Fremont County Government: Plan B

Coverage Period: 07/01/2016 - 06/30/2017

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

Coverage For: Single | **Plan Type:** Indemnity

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?	For participating providers $2,500 person / $5,000 family. For non-participating providers $5,000 person / $10,000 family. In-network preventive care is not subject to the deductible.	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 deductible 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. For participating providers $6,250 person / $12,500 family. For non-participating providers $12,500 person / $25,000 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 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.wyomingblue.com or call 800 442-2376 for a list of preferred providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
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 4. See your policy or plan document for additional information about excluded services.

Questions: Call 800 442-2376 or visit us at www.wyomingblue.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 800 442-2376 to request a copy.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance 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 coinsurance 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 in-network providers by charging you lower deductibles, copayments and coinsurance 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% coinsurance	30% coinsurance	$10 copay per Teledoc consultation.
	Specialist visit	20% coinsurance	30% coinsurance	----------None----------
	Other practitioner office visit	20% coinsurance	30% coinsurance	----------None----------
	Preventive care/screening/ immunization	No Charge	30% coinsurance	Benefits other than those recommended by the U.S. Preventive Services Task Force (A & B only), Center for Disease Control and Prevention's Advisory Committee on Immunization Practices, and the Health Resources and Services Administration for women's and children's preventive care will not be covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.PartnersRx.com.	Generic drugs	$10 copay per 30 day retail $25 copay per 90 day retail or mail order	Not covered.	----------None----------
	Preferred brand drugs	$35 copay per 30 day retail $87.50 copay per 90 day retail or mail order	Not covered.	Plus difference if Generic is available.
	Non-preferred brand drugs	$50 copay per 30 day retail $125 copay per 90 day retail or mail order	Not covered.	Plus difference if Generic is available.
	Specialty drugs	$100 copay per 30 day retail $250 copay per 90 day retail or mail order	Not covered.	----------None----------

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance.	----------None----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	20% coinsurance	30% coinsurance	$250 copay plus deductible and coinsurance. Waive copay if admitted directly to the hospital. All medical emergencies covered at participating provider benefit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------None----------
	Urgent care	20% coinsurance	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance.	----------None----------
	Physician/surgeon fee	20% coinsurance	30% coinsurance	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance	25 visit limit
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	10 day limit (combined with substance use limit)
	Substance use disorder outpatient services	20% coinsurance	30% coinsurance	25 visit limit
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	10 day limit (combined with mental/behavioral limit)
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	----------None----------
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	----------None----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	----------None----------
	Rehabilitation services	20% coinsurance	30% coinsurance	In-patient: 30 days per calender year, 60 days if spinal or head injury. Cardiac 20 visits per incident. Physical therapy 40 visits. Occupational therapy 40 visits. Speech therapy 25 visits.
	Habilitation services	Not covered.	Not covered.	----------None----------
	Skilled nursing care	20% coinsurance	30% coinsurance	60 day limit per confinement.
	Durable medical equipment	20% coinsurance	30% coinsurance	----------None----------
	Hospice service	0% coinsurance	30% coinsurance	----------None----------

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 your child needs dental or eye care	Eye exam	0% coinsurance	0% coinsurance	One exam covered per Calendar Year, subject to $25 deductible.
	Glasses	No Charge	No Charge	One pair of lenses per calendar year subject to the following benefit allowances: Single vision lenses $65, Bifocals $100, Trifocals $110. OR Contact lenses not to exceed $115 per calendar year. One pair of new frames or repair of existing frames covered per 2 calendar years, not to exceed $100.00.
	Dental check up	No Charge	No Charge	Limited to 2 cleanings per Calendar Year.

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
- Cosmetic surgery - Limited to pre-approved restorative surgery.
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot 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 - Requires pre-approval, limited to 1 per lifetime.
- Chiropractic care - Limited to 15 visits per calendar year.
- Dental care (Adult)
- 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:

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 you can contact the Claim Supervisor - Blue Cross Blue Shield of Wyoming at 1-800-442-2376 or www.wyomingblue.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 $3,820**
- **Patient pays $3,720**

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	$2,500
Copays	$20
Coinsurance	$1,000
Limits or exclusions	$200
Total	$3,720

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,420**
- **Patient pays $1,980**

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	$1,200
Copays	$700
Coinsurance	$0
Limits or exclusions	$80
Total	$1,980

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, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. 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.