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, visit www.wyomingblue.com or call 1-800-442-2376. 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 https://www.healthcare.gov/sbc-glossary/ or call BCBS of Wyoming at 1-800-442-2376 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $500 person / $1,000 family; for out-of-network providers $1000 person or $2000 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. Preventive care, urgent care, primary care provider, emergency room services, and prescriptions 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?	For network providers $2,500 person / $5,000 family; for out-of-network providers $4,000 person / $8,000 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, Preauthorization penalty amounts, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See www.wyomingblue.com or call 1-800-442-2376 for a list of 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 permission from this plan, however, you will receive a higher benefit if a referral is obtained.

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
		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	$25 copay	20% coinsurance	Deductible does not apply for participating network providers. There is no charge for your initial telemedicine call with Teladoc, you will pay a $10 copay for subsequent calls. See plan for further details.
	Specialist visit	$25 copay	20% coinsurance	In network Chiropractic manipulations: $25 copay, waive deductible and coinsurance. Limited to 20 visits per year.
	Preventive care/screening/ immunization	No charge (deductible waived)	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	The following tests are covered at 100%; Mammograms, colorectal screenings, cervical screening, well woman testing, bone density – 1 every 2 years starting at age 50, PSA Test – 1 per calendar year.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	When multiple MRI/MRT/MRA's are performed on the same day, benefits for the technical component will be subject to a 50% reduction for each MRI/MRT/MRA after the first.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wyomingblue.com	Generic drugs	$15 copay (retail	Not Covered	The deductible does not apply. Copay applies per prescription. Covers up to a 30- day supply (retail prescription); 90-day supply (retail or mail order prescription will be 2.5 times 30 day retail copay). No charge for preventive drugs.
	Preferred brand drugs	$35 copay (retail)	Not Covered	
	Non-preferred brand drugs	$50 copay (retail	Not Covered	
	Specialty drugs	See above for Specialty drugs classified as Generic, Preferred Brand or Non-preferred Brand	See above for Specialty drugs classified as Generic, Preferred Brand or Non-preferred Brand	
If you have outpatient	Facility fee (e.g., ambulatory	10% coinsurance	20% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	surgery center)			
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	Waive copay and apply deductible and coinsurance if admitted. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Deductible applies Non-participating providers paid at the participating network provider level.
	Urgent care	$75 copay per visit	20% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Preauthorization must be obtained prior to an inpatient admission.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	20% coinsurance	For office visits from a participating provider, you will pay a $25 copay and the deductible does not apply.
	Inpatient services	10% coinsurance	20% coinsurance	Preauthorization must be obtained prior to an inpatient admission..
If you are pregnant	Office visits	No Charge (deductible waived) for preventive services. Other services $25 copay for initial visit.	20% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Cost-sharing does not apply to preventive services from a participating provider. Depending on the type of services, a coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Limited to 120 visits per calendar year. Preauthorization by Case Management required.
	Rehabilitation services	10% coinsurance	20% coinsurance	Inpatient will be paid at 100% after deductible for the first 60 days.
	Habilitation services	Not Covered	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	10% coinsurance	20% coinsurance	Preauthorization by Case Management required.
	Durable medical equipment	10% coinsurance	20% coinsurance	----------None----------
	Hospice services	10% coinsurance	20% coinsurance	Preauthorization by Case Management is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under standalone vision plan.
	Children's glasses	Not Covered	Not covered	Covered under standalone vision plan.
	Children's dental check-up	Not Covered	Not covered	Covered under standalone dental plan.

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
- Dental Care (adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing (except for home health care & hospice)
- 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.)

- Chiropractic care – Limited to 20 visits
- Bariatric Surgery – requires prior approval
- Non-emergency care when traveling outside the U.S.
- Cosmetic Surgery – Limited to pre-approved restorative surgery

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: Department of Health and Humans Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 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 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: Blue Cross Blue Shield of Wyoming at 1-800-442-2376 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 800-378-1179.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-378-1179.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-378-1179.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-378-1179.

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	$500
Initial office visit copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	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*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$25
Coinsurance	$1,070
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,655

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Office visit copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$460
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$690

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Office visit copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$750

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