

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWVA

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	PPO 70% PLAN 6000	
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,000 PCY	\$18,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance and copay if applicable (Family embedded OOP max 2X Individual)	\$8,000 PCY	Unlimited
Office Visit Cost Share	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Dep Child up to Age 18 Covered In Full; Members 18 & over OON Deductible, then Coinsurance
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	\$18,000 PCY Deductible then 50% Coinsurance
Diabetes Health Education (DE) (Unlimited)	Covered In Full	\$18,000 PCY Deductible then 50% Coinsurance
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Not Applicable

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PROFESSIONAL CARE		
Professional Office Visit	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	\$40 Copay, applies to the OOP Max	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	\$40 Copay, applies to the OOP Max	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 SERVICES		
Preventive Imaging and Laboratory	Covered in Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Diagnostic Laboratory	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Basic Diagnostic Imaging	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Major Diagnostic Imaging	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Preventive Mammography	Covered in Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Diagnostic Mammography	Covered in Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Supplemental Breast Exam	Covered in Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
FACILITY CARE		
Inpatient Facility	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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Inpatient Professional Services	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging (\$7,500 per transplant)	\$6,000 PCY Deductible, 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$6,000 PCY Deductible, 0% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$6,000 PCY Deductible and 30% Coinsurance; all cost shares apply to the \$8,000 PCY Out of Pocket Maximum	\$200 Copay then \$6,000 PCY Deductible and 30% Coinsurance; all cost shares apply to the \$8,000 PCY Out of Pocket Maximum
Emergency Room Physician	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
Urgent Care Center	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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Ambulance Transportation (Unlimited)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited 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)	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$40 Copay, applies to the \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$6,000 PCY Deductible, then 30% Coinsurance, applies to \$8,000 PCY Out of Pocket Maximum	\$18,000 PCY Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered

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SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	\$40 Copay	Subject to OON Deductible, then OON Coinsurance
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

Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWWA

Effective Date: 10/01/2025

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN		PPO 70% PLAN 6000 - RX
PRESCRIPTION DRUGS		
Formulary Drug List	Preferred B4: Tier 1 - Generic, Tier 2 - Preferred Brand, Tier 3 - Non-Preferred Brand, Tier 4 - Specialty	
Annual Benefit Maximum	Unlimited	
Individual Deductible PCY	\$0	
Family Deductible PCY	No Family Deductible	
Out of Network (Non-participating retail pharmacies)	Same as In-Network	
Out of Pocket Maximum	Applies to the medical out of pocket maximum	
Retail Cost Shares	\$10/\$50/\$80/\$250	
Mail Cost Shares	\$30/\$150/\$240/\$250	
Day Supply	Retail Rx Copay = 30 Days; up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days	

