

Effective Date: 04/01/2024

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWWA

Nicotine Dependency Programs (ND) (Unlimited)

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 **OUT-OF-NETWORK IN-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 20% 40% allowable charges) Individual Out of Pocket Maximum PCY, includes deductible, coinsurance and Shared with In-Network \$6,500 PCY copay if applicable (Family embedded OOP max 2X Individual) \$3,500 PCY/\$6,000 PCY Deductible, then Shared with In-Network Deductible, then 40% Office Visit Cost Share 20% Coinsurance, applies to \$6.500 PCY Out Coinsurance, applies to Shared with In-Network Out of Pocket Maximum of Pocket Maximum All services rendered and billed by any Kinwell Connect Cost Share Waiver (Excluded) Kinwell clinic are subject to standard cost Not Applicable shares PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of **Preventive Office Visit** (Unlimited, subject to standard medical guidelines) Covered in Full Pocket Maximum Waive Deductible, then 40% Coinsurance. **Immunizations** (Unlimited, subject to standard medical guidelines) Covered In Full applies to Shared INN & OON Out of Pocket Max Health Education (HE) (Unlimited) Covered In Full Not Covered Waive Deductible, then 40% Coinsurance.

1-KGBSZN Rev #2 Q 2/12/2024 07:08 PM Page 1 of 0

Covered In Full

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

MEDICAL PLAN	HSA 3500	
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
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	-	

MEDICAL PLAN	HSA 3500	
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
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

MEDICAL PLAN	HSA 3500	
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
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



Discrimination is Against the Law

LifeWise Health Plan of Washington (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities 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). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396. Fax: 425-918-5592. TTY: 711. Email Appeals Department Inquiries @LifeWiseHealth.com, You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-592-6804 (TTY: 711). 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 800-592-6804 (TTY: 711)。 CHÚÝ: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-592-6804 (TTY: 711). 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-592-6804 (TTY: 711) 번으로 전화해 주십시오. ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-592-6804 (телетайп: 711). РАUNAWA: Кипр падзазаlita ка пр Тадаlод, тадані капр gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Титаwag sa 800-592-6804 (ТТY: 711). УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-592-6804 (телетайп: 711).

<u>ملحوظة:</u> إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-592-6804 (رقم هاتف الصم والبكم: 117). पिਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-592-6804 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। <u>ACHTUNG</u>: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-592-6804 (TTY: 711). <u>ਪਿਨ੍ਰਾ</u>υ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-592-6804 (TTY: 711). <u>ATANSYON</u>: Si w pale Kreyöl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-592-6804 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-592-6804 (ATS: 711). <a href="https://doi.org/10.2016/journal.org/linearing/lin

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-592-6804 (TTY: 711).

<u>ATTENZIONE</u>: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-592-6804 (TTY: 711). توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 800-592-6804 (TTY: 711) ماس بگیرید.

037336 (07-01-2021)