

# 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.

<b>MEDICAL PLAN</b>		<b>TITANIUM 350</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>MEDICAL COST SHARES</b>			
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$350 PCY	\$700 PCY	
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	10%	50%	
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$4,000	Unlimited	
<b>Office Visit Cost Share</b>	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Kinwell Connect Cost Share Waiver</b> (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable	
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Not Covered	
<b>CHRONIC CONDITION MANAGEMENT PROGRAMS</b>			
<b>Diabetes Management Plus</b>	Included	Included	
<b>Diabetes Prevention Plus</b>	Excluded	Excluded	
<b>Hypertension Plus</b>	Excluded	Excluded	
<b>Weight Management</b>	Excluded	Excluded	

MEDICAL PLAN		TITANIUM 350	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Telemedicine with Traditional Providers - General Medical</b>	\$30 Copay, applies to the OOP Max	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>VIRTUAL CARE SERVICES</b>			
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$30 copay, applies to the OOP Max	Not Applicable	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	\$30 copay, applies to the OOP Max	Not Applicable	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	\$30 copay, applies to the OOP Max	Not Applicable	
<b>DIAGNOSTIC SERVICES</b>			
<b>Preventive Imaging and Laboratory</b>	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Diagnostic Laboratory</b>	Waive Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Basic Diagnostic Imaging</b>	Waive Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Major Diagnostic Imaging</b>	Waive Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Preventive Mammography</b>	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Supplemental Breast Exam</b>	Covered in Full	Covered as any other service	
<b>FACILITY CARE</b>			
<b>Inpatient Facility</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Hospital Outpatient Surgery Facility</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Ambulatory Surgery Center</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		TITANIUM 350	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (Unlimited; within the 6 month lifetime maximum)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Birth Center</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$350 PCY Deductible, 0% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$350 PCY Deductible, 0% Coinsurance, applies to \$4,000 Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$350 PCY Deductible and 10% Coinsurance; all cost shares apply to the \$4,000 Out of Pocket Maximum	\$200 Copay then \$350 PCY Deductible and 10% Coinsurance; all cost shares apply to the \$4,000 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	
<b>Urgent Care Center</b>	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Ambulance Transportation</b> (Unlimited)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	
<b>ALTERNATIVE CARE</b>			
<b>Acupuncture</b> (12 visits PCY)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>			

MEDICAL PLAN		TITANIUM 350	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>REHABILITATION &amp; NEURODEVELOPMENTAL THERAPY</b>			
<b>Inpatient Rehab</b> (30 days PCY)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Rehab, Including Physical and Occupational Therapy</b> (45 visits PCY)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b> (Unlimited)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Massage Therapy</b> (Applies to the outpatient rehab limit)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Speech Therapy</b> (Applies to the outpatient rehab limit)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Inpatient Neurodevelopmental Therapy</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Outpatient Neurodevelopmental Therapy</b> (45 visits PCY)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$350 PCY Deductible, then 10% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>			
<b>Routine Hearing Exam</b> (1 every 36 months)	\$30 Copay, applies to the \$4,000 Out of Pocket Maximum	\$700 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Hearing Hardware</b> (1 device per ear every 36 months)	Covered in Full	Covered in Full	
<b>ANNUAL PLAN MAXIMUM</b>			

<b>MEDICAL PLAN</b>	<b>TITANIUM 350</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Annual Plan Maximum</b>	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](http://www.premera.com) to find drug costs and coverages specific to your plan.

PHARMACY PLAN		TITANIUM 350 - RX
<b>PRESCRIPTION DRUGS</b>		
<b>Formulary Drug List</b>	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty	
<b>Annual Benefit Maximum</b>	Unlimited	
<b>Individual Deductible PCY</b>	\$0	
<b>Family Deductible PCY</b>	No Family Deductible	
<b>Out of Network (Non-participating retail pharmacies)</b>	Cost Share, then 40% (to allowable)	
<b>Out of Pocket Maximum</b>	Applies to the medical out of pocket maximum	
<b>Retail Cost Shares</b>	\$10/\$20/\$40/\$250	
<b>Mail Cost Shares</b>	\$30/\$60/\$120/\$250	
<b>Day Supply</b>	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.*

