

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		HSA 5500
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$5,500 PCY/\$6,000 PCY	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)	\$6,500 PCY	Shared with In-Network
Office Visit Cost Share	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 INN & OON Out of Pocket Max
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

MEDICAL PLAN		
	HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Not Applicable
PROFESSIONAL CARE		
Professional Office Visit	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Diagnostic Laboratory	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Preventive Mammography	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		

MEDICAL PLAN		HSA 5500
	IN-NETWORK	OUT-OF-NETWORK
Inpatient Facility	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		

MEDICAL PLAN			HSA 5500
	IN-NETWORK	OUT-OF-NETWORK	
Emergency Care	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Emergency Room Physician	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Urgent Care Center	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Not Covered	

MEDICAL PLAN		
	HSA 5500	
	IN-NETWORK	OUT-OF-NETWORK
REHABILITATION & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 every 36 months)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 36 months)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY 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 Premiera 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.

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 ሲጨ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

မှတ်တမ်း မှားယွင်းမှုများကို ရှောင်ရှားရန် အသုံးပြုသူများသည် ဤစာမျက်နှာတွင် ပါရှိသော အချက်အလက်များကို သေချာစိစစ်ပါ။

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອເພື່ອຕອບສະໜອງຕໍ່ຄວາມຕ້ອງການຂອງທ່ານ.

Lte pou w iwenñ sêvis assistants lengwistik gratis ak èd epi sêvis oksiyèl 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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