other service	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$250 Deductible and 20% Coinsurance; all cost shares apply to the \$3,750 Out of Pocket Maximum	\$200 Copay then \$250 Deductible and 20% Coinsurance; all cost shares apply to the \$3,750 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	
<b>Urgent Care Center</b>	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Ambulance Transportation</b> (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	
<b>Air Ambulance</b> (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			

<b>MEDICAL PLAN</b>		
	<b>STERLING 250</b>	
	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Allergy/Therapeutic Injections</b>	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Telemedicine - Mental Health</b>	Covered In Full	Not Applicable
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Rehab Inpatient Facility</b> (30 days PCY)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (45 visits PCY)	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (\$300 PCY; Includes orthotics and orthopedic shoes)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Home Health Visits</b> (130 visits PCY)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$250 Deductible, then 20% Coinsurance, applies to \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>TMJ (Temporomandibular Joint Disorders)</b> (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
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered
<b>ALTERNATIVE CARE</b>		
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Acupuncture</b> (12 visits PCY)	\$30 Copay, applies to the \$3,750 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>ANNUAL PLAN MAXIMUM</b>		
<b>Annual Plan Maximum</b>	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

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2020

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](http://www.premera.com)

PHARMACY PLAN	
STERLING 250 - RX	
PRESCRIPTION DRUGS	
<b>Drug List</b>	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
<b>Retail Cost Shares</b>	\$10/\$30/\$60/\$250
<b>Mail Cost Shares</b>	\$25/\$75/\$150/\$250
<b>Day Supply</b>	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
<b>Individual Deductible PCY</b>	\$0
<b>Family Deductible PCY</b>	No Family Deductible
<b>Out of Network (Non-participating retail pharmacies)</b>	Cost Share, then 40% (to allowable)
<b>Out of Pocket Maximum</b>	Applies to the medical out of pocket maximum
<b>Annual Benefit Maximum</b>	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.*

