WSBAIT Benefit Plan Options 2022-2023

Medical

	PLAN - B		PLAN - C		PLAN - D (HDHP)		PLAN - E (HDHP)		PLAN - F		PLAN - G (HDHP)	
Deductible Amount	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
In-Network	$1,000	$2,000	$2,500	$5,000	$2,800	$5,600	$5,000	$10,000	30%		$6,500	$13,000
Out-of-Network **	$2,000	$4,000	$5,000	$10,000	$5,200	$10,400	$10,000	$20,000	50%		$13,000	$26,000
Dr. Office Co-Pay	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist
In-Network	$40	$75	$40	$75	Deductible & Co-Insurance		Deductible & Co-Insurance		30%	30%	Deductible & Co-Insurance	
Out-of-Network **	Non-Network Ded & Coins		Non-Network Ded & Coins						50%	50%		
Rx Card	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
Generic	$15	$15	$15	$15					30%	30%		
Brand Name	$45	$85	$45	$85					30%	30%		
Specialty Rx	$250		$250		Deductible & Co-Insurance		Deductible & Co-Insurance		30%		Deductible & Co- Insurance	
Mail Order & Retail Pharamacy	3 x Monthly co-pay - 3 Month Supply		3 x Monthly co-pay - 3 Month Supply						3 x Monthly co-pay - 3 Month Supply			
Hospital Co-Pay (per facility visit)	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient
In-Network	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Out-of-Network **	$1,000	$500	$1,000	$500	$1,000	$500	$1,000	$500	$1,000	$500	$1,000	$500
Emergency Room Co-pay *	$250		$250									
Urgent Care Co-pay *	$75		$75									
**True emergency apply to deductible/coinsurance. Non true emergency $250 co-pay applied followed by deductible/coinsurance. $250 applies to max out of pocket.*												
Co-Insurance *(what happens after the Deductible Amount)*												
In-Network Plan Pays	80%		80%		80%		80%		70%		100%	
Out-of-Network ** Plan Pays	50%		50%		50%		50%		50%		50%	
TOTAL Out-of-Pocket *(including Deductible, Co-insurance, Office Visit and RX Co-Pays)*												
In-Network *(Single / Family)*	$6,500	$13,000	$6,500	$13,000	$3,500	$7,000	$5,500	$11,000	$7,150	$14,300	$6,500	$13,000
Out-of-Network ** *(Single / Family)*	$12,000	$24,000	$13,000	$26,000	$7,200	$15,000	$12,000	$24,000	$14,300	$28,600	$14,300	$28,600

** Non-Network Out-of-Pocket Amount does NOT include amounts in excess of the "Allowable Medicare Reimbursement" PLUS 40%

Dental

(Available only if offered by your District)

	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Deductible Amount	$100	$300	$50	$150	$50	$150	$40	$120	$25	$75
Preventative Care	80%	80%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Care	50%	50%	80%	80%	80%	80%	80%	80%	80%	80%
Major Restorative	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontia	not covered	not covered	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontia Lifetime Max	not covered	not covered	$1,000	$1,000	$2,000	$2,000	$3,000	$3,000	$4,000	$4,000
Annual Max per Person	$750	$750	$1,000	$1,000	$1,500	$1,500	$2,000	$2,000	$3,000	$3,000

This SUMMARY is not intended as a complete description of benefits and limitations of each of the Plans offered. Please refer to the Summary Plan Document(s) for a complete listing of covered and exclusions.

This is a Non-Grandfathered Plan, one that complies with the requirements of the Afforadble Care Act as well as fully compliant plan with all State of Wyoming insurance mandates.