Woodbury County
2026 Medical Options

PLAN STATUS	PPO $500		HMO $500		Sheriff Deputies Only - HMO $250	
CARRIER	Wellmark BCBS		Wellmark BCBS		Wellmark BCBS	
PLAN(S)	PPO		HMO		HMO	
NETWORK(S)	Alliance Select		Blue Advantage		Blue Advantage	
PLAN TYPE:	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
PLAN BASICS						
Individual Deductible	$500		$500	Not Covered	$250	Not Covered
Family Deductible	$1,000		$1,000	Not Covered	$500	Not Covered
Coinsurance Level - Member Pays	20%	30%	20%	NA	20%	NA
Individual Out-of-Pocket per plan year	$1,500		$1,500	Not Covered	$750	Not Covered
Family Out-of Pocket per plan year	$3,000		$3,000	Not Covered	$1,250	Not Covered
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited	
OTHER PLAN DETAILS - Member Pays						
Preventive/Routine Care	0%	Deductible then Coinsurance	0%	Not Covered	0%	Not Covered
Primary Care Visit	$25	Deductible then Coinsurance	$25	Not Covered	$20	Not Covered
Specialist Visit	$50	Deductible then Coinsurance	$50	Not Covered	$20	Not Covered
Urgent Care	$50	Deductible then Coinsurance	$50	Not Covered	$20	Not Covered
Chiropractor	$25	Deductible then Coinsurance	$25	Not Covered	$20	Not Covered
Phys/Occ/Speech Therapy visit limits may apply	$25	Deductible then Coinsurance	$25	Not Covered	$20	Not Covered
Diagnostic Test (X-ray, blood work)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Not Covered	Deductible then Coinsurance	Not Covered
Hospital Services						
Inpatient Hospital	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Not Covered	Deductible then Coinsurance	Not Covered
Outpatient Surgery	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Not Covered	Deductible then Coinsurance	Not Covered
Emergency Care	Deductible then Coinsurance	Same as In-Network	Deductible then Coinsurance	Same as In-Network	Deductible then Coinsurance	Same as In-Network
Prescription Drugs						
Deductible	NA		NA	NA	NA	NA
Generic	Greater of $6 or 20% Coinsurance		Greater of $6 or 20% Coinsurance	Not Covered	Greater of $6 or 20% Coinsurance	Not Covered
Preferred Brand Drugs	Greater of $25 or 20% Coinsurance		Greater of $25 or 20% Coinsurance	Not Covered	Greater of $25 or 20% Coinsurance	Not Covered
Non-Preferred Brand Drugs	Greater of $50 or 20% Coinsurance		Greater of $50 or 20% Coinsurance	Not Covered	Greater of $50 or 20% Coinsurance	Not Covered
Specialty Drugs	Same as listed above		Same as listed above	Not Covered	Same as listed above	Not Covered
Mail Order	90 Day Supply		90 Day Supply	Not Covered	90 Day Supply	Not Covered
Tier I / Tier II / Tier III	3 Copayments or Coinsurance		3 Copayments or Coinsurance	Not Covered	3 Copayments or Coinsurance	Not Covered
					Sheriff Deputies Only	
Woodbury Employee Health Rates Month	PPO $500 Monthly Rate		HMO $500 Monthly Rate		HMO $250 Monthly Rate	
Employee	$95.00		$75.00		$56.98	
Employee/Spouse	$195.00		$170.00		NA	
Employee/Child(ren)	$185.00		$165.00		NA	
Family	$285.00		$180.00		$136.36	

Please circle the rate option per pay period for Health coverage above, or indicate that you wish to waive coverage. Then sign and date below.
Return to Human Resources when completed.

Important: If newly electing, adding or removing dependents from coverage, please see Human Resources to obtain the applicable Wellmark form.

_____ **I elect to waive medical coverage.**

Name: _____ **Signature:** _____