

## COBRA/Retiree

### AFSCME, Joint Communications, Library, Non-Bargaining 2026 Traditional POSN vs. Choice POSN Side by Side

	Traditional Plan POSN	Choice Plan POSN
<b>Deductible</b>	<p style="text-align: center;">\$500 Single / \$1,000 Family</p> <p><b>Applies to the following services only:</b> Ambulance, Physical Therapy, Home Health Care, Home Skilled Nursing, Durable Medical Equipment, Oxygen, Blood</p>	<p style="text-align: center;">\$1,000 Single / \$2,000 Family</p> <p><b>Applies to ALL medical services except preventive and office visits.</b></p>
<b>Coinsurance</b>	Plan Pays 90% In-Network / 80% Out-of-Network	Plan Pays 90% In-Network / 80% Out-of-Network
<b>Out of Pocket Maximum</b>	\$1,500 Single / \$3,000 Family	\$3,000 Single / \$6,000 Family
<b>Preventive Care</b>	<p style="text-align: center;">Plan Pays 100% In-Network / 80% Out-of-Network</p> <p style="text-align: center;">Routine Physicals, Gynecological Exams, Mammograms, Colonoscopies, Well Child Care, Immunizations, X-Ray &amp; Lab Services provided during exam</p>	Plan Pays 100% In-Network / 80% Out-of-Network
<b>Office Visits</b>	\$25 PCP Copay/ \$25 Urgent Care Copay/ \$25 Specialist Copay/ \$10 Chiropractor Copay	\$25 PCP Copay/ \$25 Urgent Care Copay/ \$25 Specialist Copay/ \$10 Chiropractor Copay
<b>Inpatient Hospital</b>	You pay a co-pay of \$500 then Plan pays 90% In-Network / 80% Out-of-Network	You pay Deductible then Plan pays 90% In-Network / 80% Out-of-Network
<b>All Other Services</b>	<p style="text-align: center;">Plan Pays 90% In-Network / 80% Out-of-Network</p> <p><b>You pay deductible on these limited services only:</b> Ambulance, Physical Therapy, Home Health Care, Home Skilled Nursing, Durable Medical Equipment, Oxygen, Blood</p>	You pay Deductible then Plan pays 90% In-Network/ 80% Out-of-Network
<b>Prescription Benefits (No Prescription Coordination of Benefits)</b>	<p style="text-align: center;">You pay \$100 Single or \$300 Family Deductible</p> <p style="text-align: center;">Then Tiered Coinsurance 10%/25%/40% until \$500 Out of Pocket Maximum (separate from medical) then Plan pays 100%</p> <p style="text-align: center;">**RxCap program eligible (Out of pocket maximum removed for non-enrollees)</p>	<p style="text-align: center;">No Deductible</p> <p style="text-align: center;">Tiered Coinsurance 10%/25%/50%</p> <p style="text-align: center;">Out of Pocket Maximum is \$1,500 Individual / \$4,500 Family (separate from medical)</p> <p style="text-align: center;">**RxCap program eligible (Out of pocket maximum removed for non-enrollees)</p>

\*An HMO plan generally only allows you to use Wellmark's HMO In-Network providers within the state of Iowa, *with the exception of true emergent situations*. 100% of the hospitals and ~96% of the providers in the state of Iowa are covered under Wellmark's HMO. This is general information only. Please refer to your Summary of Benefits and Coverage (SBC) for specific coverage information.

\*\*RxCap Program: Offers \$0 cost to the employee/member as well as lower overall cost to the Plan, if you are utilizing a drug that is eligible for the RxCap program. You will receive instructions on how to enroll in this program at the time that an eligible drug is filled. If you do not enroll, there is NO out of pocket maximum, so you will continue to pay the Tiered Coinsurance for the calendar year.

# COBRA/Retiree

## AFSCME, Joint Communications, Library, Non-Bargaining 2026 Traditional HMO vs. Choice HMO Side by Side

	Traditional Plan HMO*	Choice Plan HMO*
<b>Deductible</b>	<p>\$500 Single / \$1,000 Family</p> <p><b>Applies to the following services only (within HMO Iowa network):</b> Ambulance, Physical Therapy, Home Health Care, Home Skilled Nursing, Durable Medical Equipment, Oxygen, Blood</p>	<p>\$1,000 Single / \$2,000 Family</p> <p><b>Applies to ALL medical services except preventive and office visits (within HMO Iowa network)</b></p>
<b>Coinsurance</b>	Plan pays 90% In-Network / 0% Out-of-Network except for Emergency Services*	Plan pays 90% In-Network / 0% Out-of-Network except for Emergency Services*
<b>Out of Pocket Maximum</b>	\$1,500 Single / \$3,000 Family (within HMO Iowa Network)	\$3,000 Single / \$6,000 Family (within HMO Iowa Network)
<b>Preventive Care</b>	<p>Plan pays 100% In-Network/ 0% Out-of-Network</p> <p>Routine Physicals, Gynecological Exams, Mammograms, Colonoscopies, Well Child Care, Immunizations, X-Ray &amp; Lab Services provided during exam</p>	Plan pays 100% In-Network/ 0% Out-of-Network
<b>Office Visits</b>	\$25 PCP Copay/ \$25 Urgent Care Copay/ \$25 Specialist Copay/ \$10 Chiropractor Copay (within HMO Iowa Network)	\$25 PCP Copay/ \$25 Urgent Care Copay/ \$25 Specialist Copay/ \$10 Chiropractor Copay (within HMO Iowa Network)
<b>Inpatient Hospital</b>	You pay a co-pay of \$500 (within HMO network) then Plan pays 90% In-Network / 0% Out-of-Network	You pay Deductible (within HMO network) then Plan pays 90% In-Network / 0% Out-of-Network
<b>All Other Services</b>	<p>Plan pays 90% In-Network / 0% Out-of-Network</p> <p><b>You pay deductible on these limited services only:</b> Ambulance, Physical Therapy, Home Health Care, Home Skilled Nursing, Durable Medical Equipment, Oxygen, Blood</p>	You pay Deductible (within HMO Iowa network) then Plan pays 90% In-Network / 0% Out-of-Network
<b>Prescription Benefits (No Prescription Coordination of Benefits)</b>	<p>You pay \$100 Single or \$300 Family Deductible</p> <p>Then Tiered Coinsurance 10%/25%/40% until \$500 Out of Pocket Maximum (separate from medical) then Plan pays 100%</p> <p>**RxCap program eligible (Out of pocket maximum removed for non-enrollees)</p>	<p>No Deductible</p> <p>Tiered Coinsurance 10%/25%/50%</p> <p>Out of Pocket Maximum is \$1,500 Individual / \$4,500 Family (separate from medical)</p> <p>**RxCap program eligible (Out of pocket maximum removed for non-enrollees)</p>

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# COBRA/Retiree AFSCME, Joint Communications, Library, Non-Bargaining

## 2026 Health Insurance Premiums

RETIRES and COBRA:	Traditional POSN	Choice POSN	Traditional HMO	Choice HMO
Single	\$1,576.27	\$768.63	\$1,481.72	\$722.53
Former Employee + Spouse	\$3,020.86	\$1,537.28	\$2,943.83	\$1,445.04
Former Employee + Child(ren)	\$2,324.76	\$1,183.05	\$2,265.49	\$1,112.07
Family	\$3,745.58	\$2,078.67	\$3,520.92	\$1,953.94

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