

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	TITANIUM 200	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$200	\$400
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$2,000	Unlimited
Office Visit Cost Share	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 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
Hypertension Plus	Excluded	Excluded
Weight Management	Excluded	Excluded

MEDICAL PLAN		TITANIUM 200	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
PROFESSIONAL CARE			
Professional Office Visit	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Telemedicine with Traditional Providers - General Medical	\$15 Copay, applies to the OOP Max	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$15 copay, applies to the OOP Max	Not Applicable	
Telemedicine - Mental Health (Virtual Care Only)	\$15 copay, applies to the OOP Max	Not Applicable	
Telemedicine - Chemical Dependency (Virtual Care Only)	\$15 copay, applies to the OOP Max	Not Applicable	
DIAGNOSTIC SERVICES			
Preventive Imaging and Laboratory	Covered in Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Laboratory	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Basic Diagnostic Imaging	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Major Diagnostic Imaging	Waive Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Preventive Mammography	Covered in Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	\$400 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	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospital Outpatient Surgery Facility	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulatory Surgery Center	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		TITANIUM 200	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered in Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Covered in Full	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
MEDICAL TRANSPORTATION BENEFITS			
Transplant Travel & Lodging (\$7,500 per transplant)	\$200 Deductible, 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$200 Deductible and 10% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum	\$200 Copay then \$200 Deductible and 10% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum	
Emergency Room Physician	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
Urgent Care Center	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Manipulations (Spinal and other) (12 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
REHABILITATION & NEURODEVELOPMENTAL THERAPY			
Inpatient Rehab (30 days PCY)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		TITANIUM 200	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Neurodevelopmental Therapy	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Neurodevelopmental Therapy (45 visits PCY)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$200 Deductible, then 10% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$400 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)	\$15 Copay, applies to the \$2,000 Out of Pocket Maximum	\$400 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.

Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2026

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	
TITANIUM 200 - 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	\$10/\$20/\$40/\$250
Mail Cost Shares	\$30/\$60/\$120/\$250
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days

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.

