LEOFF Health and Welfare Trust

2020 Medical Benefits

	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%
Teladoc 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
Home Health	Subject to Ded, then Covered at 80% Limited to 130 visits PCY	Subject to Ded, then Covered at 80% Limited to 130 visits PCY	Subject to Ded, then Covered at 80% Limited to 130 visits PCY	Subject to Ded, then Covered at 90% Limited to 130 visits PCY	Subject to Ded, then Covered at 80% Limited to 130 visits PCY
Hospice	Subject to Ded, then Covered at 80% Limited to 6 months lifetime max.	Subject to Ded, then Covered at 80% Limited to 6 months lifetime max.	Subject to Ded, then Covered at 80% Limited to 6 months lifetime max.	Subject to Ded, then Covered at 90% Limited to 6 months lifetime max.	Subject to Ded, then Covered at 80% Limited to 6 month lifetime maximum
Naturopathy	$10 Copay	$35 Copay	$20 Copay	$10 copay	Subject to Ded, then Covered at 80%
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
Skilled Nursing Facility	Subject to Ded, then Covered at 80% Limited to 60 days PCY	Subject to Ded, then Covered at 80% Limited to 60 days PCY	Subject to Ded, then Covered at 80% up to 60 days PCY.	Subject to Ded, then Covered at 90% up to 60 days PCY.	Subject to Ded, then Covered at 80% Limited to 60 days 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/$35/30%	$15/$35/30%	$15/$35/30%	$5/$25/$50	Subject to Ded, then Covered at 80%
Mail Order 90-day Supply	$30/$70/30%	$30/$70/30%	$30/$70/30%	$10/$50/$100	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	Not Covered
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	Not Covered
	Plan A	**Plan B**	**Plan FX**	**Plan F**	**Plan H**
Employee Only	***$959.40***	***$654.64***	***$767.89***	***$801.87***	***$573.65***
Emp/Spouse	***$2,044.64***	***$1,395.14***	***$1,636.49***	***$1,708.90***	***$1,222.53***
Emp/Spouse/1 Child	***$2,642.32***	***$1,802.97***	***$2,114.88***	***$2,208.46***	***$1,579.90***
Emp/Spouse/Children	***$2,956.87***	***$2,017.57***	***$2,366.60***	***$2,471.32***	***$1,767.95***
Emp/1 Child	***$1,557.07***	***$1,062.48***	***$1,246.28***	***$1,301.43***	***$931.02***
Employee/Children	***$1,871.63***	***$1,277.09***	***$1,498.02***	***$1,564.31***	***$1,119.08***
Spouse Only	*$1,085.24*	*$740.49*	*$868.60*	*$907.03*	*$648.88*
Spouse/Child	*$1,682.92*	*$1,148.33*	*$1,346.98*	*$1,406.58*	*$1,006.25*
Spouse/Children	*$1,997.47*	*$1,362.93*	*$1,598.71*	*$1,669.45*	*$1,194.30*
Child Only	*$597.67*	*$407.83*	*$478.39*	*$499.55*	*$357.38*
Children Only	*$912.23*	*$622.45*	*$730.13*	*$762.44*	*$545.44*
2020 Rate Increase	**5.0%**	**5.0%**	**5.0%**	**5.0%**	**5.0%**

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

Alliant EMPLOYEE BENEFITS