



Anamosa Community School District

EDUCATORS GROUP PLAN OPTIONS

EFFECTIVE JULY 1, 2025 - JUNE 30, 2026

Medical		HMO 500		Copay Select 1500 *FROZEN*		Copay Select 2500		HDHP 2500 NE	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network		Wellmark Health Plan of Iowa		Alliance Select		Alliance Select		Alliance Select	
Deductible (Annual)	Employee	\$500	NA	\$1,500		\$2,500		\$2,500	
	Family	\$1,000	NA	\$3,000		\$5,000		\$5,000	
Out-of-Pocket Maximum (Annual)	Employee	\$1,000	NA	\$3,000		\$5,000		\$2,500	
	Family	\$2,000	NA	\$6,000		\$10,000		\$5,000	
Coinsurance		10%	NA	20%	30%	25%	35%	NA	
Office Visits - Primary Care		\$5 Copay Designated PCP \$10 Copay PCP	NA	\$15 Copay	30% coinsurance after deductible	\$20 Copay	35% coinsurance after deductible	Deductible Applies	
Office Visits - Specialty Care		\$10 Copay	NA	\$30 Copay	30% coinsurance after deductible	\$40 Copay	35% coinsurance after deductible	Deductible Applies	
Telehealth - Doctor on Demand		\$10 Copay	NA	\$15 Copay - PCP \$30 Copay - Specialist	NA	\$20 Copay - PCP \$40 Copay - Specialist	NA	\$61 per virtual medical visit	NA
Preventive Care: <i>Adult Health Exam; Well Child to age 7; Well-Woman Services; Immunizations and Routine Vision Exam</i>		0% In-Network	NA	0% In-Network	30% coinsurance after deductible	0% In-Network	35% coinsurance after deductible	0% In-Network	Deductible Applies
Hospitalization - Inpatient or Outpatient		10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Emergency Room		\$50 Copay		20% coinsurance after deductible		25% coinsurance after deductible		Deductible Applies	
Mental Health / Chemical Dependency - Inpatient or Outpatient		10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Ambulance		10% coinsurance after deductible		20% coinsurance after deductible		25% coinsurance after deductible		Deductible Applies	
Durable Medical Equipment		10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Outpatient Therapy (Speech, occupational, physical)		10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Diagnostic X-Rays and Labs		Independent Lab: \$10 Copay Facility: 10% coinsurance	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Infertility Benefits*		\$15,000 lifetime maximum for transfer procedures		\$25,000 lifetime maximum for transfer procedures		\$25,000 lifetime maximum for transfer procedures		Excludes Some Services	
Orthotic Devices		10% coinsurance	NA	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Not Covered	

Pharmacy		HMO 500		Copay Select 1500 *FROZEN*		Copay Select 2500		HDHP 2500 NE	
Network		In-Network Blue Rx Value Plus		In-Network Blue Rx Value Plus		In-Network Blue Rx Value Plus		In-Network Blue Rx Value Plus	
Rx Deductible (Waived for Tier 1)	Single	NA		\$50		\$50		Medical Deductible Applies	
Retail Pharmacy (30-day supply)	Family			\$100		\$100			
	Tier 1	\$10		\$10		\$8			
	Tier 2	\$25		\$25		\$35			
	Tier 3	\$40		\$40		\$50 or 50%, whichever is greater			
Biosimilar or Generic Specialty		\$50		\$50		\$50			
Specialty Preferred		\$85		\$85		\$85			
Specialty Non-Preferred		\$100		\$100		\$100			
RX Out-of-Pocket Maximum	Single	\$1,500		\$1,500		\$1,500			
	Family	\$3,000		\$3,000		\$3,000			
Mail Order (90-day supply)	Tier 1	\$20		\$20		\$16			
Rx Deductible applies; is waived for Tier 1	Tier 2	\$50		\$50		\$70			
	Tier 3	\$80		\$80		\$100 or 50%, whichever is greater			
Premium Rates		HMO 500		Copay Select 1500 *FROZEN*		Copay Select 2500		HDHP 2500 NE	
		Employee	Family	Employee	Family	Employee	Family	Employee	Family
Monthly Premiums by Plan		\$754.58	\$1,831.04	\$755.67	\$1,833.75	\$696.74	\$1,686.42	\$673.16	\$1,627.46
Annual Premiums by Plan		\$9,054.96	\$21,972.48	\$9,068.04	\$22,005.00	\$8,360.88	\$20,237.04	\$8,077.92	\$19,529.52

Notes:

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

Copay Select/HMO: Infertility services and prescription drugs for infertility are covered. *Note: Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures are limited to the noted lifetime maximum.

HDHP: Infertility benefits do NOT include artificial insemination, in-vitro fertilization, or other transfer procedures. Treatment and prescription drugs for infertility are no longer covered once a transfer procedure is performed (Option 3)

Doctor on Demand: Doctor On Demand is a virtual visit platform that immediately connects you to a board-certified physician by live video on your smartphone, tablet or computer. - Member cost to use Doctor on Demand is the same coinsurance % or Copay \$ as that for a Primary Office Visit.

HDHP: Member cost to use Doctor On Demand is \$59 (medical); or \$80 to \$189 (depending on length) for Psychologist. Coverage for psychiatry services is available as well as Office Medication Management services. Deductible is waived.

HDHP: No 4th quarter deductible carry-over.

Health Flexible Spending Account (HFSA): General Purpose - available to employees enrolled in a non-HDHP;

Limited Purpose FSA - Available to employees enrolled in HDHP, unreimbursed dental and vision expenses.

HSA: available to employees enrolled in HDHP; must meet certain requirements to be eligible to open/contribute to a HSA..

Non-Embedded Deductible: This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one family member or a combination of family members. You must satisfy the entire family deductible before Wellmark will make benefit payments. The out-of-pocket maximum functions in the same way.

Embedded Deductible: If more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a family member meets his or her individual deductible, benefits begin for that family member only, but not for the other family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by a combination of family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way.

Pharmacy: If you use a nonparticipating pharmacy, you must pay the amount charged at the time of purchase, and the amount Wellmark reimburses you may be less than what you paid. You are responsible for this difference.

All Other Plans: Product Selection Penalty Rule: When a brand drug is obtained and there is an equivalent generic drug available, the member is responsible for paying their payment obligation for the equivalent generic (i.e. lowest payment application) and any remaining cost difference up to the maximum allowed fee for the brand name drug.

HMO/HDHP: Product Selection Penalty Rule: When a brand drug is obtained and there is an equivalent generic drug available, the member is responsible for paying their payment obligation for the equivalent generic (i.e. lowest payment application) and any remaining cost difference up to the maximum allowed fee for the brand name drug except when the provider writes "Dispense as Written" (in this case, the member pays only the appropriate payment application).