

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWVA

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 | | HSA 1700 | |
|---|--|--|--|
| | LW HEALTH PLAN OF WA PREFERRED IN-NETWORK | OUT-OF-NETWORK | |
| MEDICAL COST SHARE OPTIONS | | | |
| Individual Deductible PCY (Family aggregate deductible 2x Individual) | \$1,700/\$3,400 | 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) | \$4,500 PCY | Shared with In-Network | |
| Office Visit Cost Share | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 1700 |
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| | 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum | Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max |
| Professional Diagnostic Major Imaging | \$1,700 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum | Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max |
| Other Professional Diagnostic Laboratory/Pathology | \$1,700 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum | Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max |

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|---|--|--|
| | LW HEALTH PLAN OF WA PREFERRED IN-NETWORK | OUT-OF-NETWORK |
| Diagnostic Mammography | Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$4,500 PCY Out of Pocket Max | Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max |
| Supplemental Breast Exam | Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$4,500 PCY Out of Pocket Max | Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max |
| FACILITY CARE OPTIONS | | |
| Inpatient Facility | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 \$4,500 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 | | |

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|---|--|--|---------|
| | LW HEALTH PLAN OF WA PREFERRED IN-NETWORK | OUT-OF-NETWORK | |
| Transplant Travel & Lodging (\$7,500 per transplant) | \$1,700/\$3,400 Deductible, 0% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | \$1,700/\$3,400 Deductible, 0% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | |
| EMERGENCY CARE AND TRANSPORTATION OPTION | | | |
| Emergency Care | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | |
| Emergency Room Physician | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | |
| Urgent Care Center | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | |
| ALTERNATIVE CARE | | | |
| Acupuncture (12 visits PCY) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 |

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|---|--|--|
| | LW HEALTH PLAN OF WA PREFERRED IN-NETWORK | OUT-OF-NETWORK |
| Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 PCY Out of Pocket Maximum | Not Covered |
| REHABILITATION & NEURO | | |
| Rehab Inpatient Facility (30 days PCY combined limit for inpatient services) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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) | \$1,700/\$3,400 Deductible, then 20% Coinsurance, applies to \$4,500 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 \$4,500 PCY Out of Pocket Maximum | Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$4,500 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 AppealsDepartmentInquiries@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)。

CHÚ Ý: 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).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-592-6804 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-592-6804 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយមិនគិតថ្លៃសម្រាប់អ្នក។ ចូរទូរស័ព្ទ 800-592-6804 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-592-6804 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የግናገራት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያግዙት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ደደውሉ 800-592-6804 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-592-6804 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 800-592-6804 (رقم هاتف الصم والبكم: 711).

ग्रिभाठ दिउ: ने दुर्मी पंजाबी बोलते हे, उां डामा विच सहाइता मेदा डुवाडे लयी मुदत उुपलबध है। 800-592-6804 (TTY: 711) 'उे बाल बवे।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-592-6804 (TTY: 711).

ໄປັດອຸກາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສ່ຽງຄ່າ, ຄວນມີຜ່ອມໃຫ້ທ່ານ. ໂທສ 800-592-6804 (TTY: 711).

ATANSYON: Si w pale Kreyòl 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).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-592-6804 (TTY: 711).

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

ATTENZIONE: 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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-592-6804 (TTY: 711) تماس بگیرید.

037336 (07-01-2021)