WSBAIT Benefit Plan Options for 2018-2019

Medical

	PLAN - B		PLAN - C		PLAN - D		PLAN - E		PLAN - G	
Deductible Amount	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
In-Network	$1,000	$2,000	$2,500	$5,000	$2,700	$5,200	$5,000	$10,000	$6,500	$13,000
Out-of-Network **	$2,000	$4,000	$5,000	$10,000	$5,200	$10,400	$10,000	$20,000	$13,000	$26,000
Dr. Office Co-Pay	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist
In-Network	$35	$75	$35	$75	Deductible & Co-Insurance		Deductible & Co-Insurance		Deductible & Co-Insurance	
Out-of-Network **	Non-Network Ded & Coins		Non-Network Ded & Coins							
Rx Card	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
Generic	$0	$0	$0	$0	Deductible & Co-Insurance		Deductible & Co-Insurance		$0	$0
Brand Name	$45	$85	$45	$85					$45	$85
Specialty Rx	$250		$250						$250	
Mail Order & Retail Pharamacy	3 x Monthly co-pay - 3 Month Supply		3 x Monthly co-pay - 3 Month Supply						Co-pays Apply AFTER Deductible Amount	
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-Network	$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
Emergency Room Co-pay *	$250		$250							
Urgent Care Co-pay *	$75		$75							
Co-Insurance *(what happens after the Deductible Amount)*										
In-Network Plan Pays	80%		80%		80%		80%		100%	
Out-of-Network ** Plan Pays	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	$6,550	$13,100
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

**True emergency apply to deductible/coinsurance. Non true emergency $250 co-pay applied followed by deductible/coinsurance. $250 applies to max out of pocket.*

** 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 2		Plan 3		Plan 5	
	Single	Family	Single	Family	Single	Family
Deductible Amount	$50	$150	$50	$150	$25	$75
Preventative Care	100%	100%	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%	80%	80%
Major Restorative	50%	50%	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%	50%	50%
Orthodontia Lifetime Max	$1,000	$1,000	$2,000	$2,000	$4,000	$4,000
Annual Max per Person	$1,000	$1,000	$1,500	$1,500	$3,000	$3,000

Vision

(Available only if offered by your District)

	Plan 2	Plan 3	Plan 5
Deductible per Person	$50	$50	$0
Coinsurance	50%	50%	100%
Annual Max per Person	$300	$450	$500

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.

2018 - 2019 INSURANCE COSTS &
AMOUNT DISTRICT PAYS TOWARD INSURANCE

Single Costs (Monthly)

Health		Dental		Vision			
PLAN	COST	PLAN	COST	PLAN	COST		
B	$ 639.21	2	$ 37.68	2	$ 6.13		
C	$ 594.05	3	$ 39.55	3	$ 8.95		
D	$ 578.79	5	$ 52.76	5	$ 26.85		
E	$ 428.01						
G	$ 389.49						
CCSD#1 PAYS	**$542.00**	**CCSD#1 PAYS**	**$45.00**	**CCSD#1 PAYS**	**$23.00**	**MAX AMT PAID BY CCSD#1**	**$ 610.00**

Family Costs (Monthly)

Health		Dental		Vision			
PLAN	COST	PLAN	COST	PLAN	COST		
B	$ 1,582.57	2	$ 103.63	2	$ 15.55		
C	$ 1,470.84	3	$ 108.46	3	$ 19.31		
D	$ 1,433.00	5	$ 168.64	5	$ 60.30		
E	$ 1,059.70						
G	$ 964.33						
CCSD#1 PAYS	**$ 1,346.00**	**CCSD#1 PAYS**	**$ 143.00**	**CCSD#1 PAYS**	**$ 51.00**	**MAX AMT PAID BY CCSD#1**	**$ 1,540.00**

The information given here show monthly amounts. CCSD#1 prorates insurance costs over 9 months, beginning in October of each school year and continuing through June. To arrive at the prorated amount for each pay period, multiply the monthly amount by 12 and divide by 9.