

Benefits enrollment 2026

emc
INSURANCE

Iowa health
plan options



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Useful resources and terms to know

Doctor on Demand™

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2. Have your Wellmark ID card ready
3. Create an account or sign in
4. Click [See a doctor](#)

SaveonSP

Specialty Medication Copayment Assistance Program

Drug manufacturers provide copay assistance for certain specialty medications. The SaveonSP program allows members and health plans the opportunity to take advantage of the savings.

If your specialty medication qualifies, you can enroll in the SaveonSP program and have your specialty medication copay reduced to \$0. Specialty medications on the SaveonSP drug list are considered non-essential health benefits and the copay will not apply to the out-of-pocket maximum. To find out more information on participating in this program, simply call SaveonSP at 800-683-1074.

Member resource accounts

Each benefit vendor offers an online member resources account where you can access your benefits, file claims, and send messages securely to customer service. If you have a specific question, contact the vendor's customer service number found on the back of your ID card or within the corresponding article in Workday.

Definitions of common terms

Copayment

A fixed dollar amount you pay for a covered health care service. For example, for an office visit, you may pay \$30 at the time you receive certain covered services. The amount can vary by the type of service.

Coinsurance

Refers to how the cost of a covered health care service is shared between you and your health plan. It is calculated as a percent of the allowed amount for the service. For example, 80/20 coinsurance means your health plan pays 80% and you pay 20% for a covered service. You pay any deductible you owe for the plan, then coinsurance amounts apply.

Deductible

The amount you owe for health care services before your health insurance plan begins to pay. For example, if your deductible is \$750, your plan won't pay anything until you have paid \$750 out of your own pocket for covered health care services subject to the deductible. Not all services are subject to the deductible.

Out-of-pocket maximum

The most you will have to pay for covered services in a plan year. After you spend this amount on deductibles, copayment, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket maximum doesn't include your monthly premium; it also doesn't include anything you may spend for services your plan doesn't cover.

Point of Service (POS) Plan

A health plan that allows for the flexibility to go to almost any provider you choose; however, how you access care can affect what you pay. You may pay less if you go to your primary care provider and use doctors, hospitals, and other health care providers that belong to the plan's network in Iowa.

Preferred Provider Organization (PPO) Plan

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network; however, you may pay more for these services.

Premium

The amount that must be paid for your health plan. You pay a portion of the monthly health plan premium through automatic payroll deduction, and EMC pays the remaining portion.

Qualifying life event

Refers to a change in your family or employment status that may allow you to make changes to your benefits. Changes need to be made within 31 days of a qualifying life event. For more information on what events qualify and the documentation you need to send to Human Resources, search "supporting documentation" in Workday.

Medical and prescription drug

The following summary is for reference purposes only. For full details, review the Summary Plan Description by searching “medical insurance” and “prescription drug” in Workday. Medical benefits are determined by where you access your care. Prescription drug coverage is included for all team members and dependents who are enrolled in a health plan.



Wellmark Blue POS

	Primary care	Open access	Out-of-network ³
Annual deductible	None	None	\$1,250 per individual; \$2,500 per family
Annual out-of-pocket maximum All applicable coinsurances, copays, and deductibles apply	\$3,500 per individual; \$7,000 per family	\$3,500 per individual; \$7,000 per family	\$5,000 per individual; \$10,000 per family
Physician office services			
Office visits	\$0 preventive; \$25 non-preventive Copayment applied once per provider ¹ per date of service	\$30 copayment applied once per provider ¹ per date of service; \$0 copayment for virtual visits through Doctor on Demand	70/30 coinsurance
Maternity	\$50 copayment per pregnancy	\$50 copayment per pregnancy	70/30 coinsurance
Allergy injections	\$3 copayment applied once per provider ¹ per date of service	\$3 copayment applied once per provider ¹ per date of service	No coverage
Administration of specialty medication	\$100 copay	\$100 copay	70/30 coinsurance
Lab services			
Physician’s office	Paid in full	Paid in full	70/30 coinsurance
Freestanding lab and hospital lab	Paid in full	Paid in full	70/30 coinsurance
Hospital services²			
Inpatient and maternity	\$500 copayment	\$500 copayment	70/30 coinsurance
Physician services and outpatient	\$50 copayment applied once per provider ¹ per date of service	\$50 copayment applied once per provider ¹ per date of service	70/30 coinsurance
Emergency services			
In-area and out-of-area	\$300 copayment for emergency room	\$300 copayment for emergency room	\$300 copayment for emergency room
Ambulance	Paid in full	Paid in full	Paid in full up to maximum allowable fee ³
Infertility and transfer services	Covered up to \$15,000 lifetime maximum		

Express Scripts Prescription Drug Plan

Administered through RxBenefits, Inc.

30-day supply	\$10 for Tier 1; \$40 for Tier 2; \$60 for Tier 3 Specialty drug: \$100 copay for preferred; 50% coinsurance for non-preferred
90-day supply	\$20 for Tier 1; \$80 for Tier 2; \$120 for Tier 3
Annual out-of-pocket maximum	\$3,500 per individual; \$7,000 per family ⁴ ; all applicable coinsurances and copayments apply

¹ A provider includes a facility or practitioner that may provide certain covered medical services in an office setting or via a virtual visit.

² Surgical procedures for bariatric surgery, spine surgery, and transplants will only be covered when performed at a Blue Distinction Center facility.

³ Copayment/coinsurance/deductible is based on a maximum allowable fee. Charges above this limit are your responsibility.

⁴ Certain specialty pharmacy drugs fall under the SaveonSP copay assistance program and will not count towards the out-of-pocket maximum.

You are covered for drugs listed on the Express Scripts National Preferred drug list. Check if a drug is covered at express-scripts.com/natplsnatpref14. This list may change, and not all drugs are covered. You may purchase specialty drugs only through the preferred specialty pharmacy, Accredo Specialty. Copay amounts for specialty drugs on the SaveonSP drug list may vary.

Monthly premiums

Medical, prescription drug, dental, and vision are combined into the monthly premium listed below and do not reflect any available premium reductions. The premium will be split equally between the first two paychecks of every month.

Blue POS	Employee only	Employee/spouse	Employee/family	Employee/child(ren)
	\$93.88	\$300.80	\$418.88	\$224.22



Medical and prescription drug

The following summary is for reference purposes only. For full details, review the Summary Plan Description by searching “medical insurance” and “prescription drug” in Workday. Medical benefits are determined by which provider organization you use. Prescription drug coverage is included for all team members and dependents who are enrolled in a health plan.

Wellmark Alliance Select PPO

	PPO	Non-PPO (out-of-network) ³
Annual deductible	\$750 per individual; \$1,500 per family	\$1,250 per individual; \$2,500 per family
	For both PPO and non-PPO, the deductible must be met before coinsurance applies. Copayments are not subject to the deductible and cannot be used to satisfy the deductible.	
Annual out-of-pocket maximum All applicable coinsurances, copays, and deductibles apply.	\$3,500 per individual; \$7,000 per family	\$5,000 per individual; \$10,000 per family
Physician office services		
Office visits	\$0 preventive \$30 copayment applied once per provider ¹ per date of service \$0 copayment for virtual visits through Doctor on Demand	60/40 coinsurance
Maternity	\$30 copayment applied once per provider ¹ per date of service	60/40 coinsurance
Allergy injections	\$3 copayment applied once per provider ¹ per date of service	60/40 coinsurance
Administration of specialty medication	\$100 copay	60/40 coinsurance
Lab services		
Physician’s office	\$30 copayment applied once per provider ¹ per date of service	60/40 coinsurance
Freestanding lab and hospital lab	80/20 coinsurance	60/40 coinsurance
Hospital services²		
Inpatient, maternity, physician services, and outpatient	80/20 coinsurance	60/40 coinsurance
Emergency services		
In-area and out-of-area	\$300 copayment for emergency room	\$300 copayment for emergency room
Ambulance	80/20 coinsurance	80/20 coinsurance up to the maximum allowable fee ³
Infertility and transfer services	Covered up to \$15,000 lifetime maximum	



Express Scripts Prescription Drug Plan

Administered through RxBenefits, Inc.

30-day supply	\$10 for Tier 1; \$40 for Tier 2; \$60 for Tier 3 Specialty drug: \$100 copay for preferred; 50% coinsurance for non-preferred
90-day supply	\$20 for Tier 1; \$80 for Tier 2; \$120 for Tier 3
Annual out-of-pocket maximum	\$3,500 per individual; \$7,000 per family ⁴ ; all applicable coinsurances and copayments apply

¹ A provider includes a facility or practitioner that may provide certain covered medical services in an office setting or via a virtual visit.

² Surgical procedures for bariatric surgery, spine surgery, and transplants will only be covered when performed at a Blue Distinction Center facility.

³ Copayment/coinsurance/deductible is based on a maximum allowable fee. Charges above this limit are your responsibility.

⁴ Certain specialty pharmacy drugs fall under the SaveonSP copay assistance program and will not count towards the out-of-pocket maximum.

You are covered for drugs listed on the Express Scripts National Preferred drug list. Check if a drug is covered at [express-scripts.com/natplsnatpref14](https://www.express-scripts.com/natplsnatpref14). This list may change, and not all drugs are covered. You may purchase specialty drugs only through the preferred specialty pharmacy: Accredo Specialty. Copay amounts for specialty drugs on the SaveonSP drug list may vary.

Monthly premiums

Medical, prescription drug, dental, and vision are combined into the monthly premium listed below and do not reflect any available premium reductions. The premium will be split equally between the first two paychecks of every month.

Alliance Select PPO	Employee only	Employee/spouse	Employee/family	Employee/child(ren)
	\$100.96	\$364.96	\$524.78	\$263.46



Dental

Dental coverage is included for all team members and dependents who are enrolled in a health plan. The summary provided is a general description of coverage. It is not a statement of your plan benefit. Actual coverage is subject to terms and conditions specified within the Delta Dental Summary Plan Description, which can be found by searching “dental insurance” in Workday. Find a list of providers near you at deltadentalia.com.

Delta Dental

	PPO network		Premier network	
	Deductible \$25 Single; \$75 Family	Coinsurance	Deductible \$50 Single; \$150 Family	Coinsurance
Check-ups and teeth cleaning (diagnostic and preventive services) Dental cleaning, oral evaluations, x-rays, fluoride applications (eligible children under age 19), and sealant applications (eligible children under age 19)	Waived	0%	Waived	0%
Cavity repair and tooth extractions (routine and restorative services) Emergency treatment, general anesthesia/sedation, restoration of decayed or fractured teeth, and routine oral surgery	Yes	10%	Yes	20%
Posterior composites (white filling on back teeth)	Yes	50%	Yes	50%
Root canals (endodontic services) Apicoectomy, direct pulp cap, pulpotomy, retrograde fillings, and root canal therapy	Yes	20%	Yes	20%
Gum and bone diseases (periodontal services) Conservative procedures (non-surgical), complex procedures (surgical), and maintenance therapy	Yes	20%	Yes	20%
Guided tissue regeneration	Yes	50%	Yes	50%
High-cost restorations (cast restorations) Crowns, inlays, onlays, and posts and core	Yes	50%	Yes	50%
Dentures and bridges (prosthetics—replacement of missing teeth) Bridges, dentures, and dental implants	Yes	50%	Yes	50%
Repairs and adjustments	Yes	20%	Yes	20%
Straighter teeth (orthodontics—eligible children under age 19)	Waived	50%	Waived	50%

Delta Dental’s unique dual network gives you access to both networks of providers: Delta Dental PPO and Premier.

- Delta Dental PPO provides the lowest out-of-pocket costs, but offers a smaller selection of network dentists
- Delta Dental Premier offers the largest selection of network dentists while keeping out-of-pocket costs economical
- Use participating providers to eliminate claim forms and charges over usual and customary amounts
- Diagnostic and preventive dental services do not count toward the annual benefit maximum
- Annual benefit period maximum is \$1,500
- Orthodontics lifetime maximum is \$1,500



Vision

Vision coverage is included for all team members and dependents who are enrolled in a health plan. For full details, review the Vision insurance summary by searching “vision insurance” in Workday. EyeMed offers a nationwide network of independent and retail providers. To find a list of providers near you, go to eyemed.com, click Find a Provider and select Insight Network. Services are also available online through glasses.com and contactsdirect.com.

EyeMed

	Member cost in-network	Out-of-network reimbursement*
Exam with dilation as needed (once per calendar year)	\$0 copay	Up to \$45
Retinal imaging	Up to \$39	N/A
Frames (once every two calendar years)	\$25 copay; \$150 allowance, 20%	Up to \$70
Standard plastic lenses		
Single vision	\$0	Up to \$30
Bifocal	\$0	Up to \$50
Trifocal	\$0	Up to \$65
Lenticular	\$0	Up to \$100
Progressive - standard lens	\$55	Up to \$50
Progressive - premium tier 1-3 lens	\$75–\$100	Up to \$50
Progressive - premium tier 4 lens	\$55 copay; 80% of charge less \$120 allowance	Up to \$50
Lens options (once per calendar year)		
UV treatment	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard plastic scratch coating	\$0 copay	Up to \$5
Standard polycarbonate		
Adults	\$40	N/A
Children under age 19	\$0 copay	Up to \$5
Standard anti-reflective	\$45	N/A
Premium anti-reflective coating tier 1-2	\$57–\$68	N/A
Premium anti-reflective coating tier 3	20% off retail price	N/A
Photochromic - non-glass	\$75	N/A
All other lens options	20% off retail price	N/A
Contact lens fit and follow-up		
Standard contact lens fit	Up to \$40	N/A
Premium contact lens fit	10% off retail price	N/A
Contact lenses (once per calendar year instead of glasses)		
Conventional	\$0 copay; \$150 allowance, 15% off balance over \$150	Up to \$105
Disposable	\$0 copay; \$150 allowance, plus balance over \$150	Up to \$105
Medically necessary	\$0 copay; paid in full	Up to \$210
Other		
Lasik or PRK from U.S. laser network	15% off retail price or 5% off promotional price	N/A
Hearing care from amplifon network	Discounts on hearing exam and aids	Not covered
Additional discounts (in-network providers only)	Members also receive a 40% discount off a pair of prescription eyeglass and a 20% discount off non-prescription sunglasses and any remaining balance beyond plan coverage	N/A

* Out-of-network reimbursement will be the lesser of the listed amount of the member’s actual cost from the provider. See EyeMed’s online provider locator to determine which participating providers have agreed to the discounted rate.

Making changes to your benefits

A qualifying life event

The Internal Revenue Service (IRS) guidelines limit your ability to change your elections. Changes can only be made during the annual open enrollment period or within 31 days of one of the following qualifying life events:

- Loss of other coverage
- Eligible for other coverage
- Dependent change, including birth, adoption, placement for adoption, or legal guardianship
- Marriage
- Divorce (finalized), annulment, or legal separation
- Dependent turns age 26
- Death of spouse or dependent
- Job change (change in your benefits eligibility due to reduction or increase in hours worked)
- Court order
- Military leave or return from military leave for you, your spouse, or your dependent
- Dependent turns age 13 (Dependent Care Flexible Spending Account only)
- Change in dependent care provider (Dependent Care Flexible Spending Only)

A change to your health coverage, health care flexible spending account, or dependent care flexible spending account must be consistent with the life event.

The effective date of coverage, with the exception of birth, adoption, placement of adoption, or legal guardianship, or return from military leave is the first of the month following or coinciding with the date you submit your election.

Qualifying life event changes will not be accepted **outside of the 31-day deadline**. If you do not submit the appropriate changes within this time frame, you must wait until your next qualifying event or the annual open enrollment to make any adjustments.

Note: If a life event causes a dependent to no longer be eligible, health coverage will end the last day of the month in which the life event occurred, and any premium already deducted from your paycheck will not be refunded.

Supporting documentation is required to add a spouse and/or dependent(s) onto the EMC health insurance benefit. If documentation is not received by Human Resources within 60 days of your election, your election will be canceled retroactively. Any premium already deducted from your paycheck will not be refunded. If an additional premium is due, this will be deducted from your paycheck. A list of required documentation can be found by searching “documentation” in Workday.

Submit a case in Workday through the Help app if you have any questions.

Making changes to your benefits

Eligible dependent children

An eligible dependent must be under the age of 26 and meet one of the following dependent classifications listed below:

- Your natural child
- A legally adopted child or a child placed with you for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child)
- A child for whom you have legal guardianship
- A stepchild
- A foster child

Dependent children under the age of 26 can be covered on your health plan regardless of student status or their marital status. Dependents age 26 and older, who are permanently disabled physically or mentally, are also eligible if the disability existed when the child was under age 26, and he/she was covered under the EMC health plan prior to age 26. When your dependent reaches the qualifying age limit of 26, you must remove him/her from the health insurance, life insurance, and AD&D insurance. The coverages will end the last day of the month in which he/she turns 26. For dependents covered on the health insurance, COBRA continuation coverage will be offered and may be continued for up to 36 months.

COBRA

- Continuation of group medical/dental/vision/prescription drug coverages
- Available to all team members and dependents enrolled in an EMC health plan who lose coverage due to a qualifying life event
- WEX Health, Inc., our plan administrator for COBRA Continuation Coverage, will provide COBRA information
- Coverage must be elected within 60 days of the letter of termination of coverage or COBRA notification and make your first payment within 45 days following your COBRA election
- Premium charge is typically 100% of the total monthly premium plus a 2% administrative fee
- The period of continuation allowed varies with each qualifying life event; it may be 18, 24, 29, or 36 months
- For complete details on COBRA, search “COBRA” in Workday and review the COBRA information article



External contact information

Medical Plan

Wellmark Blue Cross and Blue Shield
800-852-9790
[wellmark.com](https://www.wellmark.com)

Prescription Drug Plan

Express Scripts
Administered through RxBenefits, Inc.
800-334-8134
rxhelp@rxbenefits.com

Dental Plan

Delta Dental of Iowa
800-544-0718
[deltadentalia.com](https://www.deltadentalia.com)

Vision Plan

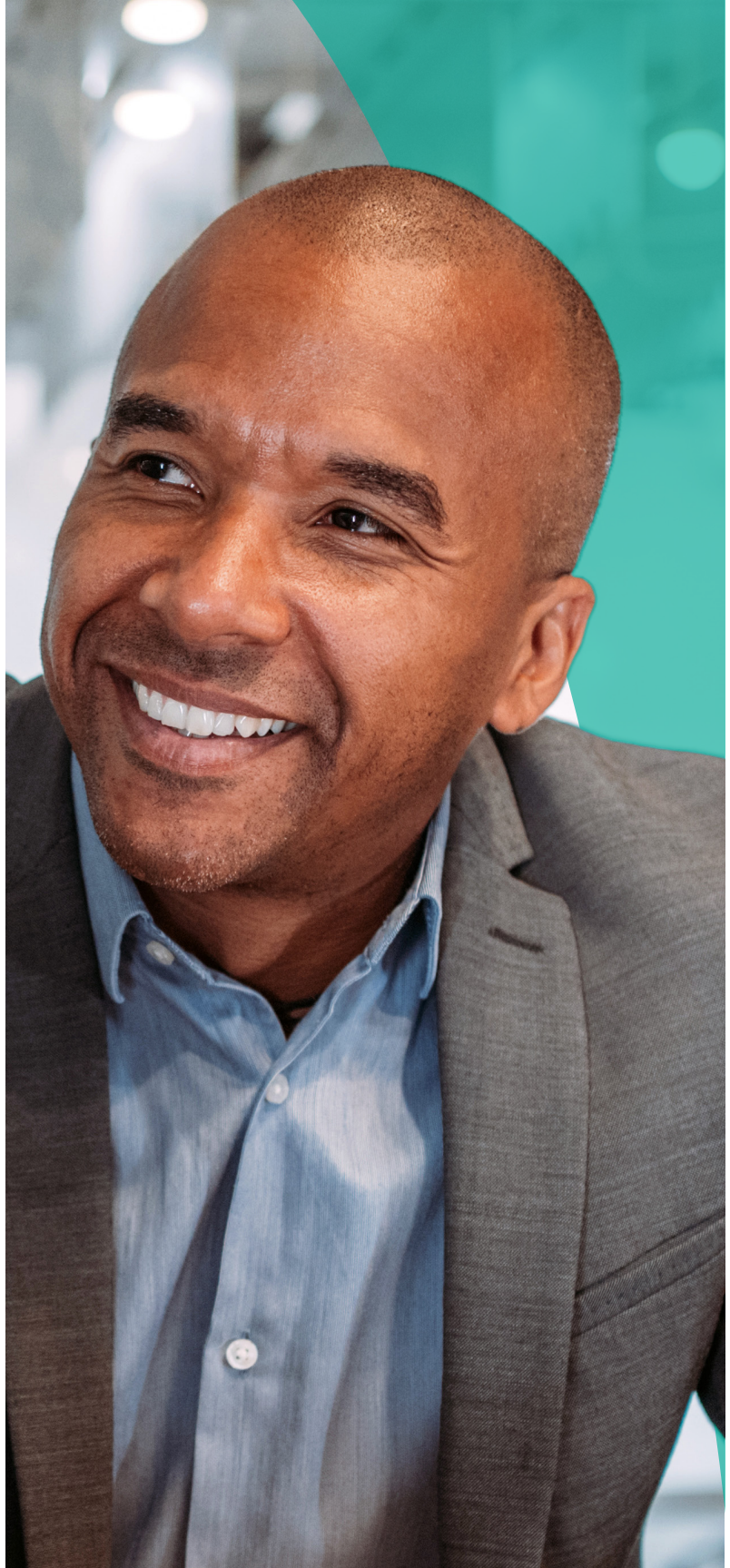
EyeMed
866-804-0982
[eyemed.com](https://www.eyemed.com)
Insight Network

EMC contact information

Human Resources — Benefits

ext. 7493
humanresources.benefits@emcins.com

Questions? Submit your question via the Workday Help app.



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