Plan Year: **Dec. 1, 2026 – Nov. 30, 2027**	**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)	$15 copay*	$15 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		

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.