

Highlights of your Health Care Coverage

Working Waterfront Coalition 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		
	PPO 100% PLAN 8000	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$8,000 PCY	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$8,000 PCY	Not Covered
Office Visit Cost Share	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
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	Covered in Full
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Covered in Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered in Full
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Not Applicable
PROFESSIONAL CARE		
Professional Office Visit	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered

MEDICAL PLAN		
PPO 100% PLAN 8000		
	IN-NETWORK	OUT-OF-NETWORK
Telemedicine with Traditional Providers - General Medical	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY 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	Not Covered
Diagnostic Laboratory	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Basic Diagnostic Imaging	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Major Diagnostic Imaging	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Preventive Mammography	Covered in Full	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered
FACILITY CARE		
Inpatient Facility	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Inpatient Professional Services	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Hospital Outpatient Surgery Facility	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Ambulatory Surgery Center	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered

MEDICAL PLAN		
PPO 100% PLAN 8000		
	IN-NETWORK	OUT-OF-NETWORK
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
MATERNITY & REPRODUCTIVE CARE		
Birth Center	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
Sterilization - Female (Unlimited)	Covered in Full	Not Covered
Sterilization - Male (Unlimited)	Covered in Full	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging (\$7,500 per transplant)	\$8,000 PCY Deductible, 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$8,000 PCY Deductible, 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
Emergency Room Physician	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
Urgent Care Center	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Ambulance Transportation (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		

MEDICAL PLAN		
	PPO 100% PLAN 8000	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Inpatient Facility Care (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
REHABILITATION & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Outpatient Rehab, Including Physical and Occupational Therapy (45 visits PCY)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Inpatient Neurodevelopmental Therapy	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Outpatient Neurodevelopmental Therapy (45 visits PCY)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered

MEDICAL PLAN		
PPO 100% PLAN 8000		
	IN-NETWORK	OUT-OF-NETWORK
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	\$8,000 PCY Deductible, then 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	Not Covered
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.

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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	
PPO 100% PLAN 8000 - RX	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred A2 Tier 1 = generic Tier 2 = brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	Shared with Medical
Family Deductible PCY	Shared with Medical
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	Tier 1 -Waive Deductible, then \$10 copay; Tier 2 – Deductible, Coinsurance; OON: Not Covered
Mail Cost Shares	Tier 1 -Waive Deductible, then \$30 copay; Tier 2 – Deductible, Coinsurance; OON: Not Covered
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.

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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。

Goi 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.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ប្រាមទាំងសេវាកម្ម និងជំនួយចាំបាច់ផលសមរម្យផ្សេងៗ

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求めください。

ለነፃ የቋንቋ ርዕረዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሲጠይቁ ኢጋዥ መሰሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

မှတ်တမ်း မှားယွင်းမှုများကို အစီအစဉ် ပြင်ဆင်ပေးခြင်း၊ အသုံးပြုသူ၏ လိုအပ်ချက်များနှင့် ကိုညီလာခံရန် နည်းလမ်းများ ရှာဖွေခြင်း။

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອເພື່ອຕີລະຄອນທີ່ເໝາະສົມແບບບໍ່ຈ່ອງຄ່າ.

Rele pou w iwenñ sêvis assistants lengwistik gratis ak èd epi sêvis oksiyèl ki apwopriye.

Appeler 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/online/services/cc/pub/complaintinformation.aspx>.