

# Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST

Effective Date: 10/01/2025

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 2500	
	IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$2,500/\$5,000	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)	\$5,500	Shared with In-Network	
Office Visit Cost Share	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 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 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 with In-Network Out of Pocket Maximum	
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 with In-Network Out of Pocket Maximum	
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 Management Plus	Included	Not Applicable	

MEDICAL PLAN		HSA 2500
	IN-NETWORK	OUT-OF-NETWORK
<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Telemedicine with Traditional Providers - General Medical</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>VIRTUAL CARE SERVICES</b>		
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Not Covered
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
<b>DIAGNOSTIC SERVICES</b>		
<b>Preventive Imaging and Laboratory</b>	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Diagnostic Laboratory</b>	\$2,500 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Basic Diagnostic Imaging</b>	\$2,500 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Major Diagnostic Imaging</b>	\$2,500 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Preventive Mammography</b>	Covered In Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Diagnostic Mammography</b>	Covered In Full	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Supplemental Breast Exam</b>	Covered In Full	Shared with INN Ded, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>FACILITY CARE</b>		
<b>Inpatient Facility</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

MEDICAL PLAN		HSA 2500
	IN-NETWORK	OUT-OF-NETWORK
<b>Inpatient Professional Services</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Outpatient Surgery Facility</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Skilled Nursing Facility</b> (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>HOSPICE &amp; HOME HEALTH CARE</b>		
<b>Hospice Inpatient Facility</b> (30 days Inpatient; within the 6 month lifetime maximum)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>		
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Sterilization - Male</b> (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>MEDICAL TRANSPORTATION BENEFITS</b>		
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$2,500/\$5,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>EMERGENCY CARE AND TRANSPORTATION</b>		
<b>Emergency Care</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>Emergency Room Physician</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>Urgent Care Center</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

MEDICAL PLAN		HSA 2500
	IN-NETWORK	OUT-OF-NETWORK
<b>Ambulance Transportation</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture</b> (12 visits PCY)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>		
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>PHARMACY</b>		
<b>Formulary Drug List</b>	Open A1 No Tiers	Open A1 No Tiers
<b>Prescription Drugs - Retail</b> (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
<b>Prescription Drugs - Mail</b> (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Not Covered
<b>REHABILITATION &amp; NEURO</b>		
<b>Rehab Inpatient Facility</b> (30 days PCY combined limit for inpatient services)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (25 visits PCY combined limit for outpatient services)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

<b>MEDICAL PLAN</b>		<b>HSA 2500</b>
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered
<b>SUPPLEMENTAL BENEFITS</b>		
<b>Routine Hearing Exam</b> (1 every 36 months)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Hearing Hardware</b> (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>ANNUAL PLAN MAXIMUM</b>		
<b>Annual Plan Maximum</b>	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.*

## Discrimination is Against the Law

Premera Blue Cross (Premera) 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. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera 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). Premera 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 Premera 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: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.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/online/services/cc/pub/complaintinformation.aspx>.

## Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (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 800-722-1471 (TTY: 711)。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

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

Телефонуйте за номером 800-722-1471 (телетайп: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (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。800-722-1471 (TTY: 711) まで、お電話にてご連絡ください。

**ማሳሰቢያ:** የሚናገሩት ቋንቋ እማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክሶሎን ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

**XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bililaa 800-722-1471 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

**பிழைப்பு:** நீ துமீ பிழைப்பு பேசுதே தே, தா துமீ பிழைப்பு மொழிதா தே துமீ பேசுதே தே துமீ பேசுதே தே. 800-722-1471 (TTY: 711) 'தே பேசுதே தே'.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

**ໄປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄວບຄຸມ, ຄ່າບໍລິການໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS: 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

**توجہ:** اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)