Allaince 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	None
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 êRoom & Board êInpatient Physician Services êInpatient Supplies êInpatient Surgery	Network 10% after deductible Non-network 20% after deductible

Allaince Select Summary

SPOC-covered Employees

	Alliance Select
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.
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	
êChemotherapy êPhysical Therapy êOccupational Therapy êRespiratory Therapy êSpeech Therapy	Network 10% after deductible Non-network 20% after deductible
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.