

## BHT Side by Side Comparison

(January 1, 2026 - December 31, 2026)



Plan Name	Deductible		Coinsurance		Office Visit Copay	Out-of-Pocket Maximum		Emergency Care <sup>1</sup>	Preventive Office Visits/Immunizations	Other Professional Diagnostic Imaging	Other Professional Diagnostic Laboratory/Pathology	Rx Cost Shares	
	Individual	Family	In Network	Out of Network		Individual	Family					Retail	Mail Order
Titanium 200	\$200	\$400	10%	50%	\$15	\$2,000	\$4,000	\$200 copay, then 10% after deductible	Covered in Full	10%, deductible waived	10%, deductible waived	\$10/\$20/\$40/\$250	\$30/\$60/\$120/\$250
Prime Titanium 200	\$200	\$400	10%	50%	\$15	\$2,000	\$4,000	\$200 copay, then 10% after deductible	Covered in Full	10%, deductible waived	10%, deductible waived	\$10/\$20/\$40/\$250	\$30/\$60/\$120/\$250
Titanium 350	\$350	\$700	10%	50%	\$30	\$4,000	\$8,000	\$200 copay, then 10% after deductible	Covered in Full	10%, deductible waived	10%, deductible waived	\$10/\$20/\$40/\$250	\$30/\$60/\$120/\$250
Titanium 500	\$500	\$1,000	20%	50%	\$30	\$4,500	\$9,000	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$20/\$40/\$250	\$30/\$60/\$120/\$250
Prime Titanium 500	\$500	\$1,000	20%	50%	\$30	\$4,500	\$9,000	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$20/\$40/\$250	\$30/\$60/\$120/\$250
Sterling 250	\$250	\$750	20%	50%	\$30	\$3,750	\$11,250	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Sterling 500	\$500	\$1,500	20%	50%	\$30	\$5,500	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Sterling 750	\$750	\$2,250	20%	50%	\$35	\$6,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Prime Sterling 750	\$750	\$2,250	20%	50%	\$35	\$6,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Sterling 1000	\$1,000	\$3,000	20%	50%	\$35	\$6,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Prime Sterling 1000	\$1,000	\$3,000	20%	50%	\$35	\$6,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$30/\$60/\$250	\$30/\$90/\$180/\$250
Sterling 1500	\$1,500	\$4,500	20%	50%	\$40	\$6,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$40/\$80/\$250	\$30/\$120/\$240/\$250
Sterling 2000	\$2,000	\$6,000	20%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$40/\$80/\$250	\$30/\$120/\$240/\$250
Prime Sterling 2000	\$2,000	\$6,000	20%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$40/\$80/\$250	\$30/\$120/\$240/\$250
Sterling 2500	\$2,500	\$7,500	20%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$40/\$80/\$250	\$30/\$120/\$240/\$250
Sterling 3000	\$3,000	\$9,000	20%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$50/\$100/\$250	\$30/\$150/\$300/\$250
Prime Sterling 3000	\$3,000	\$9,000	20%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 20% after deductible	Covered in Full	20%, deductible waived	20%, deductible waived	\$10/\$50/\$100/\$250	\$30/\$150/\$300/\$250
Sterling 4000	\$4,000	\$12,000	30%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 30% after deductible	Covered in Full	30%, deductible waived	30%, deductible waived	\$10/\$50/\$100/50%	\$30/\$150/\$300/50%
Sterling 5000	\$5,000	\$13,100	30%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 30% after deductible	Covered in Full	30%, deductible waived	30%, deductible waived	\$10/\$50/\$100/50%	\$30/\$150/\$300/50%
Prime Sterling 5000	\$5,000	\$13,100	30%	50%	\$40	\$7,000	\$14,300	\$200 copay, then 30% after deductible	Covered in Full	30%, deductible waived	30%, deductible waived	\$10/\$50/\$100/50%	\$30/\$150/\$300/50%
Cobalt 1000	\$1,000	\$2,000	30%	50%	*\$35/\$65	\$7,500	\$15,000	\$250 copay, then 30% after deductible	Covered in Full	Deductible then 30%	Deductible then 30%	\$20/\$50/50%/50%	\$60/\$150/50%/50%
Cobalt 2000	\$2,000	\$4,000	30%	50%	*\$35/\$65	\$8,000	\$16,000	\$250 copay, then 30% after deductible	Covered in Full	Deductible then 30%	Deductible then 30%	\$20/\$50/50%/50%	\$60/\$150/50%/50%
Cobalt 3000	\$3,000	\$6,000	30%	50%	*\$35/\$65	\$8,500	\$17,000	\$250 copay, then 30% after deductible	Covered in Full	Deductible then 30%	Deductible then 30%	\$20/\$50/50%/50%	\$60/\$150/50%/50%
HSA 1700	\$1,700	\$3,400	20%	50%	20% after deductible	\$6,500	\$13,000	20% after deductible	Covered in Full	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prime HSA 1700	\$1,700	\$3,400	20%	50%	20% after deductible	\$6,500	\$13,000	20% after deductible	Covered in Full	20% after deductible	20% after deductible	20% after deductible	20% after deductible
HSA 2500	\$2,500	\$5,000	20%	50%	20% after deductible	\$6,500	\$13,000	20% after deductible	Covered in Full	20% after deductible	20% after deductible	20% after deductible	20% after deductible
HSA 3500	\$3,500	\$6,500	20%	50%	20% after deductible	\$6,500	\$13,000	20% after deductible	Covered in Full	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prime HSA 3500	\$3,500	\$6,500	20%	50%	20% after deductible	\$6,500	\$13,000	20% after deductible	Covered in Full	20% after deductible	20% after deductible	20% after deductible	20% after deductible
HSA 5000	\$5,000	\$6,500	30%	50%	30% after deductible	\$6,500	\$13,000	30% after deductible	Covered in Full	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Prime HSA 5000	\$5,000	\$6,500	30%	50%	30% after deductible	\$6,500	\$13,000	30% after deductible	Covered in Full	30% after deductible	30% after deductible	30% after deductible	30% after deductible
HMO Plus 500	\$500	\$1,000	20%	N/A	**\$0/\$50	\$4,000	\$8,000	\$200 copay, then 20% after deductible	Covered in Full	20% after deductible	20% after deductible	\$10/\$25/\$45/30%	\$30/\$75/\$135/30%
HMO Plus 3000	\$3,000	\$6,000	30%	N/A	**\$5/\$60	\$6,000	\$12,000	\$300 copay, then 30% after deductible	Covered in Full	30% after deductible	30% after deductible	\$10/\$35/\$70/30%	\$30/\$105/\$210/30%

**This benefit summary is not a contract or a complete explanation of covered services, exclusions, limitations, or reductions. Please refer to the benefit highlights and booklets for additional information. Unless otherwise specified, amounts shown are for In-Network Services**

<sup>1</sup>Waive copay if admitted to inpatient facility  
 Manipulations - Spinal and other (12 visits PCY)  
 Acupuncture (12 visits PCY)  
 \*Non Specialist/ Specialist

**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.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

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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。

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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.

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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](mailto: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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