

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWVA

Effective Date: 04/01/2024

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 3500
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$3,500 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 and copay if applicable (Family embedded OOP max 2X Individual)	\$6,500 PCY	Shared with In-Network
Office Visit Cost Share	\$3,500 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
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	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

MEDICAL PLAN		HSA 3500
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Prevention	Excluded	Excluded
Diabetes Management	Excluded	Excluded
Hypertension Management	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		
Professional Office Visit	\$3,500 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	\$3,500 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)	\$3,500 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	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Other Professional Diagnostic Imaging	\$3,500 Deductible, then 20% Coinsurance, applies to \$6,500 Out of Pocket Maximum	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Professional Diagnostic Major Imaging	\$3,500 Deductible, then 20% Coinsurance, applies to \$6,500 Out of Pocket Maximum	Shared with INN De, then 40% Coinsurance, applies to Shared INN & OONd Out of Pocket Max
Other Professional Diagnostic Laboratory/Pathology	\$3,500 Deductible, then 20% Coinsurance, applies to \$6,500 Out of Pocket Maximum	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
Diagnostic Mammography	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Max	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max

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Supplemental Breast Exam	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Max	Covered as any other Service
FACILITY CARE OPTIONS		
Inpatient Facility	\$3,500 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	\$3,500 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 Surgery Facility	\$3,500 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)	\$3,500 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)	\$3,500 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)	\$3,500 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		
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)	\$3,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$3,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		

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Emergency Care	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Emergency Room Physician	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
Urgent Care Center	\$3,500 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)	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$3,500 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)	\$3,500 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)	\$3,500 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)	\$3,500 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)	\$3,500 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)	\$3,500 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			
Drug List	Open A1	Open A1	
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	\$3,500 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)	\$3,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Not Covered	

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REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$3,500 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	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 visits PCY combined limit for outpatient services)	\$3,500 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	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$3,500 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	\$3,500 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)	\$3,500 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)	\$3,500 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 (WA Mandate \$3,000 per ear with hearing loss 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	

