

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	TITANIUM 200	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$200	\$400
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$2,000	Unlimited
Office Visit Cost Share	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 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)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN		TITANIUM 200	
		HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
VIRTUAL CARE - ON DEMAND			
Virtual Care - General Medical/ Dermatology (Voice/Video)	Covered In Full	Not Applicable	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence Packaged Services (Heritage Prime Network - No Eligible Services)	Covered as any other service	Covered as any other service	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$200 Deductible and 10% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum	\$200 Copay then \$200 Deductible and 10% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum	
Emergency Room Physician	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
Urgent Care Center	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
OTHER SERVICES			

MEDICAL PLAN		TITANIUM 200	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Allergy/Therapeutic Injections	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Telemedicine - Mental Health	Covered In Full	Not Applicable	
Chemical Dependency Inpatient Facility Care (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Inpatient Facility (30 days PCY)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Home Health Visits (130 visits PCY)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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	
ALTERNATIVE CARE			
Manipulations (Spinal and other) (12 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Acupuncture (12 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 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.

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

PHARMACY PLAN	
TITANIUM 200 - RX	
PRESCRIPTION DRUGS	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Retail Cost Shares	\$10/\$20/\$40/\$250
Mail Cost Shares	\$25/\$50/\$100/\$250
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

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.

