LEOFF Health and Welfare Trust

Medical Benefits

2026	Plan A	Plan B	Plan FX	Plan F	Plan H
Benefits	**In Network**	**In Network**	**In Network**	**In Network**	**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%	First $500 Covered in Full; thereafter Subject to Ded then Covered at 80%	First $500 Covered in Full; thereafter Subject to Ded then Covered at 80%	Covered in Full	Subject to Ded, then Covered at 80%
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full	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: $5,000 Covered in Full every 48 months	Under age 19: $5,000 Covered in Full every 48 months	Under age 19: $5,000 Covered in Full every 48 months	Under age 19: $5,000 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
	Plan A	**Plan B**	**Plan FX**	**Plan F**	**Plan H**
Employee Only	***$1,133.89***	***$773.71***	***$907.55***	***$947.71***	***$677.98***
Emp/Spouse	***$2,416.51***	***$1,648.88***	***$1,934.12***	***$2,019.70***	***$1,444.87***
Emp/Spouse/1 Child	***$3,122.89***	***$2,130.89***	***$2,499.52***	***$2,610.12***	***$1,867.24***
Emp/Spouse/Children	***$3,494.65***	***$2,384.52***	***$2,797.03***	***$2,920.79***	***$2,089.49***
Emp/1 Child	***$1,840.26***	***$1,255.71***	***$1,472.95***	***$1,538.12***	***$1,100.35***
Employee/Children	***$2,212.04***	***$1,509.36***	***$1,770.47***	***$1,848.81***	***$1,322.62***
Spouse Only	*$1,282.62*	*$875.17*	*$1,026.57*	*$1,071.99*	*$766.89*
Spouse/Child	*$1,989.00*	*$1,357.18*	*$1,591.96*	*$1,662.41*	*$1,189.26*
Spouse/Children	*$2,360.76*	*$1,610.81*	*$1,889.47*	*$1,973.08*	*$1,411.51*
Child Only	*$706.37*	*$482.01*	*$565.39*	*$590.41*	*$422.37*
Children Only	*$1,078.14*	*$735.66*	*$862.92*	*$901.11*	*$644.64*

This is a benefit summary for comparison purposes only. Please refer to the benefit booklet for detailed information.

LEOFF Health and Welfare Trust

Medical Benefits

2026	PLAN MSP PLUS	PLAN MSP
Benefits	**Medicare Supplemental Plan -must be enrolled in Medicare Part A and Part B to be eligible**	**Medicare Supplemental Plan -must be enrolled in Medicare Part A, Part B and Part D to be eligible**
Deductible	Individual $1,000; Family $3,000 Waived for services covered by Medicare	Individual $1,000; Family $3,000 Waived for services covered by Medicare
Coinsurance (after Ded)	Plan pays 80%; Member pays 20% Waived for services covered by Medicare	Plan pays 80%; Member pays 20% Waived for services covered by Medicare
Total Maximum Out of Pocket	$7,150 per person - Combined maximum with prescription drugs; Waived for services covered by Medicare	$3,000 per person - Waived for services covered by Medicare
Physician Office Visit	Pays balance after Medicare	Pays balance after Medicare
Professional X-ray/ Lab	Pays balance after Medicare	Pays balance after Medicare
Preventive Care	Pays balance after Medicare	Pays balance after Medicare
Hospital Inpatient	Pays balance after Medicare	Pays balance after Medicare
Emergency Room	Pays balance after Medicare	Pays balance after Medicare
Acupuncture	Not Covered	Not Covered
Ambulance	Pays balance after Medicare	Pays balance after Medicare
Chemical Dependency and Mental Health	Inpatient - Subject to Ded, then Covered at 80% Outpatient - $25 copay	Inpatient - Subject to Ded, then Covered at 80% Outpatient - $25 copay
Chiropractic Care	$25 copay up to maximum of 24 visits PCY or Balance after Medicare	$25 copay up to maximum of 24 visits PCY or Balance after Medicare
Home Health	Pays balance after Medicare or Subject to Ded then Covered at 80% 130 visits PCY	Pays balance after Medicare or Subject to Ded then Covered at 80% 130 visits PCY
Hospice	Pays balance after Medicare or Subject to Ded then Covered at 80% to 6 months per lifetime	Pays balance after Medicare or Subject to Ded then Covered at 80% to 6 months per lifetime
Inpatient Rehab & Cardiac Rehab	Pays balance after Medicare	Pays balance after Medicare
Outpatient Physical, Speech, & Occupational Therapy, & Cardiac Rehab Care and Massage Therapy	Pays balance after Medicare - up to $3,000 for outpatient facility charges and 60 visits PCY for Outpatient Visits (Massage Therapy - not covered)	Pays balance after Medicare - up to $3,000 for outpatient facility charges and 60 visits PCY for Outpatient Visits (Massage Therapy - not covered)
Skilled Nursing Facility	Pays balance after Medicare - Limited to 60 days PCY	Pays balance after Medicare - Limited to 60 days PCY
Routine Hearing Exam	One exam PCY subject to $25 copay; Test: Covered in Full	One exam PCY subject to $25 copay; Test: Covered in Full
98point6 (Text-based Primary Care)	$0 Copay	$0 Copay
Prescription Drugs		
Retail 30-day Supply	$20/$50/30%/50%	Not Covered
Mail Order 90-day Supply	$40/$100/30%/50%	Not Covered
Vision		
Exam	Pays balance after Medicare. Subject to $25 copay if not covered by Medicare.	Pays balance after Medicare. Subject to $25 copay if not covered by Medicare.
Hardware	Covered at 100% up to $300 PCY	Covered at 100% up to $300 PCY

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