

# Highlights of your Health Care Coverage

WA FARM BUREAU HEALTHCARE TRUST - LWWA

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 50% PLAN 1000
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL COST SHARES</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$1,000	Shared with In-Network
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	50%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance and copay if applicable</b> (Family embedded OOP max 2X Individual)	\$5,500 PCY	Shared with In-Network
<b>Office Visit Cost Share</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Immunizations</b> (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
<b>Health Education (HE)</b> (Unlimited)	Covered In Full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered In Full	Shared with INN Ded, then 50% Coinsurance, applies to Shared INN & OON Out of Pocket Max
<b>CHRONIC CONDITION MANAGEMENT PROGRAMS</b>		
<b>Diabetes Management Plus</b>	Included	Not Applicable

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<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Telemedicine with Traditional Providers - General Medical</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>VIRTUAL CARE SERVICES</b>		
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY 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	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Diagnostic Laboratory</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Basic Diagnostic Imaging</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Major Diagnostic Imaging</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Preventive Mammography</b>	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Diagnostic Mammography</b>	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Supplemental Breast Exam</b>	Covered in Full	Covered as any other service
<b>FACILITY CARE</b>		
<b>Inpatient Facility</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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<b>Inpatient Professional Services</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Outpatient Surgery Facility</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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 50% 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 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum
<b>EMERGENCY CARE AND TRANSPORTATION</b>		
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$1,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,500 PCY Out of Pocket Maximum	\$200 Copay then \$1,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,500 PCY Out of Pocket Maximum
<b>Emergency Room Physician</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum
<b>Urgent Care Center</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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<b>Ambulance Transportation</b> (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture</b> (12 visits PCY)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>REHABILITATION &amp; NEURO</b>		
<b>Rehab Inpatient Facility</b> (30 days PCY combined limit for inpatient services)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered

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SUPPLEMENTAL BENEFITS			
<b>Routine Hearing Exam</b> (1 every 36 months)		\$1,000 Deductible, then 50% Coinsurance, applies to \$5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% 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)		Covered in Full	Covered in Full
ANNUAL PLAN MAXIMUM			
<b>Annual Plan Maximum</b>		Unlimited	Unlimited

# Highlights of your Health Care Coverage

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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](http://www.premera.com)

PHARMACY PLAN		PPO 50% PLAN 1000 - RX
PRESCRIPTION DRUGS		
Formulary Drug List		A1
Annual Benefit Maximum		Unlimited
Individual Deductible PCY		Shared with Medical Deductible
Family Deductible PCY		Family Deductible 2x Individual
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		50%
Mail Cost Shares		50%
Day Supply		Retail Rx Copay = 30 Days; up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days

## Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរស័ព្ទស្នើសុំសេវាជំនួយភាសាដោយគិតគូរថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដល់សមាជិកផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

મુદત ટ્રાફ મરાઈટા મેદાદ અંતે ઉચિત મરાઈક ઈજા અંતે મેદાદ દામતે વાલ વતે।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, 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, our 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>.