

# 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 500	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$500	\$1,000
<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 2X Individual)	\$4,500	Unlimited
<b>Office Visit Cost Share</b>	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$1,000 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 \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Inpatient Professional Services</b>	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Contraceptive Management Services</b> (Unlimited)	Covered In Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN		TITANIUM 500	
		HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
<b>VIRTUAL CARE - ON DEMAND</b>			
Virtual Care - General Medical/ Dermatology (Voice/Video)	Covered In Full	Not Applicable	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>FACILITY CARE OPTIONS</b>			
Inpatient Facility	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>PREMERA DESIGNATED CENTERS OF EXCELLENCE</b>			
Centers of Excellence Packaged Services (Heritage Prime Network - No Eligible Services)	Covered as any other service	Covered as any other service	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	\$200 Copay then \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	
Emergency Room Physician	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
Urgent Care Center	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			

<b>MEDICAL PLAN</b>		<b>TITANIUM 500</b>	
	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Allergy/Therapeutic Injections</b>	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$1,000 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Rehab Inpatient Facility</b> (30 days PCY)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 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 \$4,500 Out of Pocket Maximum	\$1,000 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 \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Home Health Visits</b> (130 visits PCY)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 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 \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Acupuncture</b> (12 visits PCY)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$1,000 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.*

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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)

<b>PHARMACY PLAN</b>	
<b>TITANIUM 500 - RX</b>	
<b>PRESCRIPTION DRUGS</b>	
<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/\$20/\$40/\$250
<b>Mail Cost Shares</b>	\$25/\$50/\$100/\$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

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**Discrimination is Against the Law**

Primer Blue Cross complies with applicable Federal and state laws and does not discriminate on the basis of race, national origin, age, disability, or sex. Prímer Blue Cross does not discriminate on the basis of race, national origin, age, disability, or sex. Prímer Blue Cross does not discriminate on the basis of race, national origin, age, disability, or sex.

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in large print, audio, accessible electronic formats, or other formats.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Qualified interpreters in other languages

If you need these services, contact your Civil Rights Coordinator. If you believe that Prímer Blue has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a charge with the U.S. Equal Employment Opportunity Commission. Complaints and Appeals: 700, 10th St., Suite 100, St. Louis, MO 63101. TTY: 800-642-5357. Email: [AppOpportunity@Primer.com](mailto:AppOpportunity@Primer.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [www.hhs.gov/ocr/ocomplaintportal/](http://www.hhs.gov/ocr/ocomplaintportal/), or by first mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 508F, Main Building, Washington, D.C. 20201. 1-800-368-1019. 800-637-7887 (TDD). Complaint forms are available at: [www.hhs.gov/officeforcivilrights/index.html](http://www.hhs.gov/officeforcivilrights/index.html)

**Getting Help in Other Languages**

This notice has important information. This notice may have important information about your qualifications or coverage through Prímer Blue Cross. Prímer Blue Cross may not be able to provide this notice in your language at this time. Call 800-722-1471 (TTY: 800-642-5357).

**العربية (Arabic)**  
Prímer Blue Cross قد لا تكون قادرة على توفير هذا الإشعار بلغة أمك في الوقت الراهن. اتصل بنا على رقم 800-722-1471 (TTY: 800-642-5357) لمزيد من المعلومات.

**فارسی (Farsi)**  
Prímer Blue Cross ممکن است نتواند این اطلاعیه را در زبان مادری شما ارائه دهد. برای اطلاعات بیشتر، با ما تماس بگیرید. شماره تماس: 800-722-1471 (تلفن تصویری: 800-642-5357).

**中文 (Chinese)**  
Prímer Blue Cross 可能无法为您提供此通知的中文版本。如需了解详情，请致电 800-722-1471 (TTY: 800-642-5357)。

**日本語 (Japanese)**  
Prímer Blue Cross は、現時ではこの通知を日本語で提供することができません。詳しくは、800-722-1471 (TTY: 800-642-5357) までお問い合わせください。

**한국어 (Korean)**  
Prímer Blue Cross는 현재 이 통지를 귀하의 모국어인 한국어로 제공할 수 없습니다. 자세한 내용은 800-722-1471 (TTY: 800-642-5357)로 문의하십시오.

**हिन्दी (Hindi)**  
Prímer Blue Cross अभी तक इस सूचना को हिन्दी में नहीं दे सकता है। अधिक जानकारी के लिए, कृपया 800-722-1471 (TTY: 800-642-5357) पर कॉल करें।

**සිංහල (Sinhala)**  
Prímer Blue Cross මෙම තොරතුරු සිංහල භාෂාවෙන් නොමැත. වැඩි විස්තර සඳහා, 800-722-1471 (TTY: 800-642-5357) දුරකථන කථනාතුරු මගින් සම්බන්ධ වන්න.

**မြန်မာ (Burmese)**  
Prímer Blue Cross မှာ အခု အချိန်ထိ ဤအချက်အလက်ကို မြန်မာစာဖြင့် ပေးအပ်နိုင်ပါ။ အချက်အလက်အား အကျဉ်းချုပ်အားဖြင့် သိရှိလိုပါက 800-722-1471 (TTY: 800-642-5357) သို့ ဖုန်းဆက်သွယ်ပါ။

**தமிழ் (Tamil)**  
Prímer Blue Cross இதுவரை இந்த அறிவிப்பைத் தமிழில் வழங்கவில்லை. மேலும் அறிவிப்பைப் பெற 800-722-1471 (TTY: 800-642-5357) க்கு அழைக்கவும்.

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**Overview (Czech)**

Prímer Blue Cross poskytuje zdravotní služby. Prímer Blue Cross poskytuje zdravotní služby. Prímer Blue Cross poskytuje zdravotní služby. Prímer Blue Cross poskytuje zdravotní služby. Prímer Blue Cross poskytuje zdravotní služby.

**Francia (French)**  
Prímer Blue Cross vous offre des services de santé. Prímer Blue Cross vous offre des services de santé. Prímer Blue Cross vous offre des services de santé. Prímer Blue Cross vous offre des services de santé. Prímer Blue Cross vous offre des services de santé.

**Deutsch (German)**  
Prímer Blue Cross bietet Gesundheitsleistungen an. Prímer Blue Cross bietet Gesundheitsleistungen an. Prímer Blue Cross bietet Gesundheitsleistungen an. Prímer Blue Cross bietet Gesundheitsleistungen an. Prímer Blue Cross bietet Gesundheitsleistungen an.

**हिन्दी (Hindi)**  
Prímer Blue Cross आपको स्वास्थ्य सेवाएँ प्रदान करता है। Prímer Blue Cross आपको स्वास्थ्य सेवाएँ प्रदान करता है। Prímer Blue Cross आपको स्वास्थ्य सेवाएँ प्रदान करता है। Prímer Blue Cross आपको स्वास्थ्य सेवाएँ प्रदान करता है। Prímer Blue Cross आपको स्वास्थ्य सेवाएँ प्रदान करता है।

**한국어 (Korean)**  
Prímer Blue Cross는 건강 서비스를 제공합니다. Prímer Blue Cross는 건강 서비스를 제공합니다. Prímer Blue Cross는 건강 서비스를 제공합니다. Prímer Blue Cross는 건강 서비스를 제공합니다. Prímer Blue Cross는 건강 서비스를 제공합니다.

**မြန်မာ (Burmese)**  
Prímer Blue Cross သည် ကျန်းမာရေး ဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ Prímer Blue Cross သည် ကျန်းမာရေး ဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ Prímer Blue Cross သည် ကျန်းမာရေး ဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ Prímer Blue Cross သည် ကျန်းမာရေး ဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။ Prímer Blue Cross သည် ကျန်းမာရေး ဝန်ဆောင်မှုများကို ပေးအပ်ပါသည်။

**தமிழ் (Tamil)**  
Prímer Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது. Prímer Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது. Prímer Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது. Prímer Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது. Prímer Blue Cross ஆரோக்கிய சேவைகளை வழங்குகிறது.

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