LEOFF
Health & Welfare Trust

2027	Plan F
Benefits	**In Network**
Deductible	$100 Indiv $200 Family
Coinsurance (after Ded)	Plan pays 90%; Member pays 10%
Total OOP Maximum	$1,100 per person $2,200 per Family
Physician Office Visit	$10 copay
Transcarent/SpringHealth/TalkSpace Virtual Visits	$0 Copay
Telemedicine with Traditional Providers	$5 Copay
Professional X-ray/ Lab	Covered in Full
Preventive Care	Covered in Full
Hospital Inpatient	Subject to Ded, then Covered at 90%
Emergency Room	$100 copay per visit, then Subject to Ded, then covered at 90%
Acupuncture	$10 copay 24 visits PCY
Ambulance	Subject to Ded, then Covered at 90%
Chiropractic Care	$10 copay 24 visits PCY
Inpatient Rehab	Subject to Ded, then Covered at 90% 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;
Routine Hearing Exam	One exam PCY subject to $10 Copay
Hearing Hardware	Under age 19: One device per ear covered in full every 48 months
Prescription Drugs	
Ded/Max OOP	None
Retail 30-day Supply	$10/$25/$45/30%
Mail Order 90-day Supply	$20/$50/$45/30%
Vision	
Exam	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
	Plan F
Employee Only	***$1,004.57***
Emp/Spouse	***$2,140.89***
Emp/Spouse/1 Child	***$2,766.72***
Emp/Spouse/Children	***$3,096.04***
Emp/1 Child	***$1,630.41***
Employee/Children	***$1,959.74***
Spouse Only	*$1,136.31*
Spouse/Child	*$1,762.15*
Spouse/Children	*$2,091.46*
Child Only	*$625.84*
Children Only	*$955.17*

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

Alliant