

**Plan Year:**  
**Dec. 1, 2025 – Nov. 30, 2026**

**PLAN A**

**PLAN B**

**IN-NETWORK – UnitedHealthcare**

**DEDUCTIBLE**

Individual / Family	\$2,000 / \$4,000	\$1,500 / \$3,000
---------------------	-------------------	-------------------

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount

**MAXIMUM OUT-OF-POCKET**

Individual / Family	\$5,000 / \$10,000	\$5,500 / \$11,000
---------------------	--------------------	--------------------

**PREVENTIVE CARE**

Annual Well Check, Immunizations, and Other Related Services	\$0	
--	-----	--

**FACILITY VISITS**

Primary Care	\$40 copay	\$10 copay
Specialist Visits	\$80 copay*	\$100 copay*
Telemedicine	\$0	\$0
Urgent Care	\$75 copay*	\$100 copay*
Inpatient Hospital	\$800 copay per admission*	\$1,000 copay per admission*
Outpatient Surgery	\$400 copay*	\$500 copay*
Emergency Room	\$500 copay*	\$750 copay*

**OUTPATIENT DIAGNOSTIC SERVICES**

X-Ray Services (with designated provider)	\$75 copay*	\$75 copay*
CT/PET Scan, MRI (with designated provider)	\$250 copay after deductible*	\$500 copay after deductible*

**PRESCRIPTIONS (Retail – 30-day supply)**

Tier 1 – Generic	\$10 copay
Tier 2 – Preferred Brand	\$40 copay
Tier 3 – Non-Preferred Brand	\$110 copay
Tier 4 – Specialty	\$250 copay

**OUT-OF-NETWORK – Refer to Summary of Benefits and Coverage found at [www.ilerabenefits.com/legal](http://www.ilerabenefits.com/legal)**

**BI-WEEKLY COST FOR MEDICAL & PRESCRIPTION COVERAGE**

Employee Only	\$20.40	\$0.00
Employee + Spouse	\$122.66	\$81.86
Employee + Child(ren)	\$87.57	\$49.83
Employee + Family	\$267.93	\$209.80

\*Benefits with an asterisk ( \* ) require that the deductible be met before the plan begins to pay.