PLEASE NOTE

Information provided references In-network
Values showns as individual / family, where applicable
All percentages are after deductible has been reached
Deductible must be met before plan begins to pay
Coinsurances and Copays shown represent what the member is responsible for paying
If you have questions, please contact the Graham Benefits team at ushrbenefits@graham.ca

2026 VS 2027 PPO MEDICAL PLANS

	2026 Base Plan	2027 PPO
Premium	Voluntary - Shared premium	Voluntary - Shared premium
Deductible	$250 / $750	$1,500 / $3,000
Out-of-Pocket Maximum	$2,500 / $5,000	$5,000 / $10,000
Office Visit PCP copay	$20	$40
Office Visit Specialist copay	$40	$60
Emergency Room copay	$150 + 20%	$250
Urgent Care copay	$20	$60
Inpatient Hospital	20%	20%
Rx Retail copay (G / BF / BNF / S)	$10 / $30 / $50 / $250	$20 / $40 / $60 / $150
Rx Mail Order copay (G / BF / BNF / S)	$30 / $90 / $150 / $250	$40 / $80 / $120 / $300
Coinsurance	20%	20%

2026 VS 2027 HDHP MEDICAL PLANS

	2026 HDHP	2027 HDHP 4K	2027 HDHP 2K
Premium	Voluntary - Shared premium	Voluntary - Company paid	Voluntary - Shared premium
Deductible	$2,000 / $4,000	$4,000 / $8,000	$2,000 / $4,000
Out-of-Pocket Maximum	$3,000 / $6,000	$10,000 / $20,000	$4,000 / $8,000
Coinsurance	20%	20%	20%

NEW HMO MEDICAL PLAN (CALIFORNIA ONLY)

	2026 HMO	2027 Plans
Premium	Voluntary - Shared premium	Voluntary - Shared premium
Deductible	$0 / $0	$250 / $500
Out-of-Pocket Maximum	$1,500 / $3,000	$1,500 / $3,000
Office Visit PCP copay	$20	$20
Office Visit Specialist copay	$20	$35
Emergency Room copay	$100	$150
Inpatient Hospital copay	$500	$300
Urgent Care copay	$20	$20
Rx Retail copay (G / BF / BNF / S)	$15 / $35 / $35 / $250	$10 / $30 / $30 / $100
Rx Mail Order copay (G / BF / BNF / S)	$30 / $70 / $70 / $250	$20 / $60 / - / -
Coinsurance	N/A	10%

2026 VS 2027 SAVINGS PLANS

Health Spending Account (HSA)

	2026 HSA	2027 HDHP 4K - HSA	2027 HDHP 2K - HSA
Employer Annual Maximum Contribution	Individual: $2,000 Family: $4,000	Individual: $1,000 Family: $2,000	Individual: $1,000 Family: $2,000
Frequency	Fixed - Per pay amount	Fixed - Per pay amount	Fixed - Per pay amount

Flexible Spending Account (FSA)

	2026 FSA-HC	2027 FSA-HC
FSA - Health Care	Employee funded	Employee funded

	2026 FSA-DC	2027 FSA-DC
FSA - Dependent Care	Employee funded	Employee funded

	2026 LP-FSA	2027 LP-FSA
FSA - Limited Purpose (Dental and Vision expenses only)	Employee funded	Employee funded

2026 VS 2027 DISABILITY AND LIFE INSURANCE

Benefit		2026 Plans	2027 Plans
Basic Life and AD&D Insurance - Salary	Premium	Mandatory - Company paid	Mandatory - Company paid
	Benefit	2x annual salary, $400,000 maximum	2x salary, $500,000 maximum
Basic Life and AD&D Insurance - Hourly	Premium	Not offered	Company paid
	Benefit		Flat $20,000
Short-Term Disability - Salary & Hourly	Premium	Not Offered	Voluntary - Employee paid
	Elimination period		14 days
	Weekly benefit %		70%
	Weekly benefit maximum		$3,000 per week
	Benefit duration		11 weeks
Benefit		**2026 Plans**	**2027 Plans**
Long-Term Disability - Salary	Premium	Mandatory - Company paid	Mandatory - Company paid
	Elimination period	90 days	90 days
	Monthly benefit %	60%	60%
	Monthly benefit maximum	$12,000	$15,000
Long-Term Disability - Hourly	Premium	Not offered	Voluntary- Employee paid
	Elimination period		90 days
	Monthly benefit %		60%
	Monthly benefit maximum		$15,000

2026 VS 2027 NON-MEDICAL BENEFIT PLANS

Benefit		2026 Plans	2027 Plans
Dental Plan	Premium	Voluntary - Shared premium	Voluntary - Shared premium
	Offered	PPO	PPO DHMO
	Deductible	PPO - $50 / $ 150	PPO - $50 / $ 150 DHMO - N/A
	Coinsurance		
	Preventative	PPO - No charge	PPO - No charge DHMO - No charge
	Basic	10%	PPO - 20% DHMO - Fixed copay
	Major	40%	PPO - 50% DHMO - Fixed copay
	Annual Maximum	$1,750	PPO - $2,000 DHMO - No annual maximum
	Orthodontic Coverage	Child and Adult - $1,500 lifetime maximum	PPO - Child and Adult - $2,000 lifetime maximum DHMO - Child and Adult - Fixed copay
Vision Plan	Premium	Voluntary - Shared premium	Voluntary - Shared premium
	Exam copay	$10	$10
	Materials copay	$25	$20
	Frame allowance	$130	$200
	Contact allowance	$130	$150
	Frequency		
	Exam	Once every 12 months	Once every 12 months
	Lenses		
	Contacts		
	Frames		Once every 24 months
	Coverage for safety glasses	No	Yes (VSP Network Plan Only)
Supplemental Life and AD&D Insurance (Employee paid)	Employee Maximum	$500,000	$500,000
	Spouse Maximum	$250,000	$250,000
	Child Maximum	$2,000	$10,000
Voluntary Insurances (Employee paid)	Accident	Yes	Yes
	Commuter Benefit	Yes	Yes
	Critical Illness	Yes	Yes
	Hospital Indemnity	Yes	Yes
	Identity Theft	Yes	Yes
	Legal Coverage	Yes	Yes
	Pet Insurance	Yes	Yes

Disclaimer: *This information is intended for informational purposes only and does not include all plan details. Official plan documents will be available on January 1, 2027. In the event of any discrepancy, the official plan documents will govern.*