

# 2024 Alliance Select Summary

SPOC-covered Employees

## Alliance Select

### General Plan Provisions

#### Benefits Available from Non-Participating Providers

*You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.*

Normal plan benefits for network/ non-network providers

#### Deductible

*Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.*

\$250 single network/non-network  
\$500 family network/non-network  
Applies to most services.

#### Medical Out-of-Pocket Maximum

*Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.*

\$750 Single  
1,500 Family  
All deductibles, copays and coinsurance go toward out-of-pocket limit.

#### Lifetime Benefits Maximum

Hospice Respite  
15 Days Inpatient  
15 Days Outpatient  
Infertility - \$25,000

#### New Employee Preexisting Condition Waiting Period

No preexisting conditions waiting period.

### Preventive Services

Affordable Care Act (ACA) preventive services

Covered at 100% per ACA guidelines. Preventive care from participating providers with Wellmark is not subject to the deductible.

### Professional Office Services

Office Services

Network 10%  
Non-network 20% after deductible

Allergy Testing

Network 10% after deductible  
Non-network 20% after deductible

Allergy Serum and Injections

Network 10% after deductible  
Non-network 20% after deductible

Chiropractor

Network 10%  
Non-network 20% after deductible

Gynecological Exam (separate from preventive physical exam)

Network 0%  
Non-network 20% after deductible

Routine Eye Exam

*One routine vision exam per calendar year.*

Network 10%  
Non-network 20% after deductible

Routine Hearing Exam

*One routine hearing exam per calendar year.*

Not covered

Maternity

Network 10% after deductible  
Non-network 20% after deductible

Surgery, Radiology & Pathology (office)

Network 10% after deductible  
Non-network 20% after deductible

### Hospital Services

#### Inpatient Hospital Services

Preapproval of Inpatient Admissions

Required

Inpatient Hospital Services

Room & Board

Inpatient Physician Services

Inpatient Supplies

Inpatient Surgery

Network 10% after deductible  
Non-network 20% after deductible

# Alliance Select Summary

SPOC-covered Employees

## Alliance Select

|   |   |
|---|---|
| <b>Outpatient Hospital Services</b>   |   |
| Ambulatory Surgical Center  | Network 10% after deductible<br>Non-network 20% after deductible  |
| Outpatient Diagnostic Lab, Radiology  | Network 10% after deductible<br>Non-network 20% after deductible  |
| <b>Infertility Services</b>   | Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures are covered up to a lifetime maximum of \$15,000. |
| <b>Emergency Care</b>   |   |
| Ambulance   | Network 10% after deductible<br>Non-network 20% after deductible  |
| Urgent Care Center  | Network 10% after deductible<br>Non-network 20% after deductible  |
| Hospital Emergency Room   | \$100 copayment   |
| <b>Behavioral Health Services</b>   |   |
| Inpatient mental health and substance abuse treatment   | Network 10% after deductible<br>Non-network 20% after deductible  |
| Outpatient/office mental health and substance abuse treatment   | 10% deductible waived   |
| <b>Outpatient Therapy Services</b>  |   |
| Chemotherapy<br>Physical Therapy<br>Occupational Therapy<br>Respiratory Therapy<br>Speech Therapy   | Network 10% after deductible<br>Non-network 20% after deductible  |
| <b>Prescription Drug Coverage</b>   |   |
| <b>Retail</b>   |   |
| Quantity  | Not restricted to a 30-day supply in all instances  |
| Tier 1 Medications  | 10% after deductible  |
| Tier 2 Medications  |   |
| Tier 3 Medications  |   |
| <b>Pharmacy Out-of-Pocket Maximum</b>   | No separate out-of-pocket maximum   |
| <b>Prescription Drug Coverage - General Information</b>   |   |
| Prescription Oral Contraceptives and Contraceptive Devices  | Covered   |
| Prescription Drugs/Items for Smoking Cessation  | Covered - coinsurance applies   |
| <b>Important Information:</b>   |   |
| This document provides a general summary of the basic benefit provisions and is not a substitute for the Benefit Booklet. If there are any inconsistencies between this summary and the benefit Booklet will prevail. Please refer to the Benefit Booklet for exact benefits, exclusions, and limitations or contact Wellmark's customer service at 1-800-532-1103. |   |

9/25/23