

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 07/01/2021

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 1000	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$1,000	\$2,000
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)	\$6,000	Unlimited
Office Visit Cost Share	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 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)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	Covered in Full	Not Applicable
Telemedicine - Mental Health (Virtual Care Only)	Covered in Full	Not Applicable

MEDICAL PLAN		STERLING 1000	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Telemedicine - Chemical Dependency (Virtual Care Only)	Covered in Full	Not Applicable	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Waive Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 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)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 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)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Covered in Full	\$2,000 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			

MEDICAL PLAN		STERLING 1000	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	\$200 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	
Emergency Room Physician	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
Urgent Care Center	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Manipulations (Spinal and other) (12 visits PCY)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 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)	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$35 Copay, applies to the \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered	
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: 07/01/2021

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 1000 - 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/\$30/\$60/\$250	
Mail Cost Shares	\$25/\$75/\$150/\$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.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera 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 grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711). ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ប្រៃសណីយ៍: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 تماس بگیرید.