


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Employers Mutual Alliance Select® WI Alt Network PPO
Express Scripts Prescription Drug Plan

Coverage Period: 01/01/2026 – 12/31/2026
Coverage for: Single & Family | Plan Type: PPO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-447-2295, ext. 7493. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 800-447-2295 ext. 7493, to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In- <u>Network</u> : \$750 person/ \$1,500 family per calendar year. Out-of- <u>Network</u> : \$1,250 person/ \$2,500 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Drug card costs, in- <u>network</u> preventive care, in- <u>network</u> independent labs, in- <u>network</u> diagnostic mammograms and services subject to <u>copayments</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Health: In- <u>Network</u> \$3,500 person/ \$7,000 family per calendar year; Out-of- <u>Network</u> \$5,000 person/ \$10,000 family per calendar year. Drug Card: \$3,500 person/ \$7,000 family per calendar year. The in- <u>network</u> health and drug card <u>out-of-pocket</u> maximum amounts accumulate separately.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they must meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance billed</u> charges, and health care this <u>plan</u> doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . The cost of certain specialty drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your <u>out-of-pocket limit</u> .

For more information about limitations and exceptions, see your plan document or call EMC Human Resources at 800-447-2295, ext. 7493.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.wellmark.com or call 800-852-9790 for a list of health <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	40% <u>coinsurance</u>	\$0 <u>copay</u> per <u>provider</u> per date of service applies to Doctor on Demand contracted telehealth services. \$100 <u>copay</u> per <u>provider</u> per date of service for office/outpatient administered <u>specialty drugs</u> .
	<u>Specialist</u> visit	\$30 <u>copay</u> per <u>provider</u> per date of service	40% <u>coinsurance</u>	One routine hearing exam per calendar year. \$100 <u>copay</u> per <u>provider</u> per date of service for office/outpatient administered <u>specialty drugs</u> .
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the <u>cost-share</u> listed above. Waive <u>cost-share</u> for <u>in-network</u> diagnostic mammograms.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the <u>cost-share</u> listed above.

For more information about limitations and exceptions, see your plan document or call EMC Human Resources at 800-447-2295, ext. 7493.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com.</p>	Generic drugs	\$10 <u>copay</u> retail/mail (1-30 day supply) \$20 <u>copay</u> retail/mail (31-90 day supply)	N/A	Dispense as Written (DAW) - If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand <u>copay/coinsurance</u> plus the difference in cost between the Generic and Brand name drug.
	Preferred brand drugs	\$40 <u>copay</u> retail/mail (1-30 day supply) \$80 <u>copay</u> retail/mail (31-90 day supply)	N/A	
	Non-preferred brand drugs	\$60 <u>copay</u> retail/mail (1-30 day supply) \$120 <u>copay</u> retail/mail (31-90 day supply)	N/A	
	Diabetic Supplies	\$0 <u>copay</u> retail/mail	Not covered	Does not include insulin
	Specialty drugs	\$100 <u>copay</u> for Generic and Preferred brand 50% <u>coinsurance</u> for Non-preferred brand	Not covered	Specialty drugs must be ordered from Express Scripts Accredo Pharmacy at 800-803-2523 and are limited to a 30-day supply; may require prior authorization and quantity limits may apply. See "Important Questions" regarding the plan's <u>out-of-pocket limit</u> . SaveonSP program provides members the opportunity to enroll and pay a \$0 <u>copay</u> on select specialty medications or a 30% <u>coinsurance</u> if they choose not to enroll. Contact SaveonSP at 800-683-1074 for more information.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call EMC Human Resources at 800-447-2295, ext. 7493.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> per visit for facility and physician(s) combined	\$300 <u>copay</u> per visit for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be <u>balance billed</u> pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be <u>balance billed</u> for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$30 <u>copay</u> /provider, physician/facility combined	40% <u>coinsurance</u>	<u>Copay</u> applies per <u>provider</u> per date of service. \$100 <u>copay</u> per <u>provider</u> per date of service for office/outpatient administered <u>specialty drugs</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services for transplants, bariatric surgery and spine surgery are limited to Blue Distinction Centers.
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services for transplants, bariatric surgery and spine surgery are limited to Blue Distinction Centers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay</u> Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> applies per <u>provider</u> per date of service. \$100 <u>copay</u> per <u>provider</u> per date of service for office/outpatient administered <u>specialty drugs</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>preventive services</u> . For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call EMC Human Resources at 800-447-2295, ext. 7493.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	Office: \$30 <u>copay</u> Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> applies per <u>provider</u> per date of service.
	<u>Habilitation services</u>	Office: \$30 <u>copay</u> Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> applies per <u>provider</u> per date of service.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call EMC Human Resources at 800-447-2295, ext. 7493.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing- short term intermittent home skilled nursing
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: EMC Human Resources at 800-447-2295, ext. 7493, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.


Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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.

About These Coverage Examples:

 **This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and may other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$750
■ PCP <u>copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Rx <u>copayment</u>	\$10

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist</u> copayment	\$30
■ Rx <u>copayments</u>	\$10 & \$40
■ <u>Durable medical equip.</u> <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist</u> copayment	\$30
■ Hospital (facility) <u>copayment</u>	\$300
■ <u>Durable medical equip.</u> <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,110

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$870

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,340

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

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Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or 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 or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 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 osobu 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، فلننا نوفر لك خدمات المساعدة اللغوية، المجانية، اتصل بالرقم 2429-425-008 أو خدمة الهاتف النصي: 2624-187-888.

ສົ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ:

ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສື່ອຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທ່ານ. (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 आपकी हिन्दी भाषा सेवाएँ, हनुशुल्की उपलब्ध हैं। 800-524-9242 पर संपर्क करे 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 Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย อยากรู้ข้อมูล กรุณาโทร 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).

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

सावाधान: याददी तोपाई नेपा ढी बोलुहुन्छ भने, तोपाईको ढाहा हनुशुल्कीभाषा सहायता सेवा उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुकस्।

ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶቻችን ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በ TTY: 888-781-4262) ደውለው ያነጋግሩን።

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

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

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