PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Working Waterfront Coalition 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	**HSA 1800**	
	HERITAGE PRIME IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$1,800/$3,600	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,500	Shared with In-Network
Office Visit Cost Share	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
PROFESSIONAL CARE		

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MEDICAL PLAN	HSA 1800	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Professional Office Visit	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 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	Waive Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Diagnostic Laboratory	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Basic Diagnostic Imaging	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Major Diagnostic Imaging	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Breast Cancer Screening (including mammography)	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
FACILITY CARE		
Inpatient Facility	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Inpatient Professional Services	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Hospital Outpatient Surgery Facility	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Ambulatory Surgery Center	$1,800/$3,600 Deductible, then 10% Coinsurance, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Birth Center	$1,800/$3,600 Deductible, then 10% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$1,800/$3,600 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,800/$3,600 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Emergency Room Physician	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Urgent Care Center	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
ALTERNATIVE CARE		

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MEDICAL PLAN	HSA 1800	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network 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)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 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)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Rehab, Including Physical and Occupational Therapy (25 visits PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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MEDICAL PLAN	HSA 1800	
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Outpatient Speech Therapy (Applies to the outpatient rehab limit)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Inpatient Neurodevelopmental Therapy	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Neurodevelopmental Therapy (25 visits PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	$1,800/$3,600 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Hearing Hardware (1 device per ear every 3 years)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $4,500 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.

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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.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ 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.

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