

2026 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. Member has benefits after single deductible/OPM are met. Entire family has benefits after family deductible/OPM has been met.

\$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. Member has benefits after single deductible/OPM are met. Entire family has benefits after family deductible/OPM has been met.

\$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 - \$15,000

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 included for members up to age 21 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

Outpatient Hospital Services

Preapproval of Inpatient Admissions

Required

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Inpatient Hospital Services Room & Board Inpatient Physician Services Inpatient Supplies Inpatient Surgery	Network 10% after deductible Non-network 20% after deductible
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Outpatient Hospital Services

Ambulatory Surgical Center	Network 10% after deductible Non-network 20% after deductible
Outpatient Diagnostic Lab, Radiology	Network 10% after deductible Non-network 20% after deductible

Infertility Services	Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures are covered up to a lifetime maximum of \$15,000.
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Emergency Care

Ambulance	Network 10% after deductible Non-network 20% after deductible
Urgent Care Center	Network 10% after deductible Non-network 20% after deductible
Hospital Emergency Room	\$100 copayment

Behavioral Health Services

Inpatient mental health and substance abuse treatment	Network 10% after deductible Non-network 20% after deductible
Outpatient/office mental health and substance abuse treatment	10% deductible waived

Outpatient Therapy Services

Chemotherapy Physical Therapy Occupational Therapy Respiratory Therapy Speech Therapy	Network 10% after deductible Non-network 20% after deductible
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Prescription Drug Coverage

Retail	
Quantity	Not restricted to a 30-day supply in all instances
Tier 1 Medications	10% after deductible
Tier 2 Medications	
Tier 3 Medications	
Pharmacy Out-of-Pocket Maximum	No separate out-of-pocket maximum

Prescription Drug Coverage - General Information

Prescription Oral Contraceptives and Contraceptive Devices	Covered
Prescription Drugs/Items for Smoking Cessation	Covered - coinsurance applies

Important Information:

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.