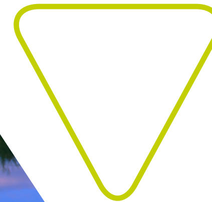
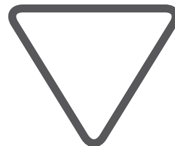
Wyoming Chambers Health Benefit Plan

Policy Dates: July 1, 2024 - June 30, 2025

https://wyomingchambersplan.com





Sponsored by:
Your local participating Chamber and
Wyoming Chambers Health Benefit Plan
Established 2007

Welcome

The Wyoming Chambers Health Benefit Plan is a non-grandfathered benefit Plan under the Patient Protection and Affordable Care Act of 2010. This means the Plan includes the mandated coverage(s) as required by law for the benefit of Plan participants. For additional information regarding the benefits provided due to this legislation, as well as all other available coverage levels limitations, please refer to the Plan Declaration and the Summary Plan Document.

Health Benefit Plan

The Wyoming Chambers Health Benefit Plan is:

- A Welfare Benefit Plan established under Internal Revenue Service Code and applicable Department of Labor regulations.
- A Plan where contributions are held in a Trust that is directed by a Board of Trustees chosen from the member participants of the Plan.
- A Plan governed by the Wyoming Chambers Health Benefits Association Board, the Plan Sponsor, and its Board of Directors who assign a Plan Administrator, retain Legal Counsel, Accounting & Auditing Services and other Administrative Services as needed for the management of the Plan; all working for the benefit of the participants.
- A Plan where claims are paid by the contracted Claims Administrator (TPA) as directed by applicable State and Federal laws, the Trust Document, the Plan Declaration and the Summary Plan Description(s) of the benefit programs offered and administered by the Association.
- A Trust which contracts with insurance and/or reinsurance companies in order to ensure the overall financial stability of the Trust and of the benefits offered. These contracts may change from time to time and are voted upon and approved by the Association Board and the Trust Board or its designee.
- A Plan where the benefits offered are reviewed annually to determine their viability for the members and participants. The Wyoming Chambers Health Benefit Association, with available contracted counsel and advice, may alter these benefits, remove a plan of benefits completely and/or add new plans for consideration, without the consent of participating employers or participating employees.
- A Trust that is participant-owned along with any surplus or deficits incurred.

Enrollment Requirements/Contingencies:

- The employer must be a current member in good standing for at least 60 days, of at least one participating Chamber of Commerce, prior to Effective Date of coverage.
- Each employer must have a minimum of 75% of eligible employees participating for groups of 5 or more, and 100% participation for groups of 4 or less (after Qualified waivers). Minimum group size is 2 employees. Husband and Wife groups of two are eligible as long as both are full-time employees and can verify both work full-time.
- Completed Employee Enrollment/Waiver Applications are required from each employee in order to qualify. Following underwriting, the entire employer group will either be accepted or denied coverage.
- The PLAN's renewal date is July 1st of each calendar year. Regardless of when enrollment is completed, any changes to the PLAN rates and/or benefits will take place on July 1st. Open enrollment (the ability to add employees who waived coverage or dependents which had previously waived) is the month of June of each year for each participating employer (subject to HIPAA Qualifying Event rules).
- Premium Contributions are made by the employer directly into the Trust Account and are used as described in the Trust Document, Summary Plan Description and Plan Declaration. The Trust is governed by a Board of Trustees, elected as described in the Trust Document.
- Employer must contribute a minimum of 50% of the employee's premium, or equivalent if multiple plans are offered. Paying too little of employee's premium may have tax implications under the ACA (for Applicable Large Employers).

Wyoming Chambers Health Benefits Association
Jim Schellinger, President
Gail Lofing, Plan Administrator

Campbell County Chamber of Commerce
409 W. 2nd St. Gillette, WY 82716
(307) 682-3673

Inside

Health Plan
Medical
Dental
Vision
Diagnosed-Call Health Navigator
Health & Wellness Resources Available On Sun Life Health 360
Life and AD&D
Employee Assistance Program (EAP)
Carrier Contact Information
HUB Contact Information

Participating Chambers

- **Campbell County Chamber of Commerce** http://gillettechamber.com
- **Sheridan County Chamber of Commerce** http://sheridanwyomingchamber.org
- **The Enterprise - Douglas, WY** http://www.seewhatconversecando.com
- **Powell Valley Chamber of Commerce** http://powellchamber.org
- **Thermopolis Chamber of Commerce** https://thermopolischamber.org
- **Lander Area Chamber of Commerce** http://landerchamber.org
- **Casper Area Chamber of Commerce** https://casperwyoming.org
- **Newcastle Chamber of Commerce** http://newcastlewyo.com
- **Star Valley Area Chamber of Commerce** https://starvalleychamber.com
- **Goshen County Economic Development Corporation** http://goshenwyo.com
- **Laramie Chamber Business Alliance** https://laramie.org
- **Sublette County Chamber of Commerce** https://sublettechamber.com
- **Worland / Ten Sleep Chamber of Commerce** http://wtschamber.org
- **Cody Country Chamber of Commerce** https://codychamber.org
- **Rock Springs Chamber of Commerce** https://www.rockspringswyoming.net
- **Riverton Chamber of Commerce** https://wyriverton.com

Health Plan

Program Objectives

- More stability in insurance premiums, now and in the future
- Broader accessibility to health insurance and coverage options within the community
- Creation of a community-wide wellness mind-set and culture
- Education about access to a broader range of choices to promote better healthcare decision making

Defined Contribution Healthcare

In a Defined Contribution Benefit Plan:

EMPLOYERS CHOOSE which of the Chamber plans they offer to their employees, and the amount of money to allocate towards benefits. It may be a different amount for coverage level(s) (Single, Family, etc.) and the amount does not need to change annually.

EMPLOYEES CHOOSE the benefit program that best fits their needs from the selection of plans offered by the Employer and their ability to afford the premiums for that benefit plan choice. The amount of premium for coverage, which is more than the employer contribution, is withheld from employee compensation.

Medical

We are proud to offer a choice of medical plans that provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help members maintain a healthy lifestyle. Following is a brief description of each plan.

Allegiance PPO Plans

These plans give you the freedom to seek care from any provider of your choice. However, IT IS IMPORTANT to seek care with a PPO Member physician and/or facility in order to protect financial exposure. This includes services from standalone laboratory and physical therapy entities. Do not assume...check and make sure.

- The plan pays the full cost of qualified in-network preventive health care services.
- You pay the full cost of non-preventive health care services until you meet the **annual deductible**. You may also have to pay a fixed dollar amount (**copay**) for certain services.
- Once you meet the deductible, you pay a percentage of certain health care expenses (**coinsurance**) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the **out-of-pocket maximum**, the plan pays the full cost of all qualified health care services for the rest of the year.

Plans 4, 5 and 7 are Qualified High Deductible Plans, meaning they are qualified insurance Benefits for Health Savings Account rules and participation

In Plans 4, 5 and 7, the Rx Discount Card is where 100% of the discounted price applies to deductible and co-insurance and is processed as any "other" type of claim.

Wellness Initiative

ONE of the only ways to maintain a "reasonable" outlook for the future of a benefit program is to be able to accurately assess the risks, and to assess those risks annually. The Chambers' Wellness Initiative, for participating adults, includes:

- Biometric Full Blood Panel Screening

  Through this Initiative, participants will receive an annual overview of their current health and a "score" that goes along with it. The reports and analysis may be used by the participant with their Medical Provider as well as the Care Managers with the Plan. By participating in the Initiative, the premium rate charged to a participating employer group is reduced.

Secure, 24-hour online access to:

- Accumulated Deductible and Maximum Out-of-Pocket (MOOP) Amounts
- Participating Pharmacies
- Drug Fill History Including Medication Information Sheet
- Drug Pricing Estimates
- Alternative Pharmacy Pricing Tool
- Member ID Cards
- Customer Service Contact Information

Registration is easy – takes only a few minutes!

1. Visit the Ventegra Member Portal at: www.myventegra.com
2. Select the "Sign Up" link. Enter your member ID, name, and date of birth
3. Create your Account by providing an email address and password
4. Verify email address using the 6-digit code sent to you. If you do not receive your code in a reasonable time, please check your spam or junk email folder.

If you have questions please contact us by phone 877-867-0943 / by email CCT@ventegra.com / by chat: www.ventegra.com

Medical

The following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	Allegiance									
	Plan 1 PPO		Plan 4 HDHP HSA		Plan 5 HDHP HSA		Plan 6 PPO		Plan 7 HDHP HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)										
Individual / Family	$1,500 / $3,000	$3,000 / $6,000	$3,200 / $6,400	$6,400 / $12,800	$5,000 / $10,000	$10,000 / $20,000	$2,500 / $5,000	$5,000 / $10,000	$6,500 / $13,000	$13,000 / $26,000
Coinsurance										
	70%	50%	70%	50%	70%	50%	60%	40%	60%	40%
Out-of-Pocket Maximum (per calendar year)										
Individual / Family	$8,500 / $17,000	$17,000 / $34,000	$7,500 / $15,000	$15,000 / $30,000	$7,500 / $15,000	$15,000 / $30,000	$8,000 / $16,000	$16,000 / $32,000	$8,000 / $16,000	$16,000 / $32,000
Out-of Pocket Maximums shown include: Deductible(s), Coinsurance, Dr. Office Copays, and RX card copays. DOES NOT include amounts in excess of Plan Allowable for Non-Network charges.										
Covered Services										
Office Visits (physician/specialist)	$45 / $85 copay	50%	70%	50%	70%	50%	$45 / $85 copay	40%	60%	40%
Wellness	100%		100%		100%		100%		100%	
Urgent Care Facility	$85 copay	50%	70%	50%	70%	50%	$85 copay	40%	60%	40%
PT / ST / OT	$85 copay	50%	70%	50%	70%	50%	$85 copay	40%	60%	40%
Prescription Drugs										
Generic Drugs	Retail: $15 copay 1-30 day supply $30 copay 31-60 day supply $45 copay 61-90 day supply Mail Order: $30 copay up to 90 day supply		Plan pays 70%, Participant pays 30% up to 90 day supply		Plan pays 70%, Participant pays 30% up to 90 day supply		Retail: $15 copay 1-30 day supply $30 copay 31-60 day supply $45 copay 61-90 day supply Mail Order: $30 copay up to 90 day supply		Plan pays 60%, Participant pays 40% up to 90 day supply	
High Cost Generic Drugs	Retail: $45 copay 1-30 day supply $90 copay 31-60 day supply $135 copay 61-90 day supply Mail Order: $90 copay up to 90 day supply						Retail: $45 copay 1-30 day supply $90 copay 31-60 day supply $135 copay 61-90 day supply Mail Order: $90 copay up to 90 day supply			
Formulary Drugs (Preferred Brand)	Retail: $45 copay 1-30 day supply $90 copay 31-60 day supply $135 copay 61-90 day supply Mail Order: $90 copay up to 90 day supply						Retail: $45 copay 1-30 day supply $90 copay 31-60 day supply $135 copay 61-90 day supply Mail Order: $90 copay up to 90 day supply			
Non-Formulary Drugs (Non-Preferred)	Retail: $85 copay 1-30 day supply $170 copay 31-60 day supply $255 copay 61-90 day supply Mail Order: $170 copay up to 90 day supply		Plan pays 70%, Participant pays 30% up to 90 day supply		Plan pays 70%, Participant pays 30% up to 90 day supply		Retail: $85 copay 1-30 day supply $170 copay 31-60 day supply $255 copay 61-90 day supply Mail Order: $170 copay up to 90 day supply		Plan pays 60%, Participant pays 40% up to 90 day supply	
Specialty Drugs	$250 copay up to 30 day supply		Plan pays 70%, Participant pays 30% up to 30 day supply		Plan pays 70%, Participant pays 30% up to 30 day supply		$250 copay up to 30 day supply		Plan pays 60%, Participant pays 40% up to 30 day supply	
All RX coverage includes: Step Therapy (some scripts start with less expensive scripts before progression to higher cost scripts) and **Starter Dose** (10 days for first time scripts) limits on some scripts.										

Self-Audit Billing Credit

The Plan offers an incentive credit to all participants to encourage examination and self-auditing of eligible medical bills to accurately reflect the services and supplies received by the participant or covered dependent. The participant is voluntarily asked to review all hospital and doctor bills and verify that he/she has received each itemized service and the bill does not represent either an overcharge or a charge for services never received, regardless of the reason. The Benefit Services Administrator agrees to assist the employee (at his/her request) in determination of errors, and recovery attempts.

In the event a participant's self-audit results in elimination or reduction of charges, twenty-five percent (25%) of the amount eliminated or reduced will be paid directly to the participant (subject to a twenty dollar ($20) minimum savings), provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Benefit Services Administrator (e.g., A copy of the incorrect bill and a copy of the corrected billing.)

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the plan as well as the plan participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the plan member's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Maximum Allowable Fee, regardless of whether the charge is or is not reduced. **Maximum benefit of $500 per episode of care**.

UCM Digital Health

Patient Centered Approach for Your Population, *Here's What Sets UCM Digital Health Apart...*

Convenience

NO waiting room, NO travel time, get care 24/7/365 in any location. Access a provider within minutes and receive high quality care where you want it, when you want it.

Compassionate Providers

Our multi-disciplinary team of ER providers, primary care providers, and mental health providers can treat a wide range of conditions.

We provide our patients with a very tailored, personalized approach and dedicated one-on-one time during a consult.

95% patient satisfaction is proof of the quality of our providers.

Care Coordinators

Our expert Care Coordinators will handle the follow-up work for patients, like ordering labs, making referrals, and scheduling follow-up appointments with a UCM provider.

Take the hassle out of the healthcare experience. Increase satisfaction and improve health outcomes.

Better Outcomes

- 98% Emergency Room avoidance
- 96% case resolution
- 100% follow-up: We provide a next step for 100% of our patients.

Whole-Person Care

UCM Digital Health is the only partner to offer a truly patient centered digitally integrated, whole person health solution.

Our solution was built around the patients' needs, including a multi-disciplinary team of compassionate providers to care for the whole person and a digital front door program that seamlessly integrates with your ecosystem, and concierge care.

Increased Savings

Enjoy an average claims savings of up to $700, while getting access to care, no matter what health issue you are facing.

Visit www.UCMDigitalHealth.com

Dental

We are proud to offer a choice of dental plans.

Delta Dental of Wyoming DPPO

These plans offer you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental of Wyoming network.

The following is a high-level overview of the coverage available.

Key Dental Benefits	Plan 1	Plan 2	Plan 3	Plan 4
	In- and Out-of-Network	In- and Out-of-Network	In- and Out-of-Network	In- and Out-of-Network
Deductible (per calendar year)				
Individual / Family	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Benefit Maximum (per calendar year; preventive, basic and major services combined)				
Per Individual	$1,000	$1,000	$2,000	$2,000
Covered Services				
Preventive Services	No charge	No charge	No charge	No charge
Basic Services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia (Child Only)	N/A	50%	N/A	50%

Coinsurance percentages shown in the above chart represent what the member is responsible for paying.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Vision

We are proud to offer a vision plan.

The Standard/VSP

This plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the The Standard/VSP network.

The following is a high-level overview of the coverage available.

Key Vision Benefits	The Standard/VSP	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10	Up to $45
Materials Copay	$25	Up to $45
Lenses (once every 12 months)	No charge after materials copay	
Single Vision		Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Frames (once every 24 months)	Covered up to $150	Up to $70
Contact Lenses (once every 12 months; in lieu of glasses)	Participant cost up to $60	N/A

Diagnosed-Call Health Navigator

Contact Health Navigator when you need access to a specialist, a new primary care doctor, or for any health-related need. Visit **sunlife.com/healthnav** or call **888-352-4969**. Representatives are available Monday - Friday, 8:00am - 6:00pm (ET).

Hub International Coordinator: Kae Jones | 307-233-8586 | Kae.jones@hubinternational.com

As a member, you have access to personal support for any healthcare challenge you are facing. Our team provides you access to top experts, and helps you navigate the complicated world of healthcare so you can have peace of mind, and focus on what really matters—your health.

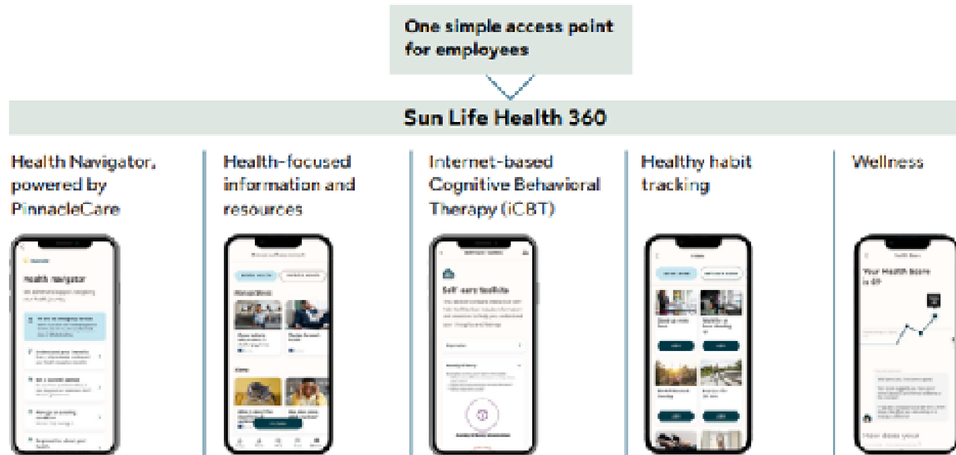
We specialize in providing access to top specialists, especially when you...

- Receive a new diagnosis
- Have a surgery recommendation
- Feel unsure of your doctor's medical advice
- Require a top healthcare specialist
- Want help to find a new primary care provider

When facing an unexpected healthcare challenge, our advisors will help you...

- Review your case
- Understand your condition
- Gather your medical records
- Understand your treatment options
- Schedule appointments
- Facilitate second opinions from experts
- Make informed decisions
- Achieve better health outcomes

Health & Wellness Resources Available On Sun Life Health 360



Benefits to your organization	Benefits to your employees
Greater visivility and awareness of available benefits, like Health Navigator.	Easy access to a variety of tools, resources, and support to get or stay healthy, including a team of care navigation and medical experts.
Expansion of your employee health and wellnedd offerings at no additional cost. Best practices and support to drive engagement and utilization.	Trusted physician-reviewed content to aid in their healthcare journey. Engage with a Health Navigator Care Advisor and explore interactive tools to support both physical and mental health.
Seamless onboarding and implementation, with your eligibility file.	Available to all eligible members at no cost.

Bill Resolve-Claims issue call 888-352-4969 for a Health Advocate.

Life and AD&D

Life Insurance The Standard provides your named beneficiary(ies) with a benefit after your death.

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Basic Life/AD&D (Provided to all Full-Time Employees)

This benefit is provided at NO COST to you through The Standard.

	Benefit Amount
Employee	$15,000

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through The Standard for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue[1]
Employee	$10,000 increments; Minimum of $10,000 up to 300,000	$200,000
Spouse/RDP	$5,000 increments; Minimum $5,000 up to $150,000	$25,000
Child(ren)	$1,000 increments; Minimum of $1,000 up to 10,000	N/A

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

Employee Assistance Program (EAP)

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The EAP is provided at NO COST to you through The Standard.

The EAP can help with the following issues, among others:

- Mental health
- Relationships or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to three (3) in-person sessions with a counselor per issue, per year, per individual
- Unlimited toll-free phone access and online resources

Carrier Contact Information

Coverage	Carrier	Website/Email
Medical	Allegiance Benefit Plan Management	www.askallegiance.com
Dental	Delta Dental of Wyoming	www.deltadentalwy.org
Vision	The Standard/VSP	www.standard.com/services
Life/AD&D	The Standard	www.standard.com
Employee Assistance Program (EAP)	The Standard	www.healthadvocate.com/standard3

Click here to view the SBC's.

HUB Contact Information

Contact	Phone	Email
Gail Lofing, Plan Administrator	307-682-3673	gaill@gillettechamber.com
Melissa Bilby, Consultant	307-233-8591	melissa.bilby@hubinternational.com
Kae Jones, Coordinator	307-233-8586	kae.jones@hubinternational.com
Nichole Simoneaux	307-233-8583	nichole.simoneaux@hubinternational.com