

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 07/01/2020

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 2500 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| MEDICAL COST SHARE OPTIONS | | | |
| Individual Deductible PCY (Family embedded deductible 3X Individual) | \$2,500 | \$5,000 | |
| 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 \$14,300) | \$7,000 | Unlimited | |
| Office Visit Cost Share | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 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 (Includes TeleMedicine) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Inpatient Professional Services | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Contraceptive Management Services (Unlimited) | Covered In Full | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |

| MEDICAL PLAN | | STERLING 2500 | |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| | HERITAGE 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 | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Other Professional Diagnostic Imaging | Waive Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Professional Diagnostic Major Imaging | Waive Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Other Professional Diagnostic Laboratory/Pathology | Waive Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Diagnostic Mammography | Waive Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| FACILITY CARE OPTIONS | | | |
| Inpatient Facility | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Outpatient Surgery Facility | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 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) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 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 | |
| Travel and Care Coordination (Limited to IRS Guidelines) | Covered In Full | Not Covered | |
| EMERGENCY CARE AND TRANSPORTATION OPTION | | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$200 Copay then \$2,500 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum | \$200 Copay then \$2,500 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum | |
| Emergency Room Physician | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | |
| Urgent Care Center | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Ambulance Transportation (Unlimited) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | |
| Air Ambulance (Unlimited) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | |

| MEDICAL PLAN | | STERLING 2500 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| OTHER SERVICES | | | |
| Allergy/Therapeutic Injections | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Mental Health Inpatient Facility Care (Unlimited) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Mental Health Outpatient Professional Care (Unlimited) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 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) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Rehab Inpatient Facility (30 days PCY) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 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) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Home Health Visits (130 visits PCY) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 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) | \$2,500 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum | \$5,000 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) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Acupuncture (12 visits PCY) | \$40 Copay, applies to the Out of Pocket Maximum | \$5,000 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.

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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 | |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| STERLING 2500 - 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/\$40/\$80/\$250 |
| Mail Cost Shares | \$25/\$100/\$200/\$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 |

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