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 1-800-442-2376 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 1-800-442-2376 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating providers: $3,000 / person, $6,000 / family. Non-participating providers: $6,000 / person, $12,000 / 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 / hospice, vision frames / lenses, dental exams / check-up, and prescription drugs 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?	Yes. $50 / person, $100 / 2-party, $150 / family for dental care. Non-par $25 / person for vision exam. There are no other specific deductibles.	You must pay for all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Participating providers: $6,500 / person, $13,000 / family. Non-participating providers: $13,000 / person, $26,000 / 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, 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 1-800-442-2376 for a list of participating 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
		Participating Provider (You will pay the least)	Non-Participating 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	$30 copayment per visit. Deductible does not apply.	40% coinsurance	$10 copayment per Teladoc consultation.
	Specialist visit	$50 copayment per visit. Deductible does not apply.	40% coinsurance	----------None----------
	Preventive care/ screening/immunization	No Charge. Deductible does not apply.	40% 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. 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	40% 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	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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/nr23	Generic drugs (Tier 1 - Preferred) (Tier 2 - Non-Preferred)	$15 copayment per 30 day supply retail / $37.50 copayment per 90 day supply mail order. Deductible does not apply.	Not covered	----------None----------
	Preferred brand drugs (Tier 3)	$40 copayment per 30 day supply retail / $100.00 copayment per 90 day supply mail order. Deductible does not apply.	Not covered	Plus difference if Generic is available. 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)	$55 copayment per 30 day supply retail / $137.50 copayment per 90 day supply mail order. Deductible does not apply.	Not covered	
	Specialty drugs (Tier 5 - Preferred) (Tier 6 - Non-Preferred)	$100 copayment per 30 day supply. Deductible does not apply.	Not covered	Must receive preauthorization from Blue Cross Blue Shield of Wyoming. Failure to obtain preauthorization may result in a denial or reduction in coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------None----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$250 copayment plus deductible and 20% coinsurance	$250 copayment plus deductible and 40% coinsurance	Waive copayment if admitted directly to the hospital. All medical emergencies covered at participating provider benefit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	All medical emergencies covered at participating provider benefit.
	Urgent care	20% coinsurance	40% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Failure to obtain pre-admission review may result in a denial or reduction in coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Failure to obtain pre-admission review may result in a denial or reduction in coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	----------None----------
	Inpatient services	20% coinsurance	40% coinsurance	Failure to obtain pre-admission review may result in a denial or reduction in coverage.
If you are pregnant	Office visits	$30 copayment per visit. Deductible does not apply.	40% coinsurance	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	40% 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	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	----------None----------
	Rehabilitation services	20% coinsurance	40% coinsurance	Inpatient physical, occupational, speech therapy and cardiac rehabilitation covered for services based on related admission. Inpatient limited to 30 days per member per calendar year. Physical, speech and occupational therapy benefits are provided for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of a post-operative brain surgery, severe burns and amputations and must be preauthorized. Limited to 60 visits per member per calendar year. Outpatient physical and occupational therapy is limited to a separate max of 40 visits. Outpatient speech therapy other than maintenance, up to a maximum of 25 visits per calendar year. Outpatient cardiac rehabilitation other than maintenance, up to a maximum of 20 visits per incident. Preauthorization required for inpatient rehabilitation services.
	Habilitation services	Not covered	Not covered	----------None----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Durable medical equipment	20% coinsurance	40% coinsurance	Some items require preauthorization. Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Hospice services	0% coinsurance	40% coinsurance	Inpatient up to $50 paid maximum per day for a private room. Failure to obtain preauthorization for inpatient hospice services may result in a denial or reduction in coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$10 copayment	0% coinsurance	One exam covered per calendar year, subject to $25 deductible. $200 maximum allowance on eye exams.
	Children's glasses	$10 copayment for lenses. Additional charges for other lense options. OR Contact lenses up to $130 + 15% of balance.	No Charge. Deductible does not apply. The following benefit allowances subject to: Single vision lenses $65, Bifocals $100, Trifocals or Progressive $110. OR Contact lenses not to exceed $115 per calendar year.	One pair of lenses per calendar year subject to the following benefit allowances: One pair of new frames or repair of existing frames covered per 2 calendar years, not to exceed $100.00
	Children's dental check-up	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Limited to 2 exams/cleanings per calendar year.

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 – limited to pre-approved restorative surgery.
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- 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 per lifetime.
- Chiropractic care - Limited to 15 visits per benefit period.
- Dental care (Adult) - Limited to 2 exams per calendar year.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Limited to inpatient services provided by an R.N.
- Routine eye care (Adult) – 1 Exam per calendar year subject to $25 vision deductible.

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 1-800-442-2376, 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 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 1-800-442-2376 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	$3,000
Specialist copayment	$50
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	$3,000
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,470**

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	$50
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	$1,200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$2,500
Specialist copayment	$50
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	$2,100
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,470**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: The Wellness Program Coordinator.

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

WYOMING

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

Translation Services

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.	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.
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.	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.
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.	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.
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.	ご本人様、またはお客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、情報を入手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。
Kung ikaw, o ang iyong tinutulangan, 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.	यदि तपाईं आफ्ना लागि आफैं 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 गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।
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.	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.
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue 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 위해서는800-442-2376 로 전화하십시오.	જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે,આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.
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.	Dii kwe'é atah nilinigii Blue Cross Blue Shield of Wyoming haada yit'éego bina'idilkidgo éí doodago háida biká anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehji háká a'doowolgo bee haz'ą doo bááh ílínígóó. Ata' halne'ígíí koji' bich'į' hodíílnih 800-442-2376.

WYOMING

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.