

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2026

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 | COBALT 1000 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| MEDICAL COST SHARES | | |
| Individual Deductible PCY (Family embedded deductible 2X Individual) | \$1,000 | \$2,000 |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 30% | 50% |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual) | \$7,500 | Unlimited |
| Non Specialist Office Visit Cost Share | \$35 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Specialist Office Visit Cost Share | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Kinwell Connect Cost Share Waiver (Excluded) | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable |
| 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 |
| CHRONIC CONDITION MANAGEMENT PROGRAMS | | |
| Diabetes Management Plus | Included | Included |
| Diabetes Prevention Plus | Excluded | Excluded |

| MEDICAL PLAN | | COBALT 1000 | |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| Hypertension Plus | Excluded | Excluded | |
| Weight Management | Excluded | Excluded | |
| PROFESSIONAL CARE | | | |
| Professional Office Visit | Non Specialist: \$35 Copay, applies to the \$7,500 Out of Pocket Maximum; Specialist: \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Telemedicine with Traditional Providers - General Medical | \$35 Non Specialist Copay, applies to the \$7,500 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) | \$35 Non Specialist Copay, applies to the \$7,500 Out of Pocket Maximum | Not Applicable | |
| Telemedicine - Mental Health (Virtual Care Only) | \$35 Non Specialist Copay, applies to the \$7,500 Out of Pocket Maximum | Not Applicable | |
| Telemedicine - Chemical Dependency (Virtual Care Only) | \$35 Non Specialist Copay, applies to the \$7,500 Out of Pocket Maximum | Not Applicable | |
| DIAGNOSTIC SERVICES | | | |
| Preventive Imaging and Laboratory | Covered in Full | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Diagnostic Laboratory | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Basic Diagnostic Imaging | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Major Diagnostic Imaging | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Preventive Mammography | Covered in Full | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Diagnostic Mammography | Covered in Full | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Supplemental Breast Exam | Covered in Full | Covered as any other service | |
| FACILITY CARE | | | |
| Inpatient Facility | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Inpatient Professional Services | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Hospital Outpatient Surgery Facility | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Ambulatory Surgery Center | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |

| MEDICAL PLAN | | COBALT 1000 | |
|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 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 30% Coinsurance, applies to \$7,500 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 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| MATERNITY & REPRODUCTIVE CARE | | | |
| Birth Center | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| 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 | |
| MEDICAL TRANSPORTATION BENEFITS | | | |
| Transplant Travel & Lodging (\$7,500 per transplant) | \$1,000 Deductible, 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$1,000 Deductible, 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum | |
| EMERGENCY CARE AND TRANSPORTATION | | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$250 Copay then \$1,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,500 Out of Pocket Maximum | \$250 Copay then \$1,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,500 Out of Pocket Maximum | |
| Emergency Room Physician | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | |
| Urgent Care Center | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |
| Ambulance Transportation (Unlimited) | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | |
| ALTERNATIVE CARE | | | |
| Acupuncture (12 visits PCY) | \$35 Copay, applies to the \$7,500 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 \$7,500 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 30% Coinsurance, applies to \$7,500 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 \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum | |

| MEDICAL PLAN | | |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| | COBALT 1000 | |
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| Mental Health Inpatient Facility Care (Unlimited) | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 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 \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| REHABILITATION & NEURODEVELOPMENTAL THERAPY | | |
| Inpatient Rehab (30 days PCY) | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PCY) | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited) | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Outpatient Massage Therapy (Applies to the outpatient rehab limit) | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Outpatient Speech Therapy (Applies to the outpatient rehab limit) | \$65 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Inpatient Neurodevelopmental Therapy | \$1,000 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Outpatient Neurodevelopmental Therapy (45 visits PCY) | \$65 Copay, applies to the \$7,500 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 30% Coinsurance, applies to \$7,500 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 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Transplants (Unlimited) | Covered as any other service | Not Covered |
| SUPPLEMENTAL BENEFITS | | |
| Routine Hearing Exam (1 every 36 months) | \$35 Copay, applies to the \$7,500 Out of Pocket Maximum | \$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| Hearing Hardware (1 device per ear every 36 months) | Covered in Full | Covered in Full |
| 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 of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

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Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

| PHARMACY PLAN | COBALT 1000 - RX |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| PRESCRIPTION DRUGS | |
| Formulary Drug List | Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty |
| Annual Benefit Maximum | Unlimited |
| 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 |
| Retail Cost Shares | \$20/\$50/50%/50% |
| Mail Cost Shares | \$60/\$150/50%/50% |
| Day Supply | Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days |

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