

**LEOFF**

Health & Welfare Trust

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Medical Benefits

2026

Benefits	Plan A	Plan B	Plan FX	Plan F	Plan H
	In Network				
Deductible	\$200 Indiv \$400 Family	\$1,500 Indiv \$3,000 Family	\$100 Indiv \$200 Family	\$100 Indiv \$200 Family	\$2,000 Indiv \$4,000 Family (Aggregating)
Coinsurance (after Ded)	Plan pays 80%; Member pays 20%	Plan pays 80%; Member pays 20%	Plan pays 80%; Member pays 20%	Plan pays 90%; Member pays 10%	Plan pays 80%; Member pays 20%
Total OOP Maximum	\$500 per Person \$1,000 per Family	\$2,000 per Person \$4,000 per Family	\$1,100 per Person \$2,200 per Family	\$1,100 per person \$2,200 per Family	\$3,425 per Person \$6,850 per Family (Aggregating)
Physician Office Visit	\$10 Copay	\$35 Copay	\$20 Copay	\$10 copay	Subject to Ded, then Covered at 80%
98point6 (Text-based Primary Care)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$5 Copay
Virtual Visit	\$5 Copay	\$20 Copay	\$10 Copay	\$5 Copay	Subject to Ded, then Covered at 80%
Professional X-ray/ Lab	First \$500 Covered in Full; thereafter Subject to Ded then Covered at 80%; Mammography Covered in Full	First \$500 Covered in Full; thereafter Subject to Ded then Covered at 80%; Mammography Covered in Full	First \$500 Covered in Full; thereafter Subject to Ded then Covered at 80%; Mammography Covered in Full	Covered in Full	Subject to Ded, then Covered at 80%; Mammography Covered in Full
Preventive Care	Covered in Full				
Hospital Inpatient	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 90%	Subject to Ded, then Covered at 80%
Emergency Room	\$100 Copay per visit, Subject to Ded, then Covered at 80%	\$200 Copay per visit, Subject to Ded, then Covered at 80%	\$200 Copay per visit, then Subject to Ded, then covered at 80%	\$100 copay per visit, then Subject to Ded, then covered at 90%	Subject to Ded, then Covered at 80%
Acupuncture	\$10 Copay 24 visits PCY	\$35 Copay 24 visits PCY	\$20 Copay 24 visits PCY	\$10 copay 24 visits PCY	Subject to Ded, then Covered at 80% 24 visits PCY
Ambulance	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 80%	Subject to Ded, then Covered at 90%	Subject to Ded, then Covered at 80%
Chemical Dependency and Mental Health	Inpatient - Subject to Ded, then Covered at 80% Outpatient - \$10 Copay	Inpatient - Subject to Ded, then Covered at 80% Outpatient - \$35 Copay	Inpatient - Subject to Ded, then Covered at 80% Outpatient - \$20 Copay	Inpatient - Subject to Ded, then Covered at 90% Outpatient - \$10 copay	Subject to Ded, then Covered at 80%
Chiropractic Care	\$10 Copay 24 visits PCY	\$35 Copay 24 visits PCY	\$20 Copay 24 visits PCY	\$10 copay 24 visits PCY	Subject to Ded, then Covered at 80% 24 visits PCY
Inpatient Rehab & Cardiac Rehab	Subject to Ded, then Covered at 80% up to 30 days PCY	Subject to Ded, then Covered at 80% up to 30 days PCY	Subject to Ded, then Covered at 80% up to 30 days PCY	Subject to Ded, then Covered at 90% up to 30 days PCY	Subject to Ded, then Covered at 80% up to 30 days PCY
Oupatient Physical, Speech, & Occupational Therapy, & Cardiac Rehab Care and Massage Therapy	Office Setting - \$10 Copay Limited to a maximum of 60 visits PCY	Office Setting - \$35 Copay Limited to a maximum of 60 visits PCY	Office Setting - \$20 Copay Limited to a maximum of 60 visits PCY	Office Setting - \$10 copay Limited to a maximum of 60 visits PCY;	Office Setting - Subject to Ded, then Covered at 80% Limited to a maximum of 60 visits PCY
Routine Hearing Exam	One exam PCY subject to \$10 Copay; Test: Covered in Full	One exam PCY subject to \$35 Copay; Test: Covered in Full	One exam PCY subject to \$20 Copay; Test: Covered in Full	One exam PCY subject to \$10 Copay; Test: Covered in Full	Not Covered
Hearing Hardware	Under age 19: One device per ear covered in Full every 48 months	Under age 19: One device per ear covered in full every 48 months	Under age 19: One device per ear covered in full every 48 months	Under age 19: One device per ear covered in full every 48 months	Not Covered
Prescription Drugs	Plan A	Plan B	Plan FX	Plan F	Plan H
Ded/Max OOP	None	None	None	None	Subject to the Medical Ded
Retail 30-day Supply	\$15/\$30/\$50/30%	\$15/\$30/\$50/30%	\$15/\$30/\$50/30%	\$10/\$25/\$45/30%	Subject to Ded, then Covered at 80%
Mail Order 90-day Supply	\$30/\$60/\$100/30%	\$30/\$60/\$100/30%	\$30/\$60/\$100/30%	\$20/\$50/\$90/30%	Subject to Ded, then Covered at 80%
Vision					
Exam	Under age 19: \$10 Copay (1 PCY) Age 19+: \$10 Copay (1 PCY)	Under age 19: \$35 Copay (1 PCY) Age 19+: One exam PCY Covered in Full	Under age 19: \$20 Copay (1 PCY) Age 19+: One exam PCY Covered in Full	Under age 19: \$10 Copay (1 PCY) Age 19+: One exam PCY Covered in Full	Under age 19: \$10 Copay (1 PCY) Age 19+: One exam PCY Covered in Full
Hardware	Under age 19: One pair glasses/frames or contacts, Covered at 100% PCY Age 19+: Covered at 100% up to \$300 PCY	Under age 19: One pair glasses/frames or contacts, Covered at 100% PCY Age 19+: Covered at 100% up to \$300 PCY	Under age 19: One pair glasses/frames or contacts, Covered at 100% PCY Age 19+: Covered at 100% up to \$300 PCY	Under age 19: One pair glasses/frames or contacts, Covered at 100% PCY Age 19+: Covered at 100% up to \$300 PCY	Under age 19: One pair glasses/frames or contacts, Covered at 100% PCY Age 19+: Covered at 100% up to \$300 PCY