

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 3000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$3,000	\$6,000	
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	\$6,000 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	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered In Full	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		STERLING 3000	
	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	\$6,000 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	\$6,000 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	\$6,000 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	\$6,000 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	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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 \$3,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum	\$200 Copay then \$3,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum	
Emergency Room Physician	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	
Urgent Care Center	\$40 Copay, applies to the Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	
OTHER SERVICES			

MEDICAL PLAN		STERLING 3000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Allergy/Therapeutic Injections	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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	\$6,000 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)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Inpatient Facility (30 days PCY)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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	\$6,000 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	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Home Health Visits (130 visits PCY)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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)	\$3,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$6,000 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	\$6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Acupuncture (12 visits PCY)	\$40 Copay, applies to the Out of Pocket Maximum	\$6,000 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 3000 - 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/\$50/\$100/\$250
Mail Cost Shares	\$25/\$125/\$250/\$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.

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Discrimination is Against the Law

Prmera Blue Cross complies with applicable Federal and state laws and does not discriminate on the basis of race, national origin, age, disability, or sex. Prmera does not exclude people or treat them differently because of race, color, 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, other formats
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Communication in other languages

If you need these services, contact your Call Rights Coordinator.

If you believe that Prmera 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 complaint through the Call Rights Coordinator, Complaints and Appeals, 700 Blue Sky Drive, Suite 400, Oak Brook, IL 60110. TTY: 800-642-5357. You file 800-332-3336, Fax 438-2266, TTY: 800-642-5357. Email: Appeal-Dep@prmerabluecross.com/Prmera.com

You can also file a complaint in person or by mail, fax, or email. If you need help filing a grievance, the Call 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/, or by mail at 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, 800-637-7897 (TDD). Complaint forms are available at: www.hhs.gov/officeforcivilrights/index.html

Getting Help in Other Languages

This notice has important information. This notice may have important information about your enrollment or coverage through Prmera Blue Cross. Please make sure you understand the notice. If you need help, you can call 800-642-5357. If you need help in a language other than English, you can call 800-642-5357. If you need help in a language other than English, you can call 800-642-5357.

हिन्दी (Hindi)
Prmera Blue Cross आपकी सुरक्षा और स्वास्थ्य को सुनिश्चित करने के लिए प्रमेरा ब्लू क्रॉस प्रोग्राम के बारे में जानकारी प्रदान करता है। यदि आपको प्रमेरा ब्लू क्रॉस प्रोग्राम के बारे में जानकारी चाहिए, तो आप 800-642-5357 पर कॉल कर सकते हैं।

العربية (Arabic)
Prmera Blue Cross आपको معلومات عن برنامج تأميننا الصحي. إذا كنت بحاجة إلى مزيد من المعلومات، يمكنك الاتصال بنا على الرقم 800-642-5357.

中文 (Chinese)
Prmera Blue Cross 提供有关您投保的健康福利计划的重要信息。如果您需要帮助，请拨打 800-642-5357。

日本語 (Japanese)
Prmera Blue Cross は、お客様の健康保険に関する重要な情報を提供しています。ご不明な点がございましたら、800-642-5357 までお問い合わせください。

한국어 (Korean)
Prmera Blue Cross는 귀하의 건강 보험에 대한 중요한 정보를 제공하고 있습니다. 도움이 필요하시면 800-642-5357로 전화하십시오.

ภาษาไทย (Thai)
Prmera Blue Cross จะแจ้งข้อมูลเกี่ยวกับแผนประกันสุขภาพของคุณ. หากคุณต้องการข้อมูลเพิ่มเติม กรุณาโทร 800-642-5357.

Portuguese (Portuguese)
Prmera Blue Cross fornece informações importantes sobre o seu plano de saúde. Se precisar de ajuda, ligue para 800-642-5357.

Spanish (Spanish)
Prmera Blue Cross le proporciona información importante sobre su plan de salud. Si necesita ayuda, llame al 800-642-5357.

Tagalog (Tagalog)
Prmera Blue Cross ay nagbibigay ng mahalagang impormasyon tungkol sa iyong pagpapalit ng mga pagpapalit. Maaaring mangyayamang makausap ang mga tagapagbigay ng serbisyo sa 800-642-5357.

Tamil (Tamil)
Prmera Blue Cross இலிருந்து உங்கள் ஆரோக்கியப் பிழைப்புத் திட்டம் குறித்து முக்கியமான தகவல்கள் கிடைக்கலாம். உதவி தேவையில் 800-642-5357-ஐ அழைக்கவும்.

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Portuguese (Portuguese)
Prmera Blue Cross fornece informações importantes sobre o seu plano de saúde. Se precisar de ajuda, ligue para 800-642-5357.

Spanish (Spanish)
Prmera Blue Cross le proporciona información importante sobre su plan de salud. Si necesita ayuda, llame al 800-642-5357.

Overview (Overview)

Prmera Blue Cross provides health insurance and other services to people who are eligible for coverage. Prmera Blue Cross is a member of Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross is a member of Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross is a member of Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross is a member of Prmera Blue Cross of Wisconsin, Inc.

English (English)
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Deutsch (German)
Prmera Blue Cross bietet Krankenversicherungsleistungen und andere Dienstleistungen für Personen an, die für die Mitgliedschaft in der Prmera Blue Cross qualifiziert sind. Prmera Blue Cross ist ein Mitglied der Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ist ein Mitglied der Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ist ein Mitglied der Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ist ein Mitglied der Prmera Blue Cross of Wisconsin, Inc.

Hindi (Hindi)
Prmera Blue Cross स्वास्थ्य बीमा और अन्य सेवाएँ प्रदान करता है जो कि योग्यता के लिए कवरेज के लिए योग्य हैं। Prmera Blue Cross Wisconsin, Inc. का एक सदस्य है। Prmera Blue Cross Wisconsin, Inc. का एक सदस्य है। Prmera Blue Cross Wisconsin, Inc. का एक सदस्य है। Prmera Blue Cross Wisconsin, Inc. का एक सदस्य है।

Arabic (Arabic)
Prmera Blue Cross يوفر خدمات تأمين صحية وخدمات أخرى للأشخاص المؤهلين للحصول على التغطية. Prmera Blue Cross هي عضو في Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross هي عضو في Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross هي عضو في Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross هي عضو في Prmera Blue Cross of Wisconsin, Inc.

Chinese (Chinese)
Prmera Blue Cross 提供健康保險和其他服務給符合資格的人。Prmera Blue Cross 是 Wisconsin 的 Prmera Blue Cross 成員。Prmera Blue Cross 是 Wisconsin 的 Prmera Blue Cross 成員。Prmera Blue Cross 是 Wisconsin 的 Prmera Blue Cross 成員。Prmera Blue Cross 是 Wisconsin 的 Prmera Blue Cross 成員。

Japanese (Japanese)
Prmera Blue Cross は、健康保険とその他のサービスを提供しています。Prmera Blue Cross は Wisconsin の Prmera Blue Cross のメンバーです。Prmera Blue Cross は Wisconsin の Prmera Blue Cross のメンバーです。Prmera Blue Cross は Wisconsin の Prmera Blue Cross のメンバーです。Prmera Blue Cross は Wisconsin の Prmera Blue Cross のメンバーです。

Korean (Korean)
Prmera Blue Cross는 건강 보험과 기타 서비스를 제공합니다. Prmera Blue Cross는 Wisconsin의 Prmera Blue Cross의 구성원입니다. Prmera Blue Cross는 Wisconsin의 Prmera Blue Cross의 구성원입니다. Prmera Blue Cross는 Wisconsin의 Prmera Blue Cross의 구성원입니다. Prmera Blue Cross는 Wisconsin의 Prmera Blue Cross의 구성원입니다.

Thai (Thai)
Prmera Blue Cross จะให้บริการประกันภัยสุขภาพและบริการอื่น ๆ แก่ผู้ที่มีสิทธิ์ได้รับประกัน. Prmera Blue Cross เป็นสมาชิกของ Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross เป็นสมาชิกของ Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross เป็นสมาชิกของ Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross เป็นสมาชิกของ Prmera Blue Cross of Wisconsin, Inc.

Portuguese (Portuguese)
Prmera Blue Cross fornece serviços de saúde e outros serviços para quem é elegível para a cobertura. Prmera Blue Cross é membro da Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross é membro da Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross é membro da Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross é membro da Prmera Blue Cross of Wisconsin, Inc.

Spanish (Spanish)
Prmera Blue Cross proporciona servicios de salud y otros servicios a quienes son elegibles para la cobertura. Prmera Blue Cross es miembro de Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross es miembro de Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross es miembro de Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross es miembro de Prmera Blue Cross of Wisconsin, Inc.

Tagalog (Tagalog)
Prmera Blue Cross ay nagbibigay ng mga serbisyo sa kalusapang pangkalahatan sa mga taong kwalipikado para sa proteksyon. Prmera Blue Cross ay kasapi ng Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ay kasapi ng Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ay kasapi ng Prmera Blue Cross of Wisconsin, Inc. Prmera Blue Cross ay kasapi ng Prmera Blue Cross of Wisconsin, Inc.

Tamil (Tamil)
Prmera Blue Cross ஆரோக்கியப் பிழைப்புத் திட்டம் மற்றும் பிற சேவைகளை தகுதியானவர்களுக்கு வழங்குகிறது. Prmera Blue Cross Wisconsin, Inc. இன் உறுப்பினர். Prmera Blue Cross Wisconsin, Inc. இன் உறுப்பினர். Prmera Blue Cross Wisconsin, Inc. இன் உறுப்பினர். Prmera Blue Cross Wisconsin, Inc. இன் உறுப்பினர்.

Portuguese (Portuguese)
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