



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.wyomingblue.com or by calling 800 442-2376.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$750 per person / \$1,500 per family	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 chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$1,750 per person / \$11,500 per family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 .
Is there an overall annual limit on what the plan pays?	Yes, \$2,000,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	No.	This plan treats providers the same in determining payment for the same services.
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 6. See your policy or plan document for additional information about excluded services .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	20% co-insurance	-----None-----
	Specialist visit	20% co-insurance	20% co-insurance	-----None-----
	Other practitioner office visit	20% co-insurance	20% co-insurance	Spinal manipulations are limited to 15 visits per calendar year.
	Preventive care/screening/immunization	No Charge	No Charge	Limited to: Employee and Spouse Under age 40: \$400/ Calendar year Age 41-49: \$600/ Calendar year Age 50 and over: \$750/ Calendar year Services beyond the maximum - apply deductible and coinsurance Cancer screening for dependents age 7 and up, limited to \$250 per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	20% co-insurance	-----None-----
	Imaging (CT/PET scans, MRIs)	20% co-insurance	20% co-insurance	-----None-----

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Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wyomingblue.com.</p>	Generic drugs	\$5 co-pay/prescription then 0% co-insurance (retail and mail order)	\$5 co-pay/prescription then 0% co-insurance (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prescription copayments and coinsurance are limited to \$2,500 maximum out-of-pocket per member per year.
	Preferred brand drugs	\$15 co-pay/prescription then 20% co-insurance (retail and mail order)	\$15 co-pay/prescription then 20% co-insurance (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prescription copayments and coinsurance are limited to \$2,500 maximum out-of-pocket per member per year.
	Non-preferred brand drugs	\$30 co-pay/prescription then 50% co-insurance (retail and mail order)	\$30 co-pay/prescription then 50% co-insurance (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prescription copayments and coinsurance are limited to \$2,500 maximum out-of-pocket per member per year.
	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.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prescription copayments and coinsurance are limited to \$2,500 maximum out-of-pocket per member per year. Certain specialty drugs may be subject to medical deductibles and coinsurance instead of the cost indicated.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	20% co-insurance.	-----None-----
	Physician/surgeon fees	20% co-insurance	20% co-insurance	-----None-----

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Converse County Employees Traditional

Coverage Period: 4/1/2013 - 3/31/2014

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

Coverage for: Single

| Plan Type: Indemnity

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Non-medical Emergency: Emergency room charge - apply \$250 copay, deductible & coinsurance
	Emergency medical transportation	20% co-insurance	20% co-insurance	-----None-----
	Urgent care	20% co-insurance	20% co-insurance	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	20% co-insurance	If pre-admission notification has not been obtained prior to an inpatient admission, a \$200 sanction will apply per admission.
	Physician/surgeon fee	20% co-insurance	20% co-insurance	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	20% co-insurance	-----None-----
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	-----None-----
	Substance use disorder outpatient services	20% co-insurance	20% co-insurance	-----None-----
	Substance use disorder inpatient services	20% co-insurance	20% co-insurance	-----None-----
If you are pregnant	Prenatal and postnatal care	20% co-insurance	20% co-insurance	-----None-----
	Delivery and all inpatient services	20% co-insurance	20% co-insurance	-----None-----

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

Coverage for: Single

| Plan Type: Indemnity

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% co-insurance	0% co-insurance	Must be pre-approved through case management.
	Rehabilitation services	Not covered.	Not covered.	-----None-----
	Habilitation services	Not covered.	Not covered.	-----None-----
	Skilled nursing care	20% co-insurance	20% co-insurance	Limited to 60 days per confinement; Institutional is reimbursed is at 50% of the skilled nursing facilities semi-private room rate.
	Durable medical equipment	20% co-insurance	20% co-insurance	-----None-----
	Hospice service	20% co-insurance	20% co-insurance	Inpatient is limited to 30 days; waive deductible and coinsurance. Outpatient is limited to a \$1500 lifetime paid maximum per member. Must be pre-approved through case management.
If your child needs dental or eye care	Eye exam	\$20 co-insurance	\$20 co-insurance	Limited to a combined maximum of \$750 per member per month.
	Glasses	\$20 co-insurance	\$20 co-insurance	Limited to a combined maximum of \$750 per member per month.
	Dental check up	No Charge	No Charge	Limited to 2 exams per calendar year.

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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
- Hearing Aids
- Routine Foot Care
- Cosmetic Surgery
- Long-Term 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
- Infertility Treatment
- Private-Duty Nursing
- Chiropractic Care
- Non-Emergency Care When Traveling Outside the U.S.
- Routine Eye Care (Adult)
- Dental Care (Adult)

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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 the plan at 1-800-442-2376. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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, refer to your benefit document for details. You can contact the Claim Supervisor - Blue Cross Blue Shield of Wyoming at 1-800-442-2376 or www.wyomingblue.com.

-----*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 will also 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 **\$5,630**
- Patient pays **\$1,910**

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	\$750
Co-pays	\$10
Co-insurance	\$1,000
Limits or exclusions	\$150
Total	\$1,910

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

- Amount owed to providers: **\$5,400**
- Plan pays **\$4,080**
- Patient pays **\$1,320**

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	\$750
Co-pays	\$400
Co-insurance	\$90
Limits or exclusions	\$80
Total	\$1,320

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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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.