WOODBURY COUNTY BOARD OF SUPERVISORS AGENDA ITEM(S) REQUEST FORM

Date: 11/14/2025 Weekly Agenda Date: 11/18/2025

ELECTED OFFICIAL / DEPARTMENT HEAD / CITIZEN: Dan Bittinger, Chairman

WORDING FOR AGENDA ITEM:

Approval of the new Woodbury County health insurance plan design

ACTION REQUIRED:

Approve Ordinance ☐	Approve Resolution ☐	Approve Motion ☑
Public Hearing ☐	Other: Informational ☐	Attachments ☑

EXECUTIVE SUMMARY:

A new plan design will enable Woodbury County's health fund to maintain financial stability.

BACKGROUND:

The new HMO and PPO plans are attached. Changes include deductible, out of pocket maximums, coinsurance and co pays. One of the biggest changes is the 4 tiers billing plan. Currently both the HMO and PPO have two tiers, employee single and employee family. This is changing to a four tier system. The rates will be based on employee, employee and spouse, employee and children and employee and family. The deputies plan will remain the same as noted in the last column. Please see pricing changes below:

PPO Current
EE Single $95.94
EE Family $219.66

PPO New
EE single $95.00
EE and spouse $195.00
EE and children $185.00
EE and family $ 285.00

HMO Current
EE Single $74.56
EE Family $172.20

HMO New
EE single $75.00
EE and spouse $170.00
EE and children $165.00
EE and family $180.00

FINANCIAL IMPACT:

The changes will increase the fund balance and help Woodbury County remain in self-funded status for their health plan.

IF THERE IS A CONTRACT INVOLVED IN THE AGENDA ITEM, HAS THE CONTRACT BEEN SUBMITTED AT LEAST ONE WEEK PRIOR AND ANSWERED WITH A REVIEW BY THE COUNTY ATTORNEY'S OFFICE?

Yes ☐ **No** ☑

RECOMMENDATION:

Pass the motion

ACTION REQUIRED / PROPOSED MOTION:

Motion to pass the new health insurance plan designs effective 01/01/2026.

Approved by Board of Supervisors April 5, 2016.

Gallagher

Woodbury County
Medical | Self-Funded Renewal | Effective 1/1/2026

	1/12026 Plan Options		
			Sheriff Deputies Only
Carrier	Wellmark	Wellmark	Wellmark
Plan Name	PPO $1,000	HMO $500	HMO $250
PLAN DESIGN*			
In-Network Benefits			
Calendar Year (CY) Deductible (Individual / Family)	$500 / $1,000	$500 / $1,000	$250 / $500
CY Out-of-Pocket Max (Individual / Family)	$1,500 / $3,000	$1,500 / $3,000	$750 / $1,250
Coinsurance (member pays after deductible)	20%	20%	20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit	$25 Copay	$25 Copay	$20 Copay
Specialist Visit	$50 Copay	$50 Copay	$20 Copay
Urgent Care	$50 Copay	$50 Copay	$20 Copay
Emergency Room	20% after deductible	20% after deductible	20% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	20% after deductible
Chiropractic (visit limits may apply)	$25 Copay	$25 Copay	$20 Copay
Phys/Occ/Speech Therapy (visit limits may apply)	$25 Copay	$25 Copay	$20 Copay
Diagnostic Test (X-ray, blood work)	20% after deductible	20% after deductible	20% after deductible
Imaging (CT/PET scan, MRI)	20% after deductible	20% after deductible	20% after deductible
Prescription Drug Benefit	Blue Rx Complete	Blue Rx Value Plus	Blue Rx Value Plus
Deductible (Individual / Family)	NA	NA	NA
Out-of-Pocket Maximum (Individual / Family)	Aggregates with Medical	Aggregates with Medical	Aggregates with Medical
Retail	30 Days	30 Days	30 Days
Tier I / Tier II / Tier III	Greater of $6 or 20% Coinsurance Greater of $25 or 20% Coinsurance Greater of $50 or 20% Coinsurance	Greater of $6 or 20% Coinsurance Greater of $25 or 20% Coinsurance Greater of $50 or 20% Coinsurance	Greater of $6 or 20% Coinsurance Greater of $25 or 20% Coinsurance Greater of $50 or 20% Coinsurance
Specialty	Same as listed above	Same as listed above	Same as listed above
Mail Order	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III	3 Copayments or Coinsurance	3 Copayments or Coinsurance	3 Copayments or Coinsurance
Out-of-Network Benefits			
CY Deductible (Individual / Family)	$500 / $1,000	N/A	N/A
CY Out-of-Pocket Max (Individual / Family)	$1,500 / $3,000	N/A	N/A
Coinsurance (member pays after deductible)	30%	N/A	N/A
COST ANALYSIS			
Employee Monthly Rates	PPO $1,000	HMO $500	HMO $250
Employee (EE) Only	$95.00	$75.00	$56.98
EE + Spouse	$195.00	$170.00	NA
EE + Child(ren)	$185.00	$165.00	NA
EE + Family	$285.00	$180.00	$136.36