PREMERA BLUE CROSS

# Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2027

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 250** | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **MEDICAL COST SHARES** | | |
| **Individual Deductible PCY** (Family embedded deductible 3X Individual) | $250 | $500 |
| **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 3X Individual) | $3,750 | Unlimited |
| **Office Visit Cost Share** | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 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** | Excluded | Excluded |
| **Diabetes Prevention Plus** | Excluded | Excluded |
| **Hypertension Plus** | Excluded | Excluded |
| **Weight Management** | Excluded | Excluded |


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| MEDICAL PLAN | STERLING 250 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Comprehensive Weight Care** | Excluded | Excluded |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit** | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Telemedicine with Traditional Providers - General Medical** | $30 Copay, applies to the OOP Max | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $30 copay, applies to the OOP Max | Not Applicable |
| **Telemedicine - Mental Health (Virtual Care Only)** | $30 copay, applies to the OOP Max | Not Applicable |
| **Telemedicine - Chemical Dependency (Virtual Care Only)** | $30 copay, applies to the OOP Max | Not Applicable |
| **DIAGNOSTIC SERVICES** | | |
| **Preventive Imaging and Laboratory** | Covered in Full | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Laboratory** | Waive Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Basic Diagnostic Imaging** | Waive Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Major Diagnostic Imaging** | Waive Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Breast Cancer Screening (including mammography)** | Covered in Full | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **FACILITY CARE** | | |
| **Inpatient Facility** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hospital Outpatient Surgery Facility** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulatory Surgery Center** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 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) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 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) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 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) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MATERNITY & REPRODUCTIVE CARE** | | |

| MEDICAL PLAN | STERLING 250 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Birth Center** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Sterilization - Female** (Unlimited) | Covered in Full | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Sterilization - Male** (Unlimited) | Covered in Full | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MEDICAL TRANSPORTATION BENEFITS** | | |
| **Transplant Travel & Lodging** ($7,500 per transplant) | $250 Deductible, 0% Coinsurance, applies to $3,750 Out of Pocket Maximum | $250 Deductible, 0% Coinsurance, applies to $3,750 Out of Pocket Maximum |
| **EMERGENCY CARE AND TRANSPORTATION** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $200 Copay then $250 Deductible and 20% Coinsurance; all cost shares apply to the $3,750 Out of Pocket Maximum | $200 Copay then $250 Deductible and 20% Coinsurance; all cost shares apply to the $3,750 Out of Pocket Maximum |
| **Emergency Room Physician** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum |
| **Urgent Care Center** | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (12 visits PCY) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Manipulations (Spinal and other)** (12 visits PCY) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Inpatient Facility Care** (Unlimited) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **REHABILITATION & NEURODEVELOPMENTAL THERAPY** | | |
| **Inpatient Rehab** (30 days PCY) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |


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| MEDICAL PLAN | STERLING 250 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Outpatient Rehab, Including Physical and Occupational Therapy** (45 visits PCY) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer** (Unlimited) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Neurodevelopmental Therapy** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Neurodevelopmental Therapy** (45 visits PCY) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | $250 Deductible, then 20% Coinsurance, applies to $3,750 Out of Pocket Maximum | $500 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 PCY) | $30 Copay, applies to the $3,750 Out of Pocket Maximum | $500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hearing Hardware** (1 device per ear every 3 years) | 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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# Highlights of your Health Care Coverage

(BHT) BUSINESS HEALTH TRUST

Effective Date: 01/01/2027

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** | **STERLING 250 - RX** |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Formulary Drug List** | Preferred B4<br>Tier 1 = generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred brands<br>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/$30/$60/$250 |
| **Mail Cost Shares** | $30/$90/$180/$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.*



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## Notice of availability and nondiscrimination    800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**Discrimination is against the law.** Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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