

Highlights of your Health Care Coverage

(BHT II) BUSINESS HEALTH TRUST

Effective Date: 07/01/2026

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		
	PRIME HSA 5000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Aggregate Family Deductible \$6,500)	\$5,000 / \$6,500	Shared with In-Network
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)	\$6,500 / \$13,000	Unlimited
Office Visit Cost Share	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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

MEDICAL PLAN		PRIME HSA 5000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Weight Management	Excluded	Excluded	
PROFESSIONAL CARE			
Professional Office Visit	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Telemedicine with Traditional Providers - General Medical	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered	
DIAGNOSTIC SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Laboratory	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Basic Diagnostic Imaging	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Major Diagnostic Imaging	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	Shared with In-Network 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	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		PRIME HSA 5000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Inpatient Professional Services	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospital Outpatient Surgery Facility	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulatory Surgery Center	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
MEDICAL TRANSPORTATION BENEFITS			
Transplant Travel & Lodging (\$7,500 per transplant)	\$5,000 / \$6,500 Deductible, 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$5,000 / \$6,500 Deductible, 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	

MEDICAL PLAN		
	PRIME HSA 5000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Emergency Room Physician	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum
Urgent Care Center	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURODEVELOPMENTAL THERAPY		

MEDICAL PLAN		PRIME HSA 5000	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
Inpatient Rehab (30 days PCY)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PCY)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Neurodevelopmental Therapy	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Neurodevelopmental Therapy (45 visits PCY)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network 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)	\$5,000 / \$6,500 Deductible, then 30% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hearing Hardware (1 device per ear every 36 months)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 / \$13,000 Out of Pocket Maximum	
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.

