

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST

Effective Date: 10/01/2024

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		HMO 4000	
	SHERWOOD HMO IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$4,000	Not Covered	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Not Covered	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$8,000	Not Covered	
PCP Office Visit Cost Share	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Specialist Office Visit Cost Share	\$65 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
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	Not Covered	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
Health Education (HE) (Unlimited)	Covered in Full	Not Covered	
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered	
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention	Excluded	Excluded	
Diabetes Management	Excluded	Excluded	

MEDICAL PLAN		HMO 4000	
	SHERWOOD HMO IN-NETWORK	OUT-OF-NETWORK	
Hypertension Management	Excluded	Excluded	
Weight Management	Excluded	Excluded	
PROFESSIONAL CARE			
Professional Office Visit	PCP: \$10 Copay, applies to the \$8,000 Out of Pocket Maximum; Specialist: \$65 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Telemedicine with Traditional Providers - General Medical	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Telemedicine with Traditional Providers - Specialist	\$65 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$10 Copay, applies to the \$8,000 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	Not Covered	
Other Professional Diagnostic Imaging	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Professional Diagnostic Major Imaging	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Other Professional Diagnostic Laboratory/Pathology	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Diagnostic Mammography	Covered in Full	Not Covered	
Supplemental Breast Exam	Covered in Full	Not Covered	
FACILITY CARE OPTIONS			
Inpatient Facility	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Inpatient Professional Services	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Outpatient Surgery Facility	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
HOSPICE & HOME HEALTH CARE			

MEDICAL PLAN		HMO 4000	
	SHERWOOD HMO IN-NETWORK	OUT-OF-NETWORK	
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
MATERNITY & REPRODUCTIVE CARE			
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)	\$4,000 Deductible, 0% Coinsurance, applies to \$8,000 Out of Pocket Maximum	\$4,000 Deductible, 0% Coinsurance, applies to \$8,000 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$300 Copay then \$4,000 Deductible and 20% Coinsurance; all cost shares apply to the \$8,000 Out of Pocket Maximum	\$300 Copay then \$4,000 Deductible and 20% Coinsurance; all cost shares apply to the \$8,000 Out of Pocket Maximum	
Emergency Room Physician	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	
Urgent Care Center	\$25 Copay, applies to the \$8,000 Out of Pocket Maximum	\$25 Copay, applies to the \$8,000 Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Manipulations (Spinal and other) (12 visits PCY)	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Mental Health Inpatient Facility Care (Unlimited)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Mental Health Outpatient Professional Care (Unlimited)	\$10 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	

MEDICAL PLAN		HMO 4000	
	SHERWOOD HMO IN-NETWORK	OUT-OF-NETWORK	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 visits PCY combined limit for outpatient services)	\$65 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$65 Copay, applies to the \$8,000 Out of Pocket Maximum	Not Covered	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$4,000 Deductible, then 20% Coinsurance, applies to \$8,000 Out of Pocket Maximum	Not Covered	
Transplants (Unlimited)	Covered as any other service	Not Covered	
SUPPLEMENTAL BENEFITS			
Routine Hearing Exam (1 every 36 months)	\$25 Copay	Not Covered	
Hearing Hardware (WA Mandate \$3,000 per ear with hearing loss 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 HMO. 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	
HMO 4000 - PHARMACY \$10/\$40/\$70/\$150	
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	NO RX DEDUCTIBLE
Family Deductible PCY	NO FAMILY DEDUCTIBLE
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	\$10/\$40/\$70/\$150
Mail Cost Shares	\$25/\$100/\$70/\$375
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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