




Wyoming Educators' Benefit Trust: \$2,500

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 1-800-210-6642 or visit <http://www.yourwyoblue.com>. 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 1-800-210-6642 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | In-network providers \$2,500 person / \$5,000 family. Out-of-network providers \$2,500 person / \$5,000 family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care , prescription drugs and services subject to a copayment are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Medical: In-network providers \$4,000 person / \$8,000 family. Out-of-network providers \$4,400 person / \$8,800 family. Rx: \$1,500 per person not to exceed a combined maximum of \$10,600 person / \$21,200 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance billing charges, sanctions, reductions and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See http://provider.bcbswy.com or call 1-800-210-6642 for a list of In-network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |



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 | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | Teladoc consultations covered at 100%. |
| | Specialist visit | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | -----None----- |
| | Preventive care/screening/immunization | No Charge. Deductible does not apply. | 20% coinsurance | Benefits include but are not limited to those recommended by the USPSTF (United States Preventive Services Taskforce) (A & B only), CDC (Center for Disease Control) Advisory Committee on Immunization Practices, and the HRSA (Health Resources and Services Administration) for women's and children's preventive care . An additional \$50 per calendar year benefit is available for the employee and spouse for limited preventive screening services. One colonoscopy, at a participating provider , payable at 100% of allowable, prior to age 45. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Certain services require preauthorization . Failure to obtain preauthorization may result in a denial or reduction in coverage. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbswy.com/nr26 | Generic drugs (Tier 1 - Preferred) (Tier 2 - Non-Preferred) | \$15 copayment per 30 day supply retail \$30 copayment per 90 day supply mail order. Deductible does not apply. | Not Covered | Covers up to a 90 day supply retail and mail order. Prescription copayments are limited to \$1,500 maximum out-of-pocket per member per year. |
| | Preferred brand drugs (Tier 3) | \$40 copayment per 30 day supply retail \$80 copayment per 90 day supply mail order. Deductible does not apply. | Not Covered | Covers up to a 90 day supply retail and mail order. Prescription copayments are limited to \$1,500 maximum out-of-pocket per member per year. Some drugs must receive preauthorization from Blue Cross Blue Shield of Wyoming. Failure to obtain preauthorization may result in a denial or reduction in coverage. |
| | Non-Preferred brand drugs (Tier 4) | \$60 copayment per 30 day supply retail \$120 copayment per 90 day supply mail order. Deductible does not apply. | Not Covered | |
| | Specialty drugs (Tier 5 - Preferred) (Tier 6 - Non-Preferred) | 20% coinsurance Deductible does not apply. | Not Covered | Must have preauthorization by Blue Cross Blue Shield of Wyoming. Covers up to a 30 day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance . No charge after deductible for services performed at an ASC or office setting. | 20% coinsurance . No charge after deductible for services performed at an ASC or office setting. | For surgeries performed in an office setting or at an ASC (ambulatory surgery center), the coinsurance may be reduced. |
| | Physician/surgeon fees | 20% coinsurance . No charge after deductible for services performed at an ASC or office setting. | 20% coinsurance . No charge after deductible for services performed at an ASC or office setting. | For surgeries performed in an office setting or at an ASC (ambulatory surgery center), the coinsurance may be reduced. |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | Out-of-network emergency will apply in-network cost share . |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network emergency air ambulance will apply in-network cost share . |
| | Urgent care | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | -----None----- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | Failure to obtain pre-admission review may result in a denial or reduction in coverage. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | Failure to obtain pre-admission review may result in a denial or reduction in coverage. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 20% coinsurance | Failure to obtain preauthorization for outpatient ABA (Applied Behavioral Analysis) therapy services may result in a denial or reduction in coverage. |
| | Inpatient services | 20% coinsurance | 20% coinsurance | Failure to obtain pre-admission review may result in a denial or reduction in coverage. |
| If you are pregnant | Office visits | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | \$45 copayment per office visit. Deductible does not apply. Related services apply 20% coinsurance after deductible . | Depending on the type of services, a coinsurance or deductible may apply. Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 0% coinsurance | -----None----- |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Failure to obtain preauthorization for inpatient therapy may result in a denial or reduction in coverage. Rehabilitation benefit is limited to specific diagnoses, see plan document for full detail. Inpatient rehabilitation is limited to patients that are able to participate in at least 5 hours of therapy. Outpatient cardiac rehabilitation is limited to 36 sessions per lifetime. Outpatient physical, occupational and/or speech therapy have a combined 30 visit limit per illness or injury per participant. Additional therapy services are covered based on medical necessity. |
| | Habilitation services | Not Covered | Not Covered | -----None----- |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Failure to obtain preauthorization may result in a denial or reduction in coverage. Limited to 90 days maximum per calendar year. Extended Care Facility services are limited to 45 days per lifetime. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Some items require preauthorization . Failure to obtain preauthorization may result in a denial or reduction in coverage. |
| | Hospice services | 0% coinsurance | 0% coinsurance | Failure to obtain preauthorization for inpatient hospice services may result in a denial or reduction in coverage. Inpatient hospice limited to 180 days per lifetime for terminally ill individuals with a life expectancy of no greater than 6 months. |
| 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----- |

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
- Dental care (Adult)
- Dental care (Child)
- [Habilitation services](#)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Child)
- 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.)

- Bariatric surgery - Requires prior approval. Limited to 1 surgery per lifetime.
- Chiropractic care - Limited to 30 visits per calendar year.
- Infertility treatment - Limited to the correction of the condition causing infertility.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Limited to inpatient services provided by an R.N.

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: Blue Cross Blue Shield of Wyoming at 1-800-210-6642, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-800-318-2596.

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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Claim Supervisor - Blue Cross Blue Shield of Wyoming at 1-800-210-6642 or www.wyomingblue.com.

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 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 section.

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 many 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 deductible | \$2,500 |
| ■ Specialist copayment | \$45 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|-----------------------------|---------|
| Deductibles | \$2,500 |
| Copayments | \$10 |
| Coinsurance | \$1,500 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$4,070 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$45 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|-----------------------------|-------|
| Deductibles | \$900 |
| Copayments | \$700 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,620 |
|-----------------------------------|----------------|

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$45 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-----------------------------|---------|
| Deductibles | \$2,500 |
| Copayments | \$10 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,510 |
|-----------------------------------|----------------|

Note: If employer has funded a Health Reimbursement Account (HRA) on your behalf, your HRA has not been taken into account in calculating the totals under these examples. An HRA allows your employer to allocate a specific amount of money to reimburse you for your out-of-pocket expenses.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



This Notice is Being Provided as Required by the Affordable Care Act

Translation Services

| | |
|--|--|
| <p>If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.</p> | <p>Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.</p> |
| <p>Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.</p> | <p>Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.</p> |
| <p>如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376]。</p> | <p>Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.</p> |
| <p>Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-2376.</p> | <p>ご本人様、またはお客様様の身の回りの方でも、Blue Cross Blue Shield of Wyoming についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。</p> |
| <p>Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.</p> | <p>चदि तपाईं आफ्ना लागि आफैँ आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ, Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा नि:शुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुभन्दा 800-442-2376 मा फोन गर्नुहोस्।</p> |
| <p>Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.</p> | <p>اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue Cross Blue Shield of Wyoming، داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 800-442-2376 تماس حاصل نمایید.</p> |
| <p>만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 800-442-2376 로 전화하십시오.</p> | <p>જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમાંથી કોઈને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુ:ભાષિયો વાત કરવા માટે, આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.</p> |
| <p>Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.</p> | <p>Dii kwe'é atah nilinigií Blue Cross Blue Shield of Wyoming haada yit'éego bina'idilkidgo éi doodago háida biká anilyeedigií t'áadoo le'é yina'idilkidgo beehaz'áanii hólq' dái t'áa hazaadk'ehji háká a'doowólgo bee haz'á doo báh'ilinigióó. Ata' halne'igií koji' bich'í' hodíilnil 800-442-2376.</p> |

Non-Discrimination Notices

Blue Cross Blue Shield of Wyoming (BCBSWY) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

BCBSWY provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

BCBSWY provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

In order to obtain the interpretation services listed in paragraphs two (2) and three (3), Participants may call (800) 442-2376 or use BCBSWY's Telecommunications Device for the Deaf (TDD) at (800) 696-4710.

Participants have the right to file a grievance regarding potential discrimination. To file a grievance, please call BCBSWY at (307) 634-1393 or (800) 442-2376 and request the Grievance Officer in the Legal Department or mail a letter describing the grievance to 4000 House Avenue, Cheyenne, WY 82001 to the attention of the Legal Department.

If a Participant believes they have been discriminated against because of their race, color, national origin, disability, age, sex or religion, the Participant may file a discrimination complaint with the Office of Civil Rights. Please visit www.hhs.gov/ocr for directions to file a complaint.