Medical Plan Comparison

In-Network Costs	Kaiser	LEOFF Trust | Plan F
Annual Deductible	$0/person $0 family	$100/person $200 family
Annual Out-of-Pocket Maximum	$1,000/person $2,000/family	$1,100/person $2,200/family
Plan Co-Insurance	n/a	10%
Emergency Room	$75 co-pay *Deductible doesn't apply*	$100 co-pay *Then subject to deductible + co-insurance*
Office Visits	$15 co-pay	$10 co-pay
Virtual Visit	$15 co-pay	$5 co-pay
Urgent Care	$15 co-pay *Deductible doesn't apply*	$15 co-pay
Chiropractic Care	$15 co-pay (20 visits) *Deductible doesn't apply*	$10 co-pay (24 visits)
Physical/Massage Therapy	$15 co-pay (35 visits) *Deductible doesn't apply*	$10 co-pay (60 visits) *Deductible doesn't apply*
Retail Prescription Drugs	$10 / $30 / $--	$5 / $25 / $50
Mail Order 90-Day	$20 / $60 / $--	$10 / $50 / $100

Vision Benefit

Deductible Type	In-Network	Out-of-Network
Routine Eye Exams (every 12 months)	$15 co-pay	No Coverage
Vision Hardware -Under 19- (lenses, frames & contacts)	No Charge: 1 per year free	No Coverage
Vision Hardware -Over 19- (lenses, frames & contacts)	24-month Max Allowance of $250 (after allowance, member pays 100%)	No Coverage

Deductible Type	In-Network	Out-of-Network
Routine Eye Exams (per calendar year)	$10 co-pay	No Coverage
Vision Hardware -Under 19- (per calendar year)	1 pair glasses/frames or contacts (covered at 100%)	No Coverage
Vision Hardware -Over 19-	100% coverage up to Max Allowance of $300 (per calendar year)	No Coverage