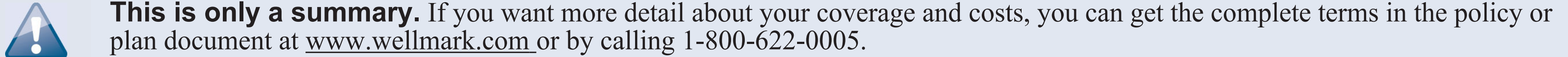
Alliance Select℠ $1,000

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Single & Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellmark.com or by calling 1-800-622-0005.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	In-Network: **$1,000** person/**$2,000** family per calendar year Out-of-Network: **$2,000** person/**$4,000** family per calendar year Does not apply to well-child care, in-network office visits/independent labs for mental health/substance abuse services, shingles/hepatitis vaccines, colonoscopies, sigmoidoscopies, in-network routine vision exam/ hearing exam/preventive care and services subject to health/drug card copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No. There are no other deductibles. The overall deductible does not apply to in-network prosthetic limbs.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event chart on the following pages for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	Yes. In-Network: **$2,000** person/ **$4,000** family per calendar year Out-Of-Network: **$4,000** person/ **$8,000** family per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, pre-service review penalties, copayments, infertility, your drug card costs, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See www.wellmark.com for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network (IN) Provider	Your Cost If You Use an Out-of-Network (OON) Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	40% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. $20 copay applies to Doctor on Demand contracted telehealth services.
	Specialist visit	$30 copay	40% coinsurance	Applies to Non-PCP providers.
	Other practitioner office visit	$20 copay for Chiropractors No charge for vision exams and hearing exams	40% coinsurance for Chiropractors, vision exams and hearing exams	One routine vision exam per calendar year. One routine hearing exam per calendar year.
	Preventive care/screening/immunization	No charge	40% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Waive cost-share for shingles and hepatitis vaccines. Well-child care is covered to age 7.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance. Radiologists and pathologists are covered at the in-network level. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Imaging (CT /PET scans, MRIs)	20% coinsurance	40% coinsurance	Radiologists are covered at the in-network level. Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network (IN) Provider	Your Cost If You Use an Out-of-Network (OON) Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com.	Generic drugs	$15 copay	$15 copay	Drugs listed on Wellmark's BlueRx Complete Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply (Specialty). 1 copay for 34-day supply. 1 copay for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights.
	Preferred brand drugs	$30 copay	$30 copay	
	Non-preferred brand drugs	$45 copay	$45 copay	
	Select non-preferred brand drugs	$45 copay	$45 copay	
	Specialty drugs	Same as cost-share above depending on drug category.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Physician / surgeon fees	20% coinsurance	40% coinsurance	Anesthesiologists are covered at the in-network level. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	For emergency medical conditions treated out-of-network you may be balance billed. Dental treatment for accidental injury is limited to care initiated within 72 hours and completed within 12 months of the injury.
	Emergency medical transportation	20% coinsurance	40% coinsurance	------None------
	Urgent care	$20 copay	40% coinsurance	------None------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network (IN) Provider	Your Cost If You Use an Out-of-Network (OON) Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
	Physician / surgeon fee	20% coinsurance	40% coinsurance	Anesthesiologists are covered at the in-network level. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: $20 PCP/ $30 Non-PCP copay Facility: 20% coinsurance	40% coinsurance	------None------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
	Substance use disorder outpatient services	Office: $20 PCP/ $30 Non-PCP copay Facility: 20% coinsurance	40% coinsurance	------None------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
If you are pregnant	Prenatal and postnatal care	0% coinsurance	40% coinsurance	Except for complications of pregnancy and mandated preventive services, maternity services for dependent children are not covered.
	Delivery and all inpatient services	Practitioner: 0% coinsurance Facility: 20% coinsurance	40% coinsurance	Anesthesiologists are covered at the in-network level. Except for complications of pregnancy and mandated preventive services, maternity services for dependent children are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network (IN) Provider	Your Cost If You Use an Out-of-Network (OON) Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per approved service.
	Rehabilitation services	Office: $20 PCP, PTs,OTs,SLPs/$30 Non-PCP copay Facility: 20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
	Habilitative services	Office: $20 PCP, PTs,OTs,SLPs/$30 Non-PCP copay Facility: 20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
	Skilled nursing care	20% coinsurance	40% coinsurance	Reduction for failure to precertify will not exceed $500 per admission.
	Durable medical equipment	20% coinsurance	40% coinsurance	Initial purchase of wig following chemotherapy is covered. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Hospice service	20% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. Hospice care is limited to 180 days per lifetime.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	One routine vision exam per calendar year.
	Glasses	Not covered	Not covered	------None------
	Dental check-up	Not covered	Not covered	------None------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment ($15,000 LTM, excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer or group sponsor.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-622-0005.

Language Access Services:

Para recibir asistencia en espanõl, por favor comuníquense al servicio de cliente, al número que aparence en su tarjeta de identificación.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,760
- **Patient pays** $1,780

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$120
Coinsurance	$510
Limits or exclusions	$150
Total	**$1,780**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,700
- **Patient pays** $1,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$20
Copays	$1,480
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,700**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

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Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意： 如果您说普通话， 我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或 （听障专线： 888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢာ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhólǫ́. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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