

LEOFF Health and Welfare Trust
Final Revised Plan 6B w/\$200 Vison and Rx \$10/\$35 Change
Effective January 1, 2010

LEOFF HEALTH AND WELFARE TRUST PLAN 6B		
Benefit	In-Network	Out-of-Network
Lifetime Maximum	\$2,000,000	
Annual Deductible	\$1,000 per person; \$2,000 per Family	
Coinsurance	Plan pays 80%; Member pays 20% up to: \$1,000 per person \$2,000 per Family	Plan pays 50%; Member pays 50% - unlimited
Out of Pocket Maximum = Deductible + Coinsurance	\$2,000 per person; \$4,000 per Family Once out of pocket maximum is met, all benefits shown at 20% are covered at 100% for remainder of calendar year. (Copays still apply)	Unlimited
Preventive Office Visits	100% up to \$400 PCY (Ded Waived)	50% (Ded Waived) up to same in-network maximum
Immunizations	Maximum applies to Exam and Immunizations only.	
Professional Office Visits	\$20 copay then 100% for 1st 4 visits PCY (Ded Waived). 5th & subsequent visits - 20% after Ded	50% after Ded
Inpatient Prof Services	20% after Ded	50% after Ded
Contraceptive Management	\$20 copay then 100%	50% after Ded
Preventive Professional Diagnostic Lab and Imaging	Pap and PSA Screening covered at 100% (Ded Waived) not subject to any limitations.	50% after Ded
All Other Diagnostic Lab/Imaging	1st \$300 allowable charges covered at 100% (Ded Waived). \$301 thereafter covered at 20% after Ded	50% after Ded
Mammography	100% (Ded Waived)	50% (Ded Waived)
Inpatient Facility	20% after Ded	50% after Ded
Outpatient Facility	20% after Ded	50% after Ded
Skilled Nursing Facility	20% after Ded up to 90 days PCY	
Emergency Room	\$100 Copay + Ded + 20% (Copay waived if admitted)	
Ambulance (air/ground)	20% after Ded	
Acupuncture	Covered under Alternative Medicine - Services for Acupuncutre; Chiropractor; Massage Therapy: \$20 copay then 100% up to 24 combined visits PCY maximum.	50% after Ded up to same in-network maximum

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Chemical Dependency	20% after Ded up to \$15,000 every 24 months; \$40,000 per lifetime	50% after Ded up to same in-network maximum
Home Health Care	20% after Ded up to 130 visits PCY	
Hospice	20% after Ded up to 6 month lifetime maximum	
Manipulations (Spinal & Other)	Covered under Alternative Medicine - Services for Acupuncutre; Chiropractor; Massage Therapy: \$20 copay then 100% up to 24 combined visits PCY maximum. Chiropractic x-rays limited to \$100 PCY Maximum.	50% after Ded up to same in-network maximum
Medical Supplies; Equipment; Prosthetics;	20% after Ded	50% after Ded
Mental Health	Outpatient - 20% after Ded up to 20 visits PCY; Inpatient - 20% after Ded up to 8 days PCY	50% after Ded up to same in-network maximum
Rehab Care - Inpatient	20% after Ded up to \$30,000 PCY maximum	50% after Ded up to same in-network maximum
Rehab Care - Outpatient - Includes: Physical Therapy; Occupational, Speech Therapy; Cardiac and Pulmonary Rehab; Chronic Pain	Outpatient Facility - 20% after Ded up to \$3,000 PCY Professional Office Visits - \$20 copay then 100% up to 45 visits PCY	50% after Ded up to same in-network maximum
TMJ Disorders	Covered as any other up to \$1,000 PCY and \$5,000/lifetime	50% after Ded up to same in-network maximum
Transplants	Covered as any other up to \$250,000 per lifetime	
Generic Preventive Medications	100% For generic medications on list only	50%
Retail	\$10 Generic/\$35 Brand	50%
Mail Order	\$20 Generic/\$70 Brand	Not Covered
	** Mandatory Generics - if Brand name is chosen over Generic then Copay plus difference in cost applies.	
Exam	20% Ded Waived	50% after Ded
Hardware	100% up to \$200 every 24 months	
Employee	Employee	\$ 379.94
Emp/Spouse	Emp/Spouse	\$ 711.87
Emp/Spouse/Child(ren)	Emp/Spouse/Child(ren)	\$ 916.17
Emp/Child(ren)	Emp/Child(ren)	\$ 618.27
Spouse Only	Spouse Only	\$ 375.80
Spouse/Child(ren)	Spouse/Child(ren)	\$ 618.27