

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		HSA 5500	
	LW HEALTH PLAN OF WA PREFERRED IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$5,500 PCY/\$6,000 PCY	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)	\$6,500 PCY	Shared with In-Network	
Office Visit Cost Share	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY 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 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	
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	

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PROFESSIONAL CARE			
Professional Office Visit	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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 SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared INN & OON Out of Pocket Max	
Diagnostic Laboratory	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Basic Diagnostic Imaging	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Major Diagnostic Imaging	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Preventive Mammography	Covered in Full	Waive Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Supplemental Breast Exam	Covered in Full	Covered as any other service	
FACILITY CARE			
Inpatient Facility	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

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Inpatient Professional Services	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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 \$6,500 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		
Transplant Travel & Lodging (\$7,500 per transplant)	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
Emergency Room Physician	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
Urgent Care Center	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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Ambulance Transportation (Unlimited)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
PHARMACY			
Formulary Drug List	Open A1	Open A1	
Prescription Drugs - Retail (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
Prescription Drugs - Mail (Retail up to 90 day supply per Rx; Mail up to 90 Day per Rx; Specialty 30 Days)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY combined limit for inpatient services)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

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OTHER SERVICES		
Allergy/Therapeutic Injections	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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)	\$5,500 PCY/\$6,000 PCY Deductible, then 20% Coinsurance, applies to \$6,500 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 \$6,500 PCY Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$6,500 PCY Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

