

**WILLIS INDEPENDENT SCHOOL DISTRICT**  
**Benefit Plan Summaries**  
**For the Plan Year 2026 - 2027**

| SUMMARY                                                             | WISD<br>Plan I- HD                        |                        | WISD<br>Plan II                           |                        |
|---------------------------------------------------------------------|-------------------------------------------|------------------------|-------------------------------------------|------------------------|
| <b>Medical</b>                                                      |                                           |                        |                                           |                        |
| Deductible - Individual                                             | \$4,000                                   |                        | \$2,500                                   |                        |
| Family                                                              | \$8,000                                   |                        | \$5,000                                   |                        |
| 3 month carry-over                                                  | No                                        |                        | Yes                                       |                        |
| Co-insurance (Plan Pays after deductible)                           | 80% of Network Charge                     |                        | 70% of Network Charge                     |                        |
| Preventative                                                        | 100%*                                     |                        | 100%*                                     |                        |
| <b>*Based on Health Care Reform's definition of preventive care</b> |                                           |                        |                                           |                        |
| Office Visit Copay - Primary                                        | 20% after deductible                      |                        | \$45                                      |                        |
| Office Visit Copay - Specialist                                     | 20% after deductible                      |                        | \$75                                      |                        |
| Emergency Room Copay                                                | 20% after deductible                      |                        | \$500                                     |                        |
| In Hospital Deductible                                              | 20% after deductible                      |                        | \$500                                     |                        |
| <b>Out-of-Pocket Maximum</b>                                        |                                           |                        |                                           |                        |
| Individual                                                          | \$6,350                                   |                        | \$6,350                                   |                        |
| Family                                                              | \$11,200                                  |                        | \$11,200                                  |                        |
| Lifetime Maximum                                                    | unlimited                                 |                        | unlimited                                 |                        |
| <b>Prescription Drugs</b>                                           |                                           |                        |                                           |                        |
| <b>Plan Year Deductible</b>                                         | Subject to plan deductible                |                        | \$0-generic                               |                        |
| <i>Retail - 30 day</i>                                              |                                           |                        | \$200-brand name                          |                        |
|                                                                     | You Pay                                   |                        | You Pay                                   |                        |
| Generic                                                             | 20% after deductible                      |                        | \$20                                      |                        |
| Brand Copay (Formulary)                                             | 25% after deductible                      |                        | \$60                                      |                        |
| Brand Copay (Non-Formulary)                                         | 40% after deductible                      |                        | \$75                                      |                        |
| Specialty Drugs                                                     | 20% after deductible                      |                        | 30% Coinsurance with a \$200 Minimum      |                        |
| <b>Premiums per Month</b>                                           | <b>WISD<br/>Plan I- HD</b>                |                        | <b>WISD<br/>Plan II</b>                   |                        |
|                                                                     | <b>Fulltime Employee<br/>Monthly Cost</b> |                        | <b>Fulltime Employee<br/>Monthly Cost</b> |                        |
|                                                                     | <b>With<br/>**HRA</b>                     | <b>Without<br/>HRA</b> | <b>With<br/>HRA</b>                       | <b>Without<br/>HRA</b> |
| Employee Only Coverage                                              | \$125                                     | \$225                  | \$225                                     | \$325                  |
| Employee Plus Children                                              | \$450                                     | \$550                  | \$552                                     | \$652                  |
| Employee Plus Spouse                                                | \$802                                     | \$902                  | \$1,078                                   | \$1,178                |
| Employee Plus Family                                                | \$1,000                                   | \$1,100                | \$1,162                                   | \$1,262                |

District pays \$450 monthly for each full time employee

\*\*Health Risk Assessment performed at Next Level Urgent Care at no cost