



## Summary of Benefits

WyoBlue Advantage Essential PPO<sup>SM</sup>

WyoBlue Advantage Enhanced PPO<sup>SM</sup>

WyoBlue Advantage Entrust PPO<sup>SM</sup>

January 1, 2026 – December 31, 2026

To join WyoBlue Advantage PPO, you must meet all of the following requirements:

- Have both Medicare Part A and Medicare Part B.
- Be a United States citizen or lawfully present in the United States.
- Live in our geographic service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Our service area includes these counties in Wyoming: Albany, Big Horn, Campbell, Carbon, Converse, Crook, Fremont, Goshen, Hot Springs, Johnson, Laramie, Lincoln, Natrona, Niobrara, Park, Platte, Sublette, Sweetwater, Teton, Uinta, Washakie, and Weston.

WyoBlue Advantage PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at [www.WyoBlueAdvantage.com](http://www.WyoBlueAdvantage.com).

Out-of-network/non-contracted providers are under no obligation to treat WyoBlue Advantage PPO members, except in emergency situations. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.



An independent licensee of the Blue Cross Blue Shield Association

[www.WyoBlueAdvantage.com](http://www.WyoBlueAdvantage.com)

# Premium/Cost-sharing Table

You must continue to pay your Medicare Part B premium.

Monthly plan premiums, deductibles and limits on how much you pay for covered services	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<b>Premium</b>	\$59	\$159	\$0
<b>Deductible</b>	<p>This plan has a \$200 deductible for hospital and medical services.</p> <p>No deductible on Part D prescription drugs in Tier 1. \$615 deductible for Part D prescription drugs in Tiers 2, 3, 4, and 5. Deductible does not apply to insulins.</p>	<p>This plan does not have a deductible for hospital and medical services.</p> <p>No deductible on Part D prescription drugs in Tier 1. \$615 deductible for Part D prescription drugs in Tiers 2, 3, 4, and 5. Deductible does not apply to insulins.</p>	<p>This plan does not have a deductible for hospital and medical services.</p> <p>This plan does not include Part D prescription drug coverage.</p>
<b>Maximum Out-of-Pocket Responsibility</b> <i>(does not include prescription drugs)</i>	<b>Combined In- and Out-of-Network</b> \$9,250 annually	<b>Combined In- and Out-of-Network</b> \$6,750 annually	<b>In-Network</b> \$6,750 <b>Combined In- and Out-of-Network</b> \$10,000 annually
	<p>The most you pay for copayments, coinsurance and other costs for medical services for the year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost sharing for your Part D drugs.</p>		

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<b>Inpatient Hospital Coverage</b>  Our plan covers an unlimited number of days for an inpatient hospital stay.	<i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i>  The copayments are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row.		
	<b>In- and Out-of-Network</b> \$450 copayment, after deductible, per day for days 1 through 4  \$0 copayment, after deductible, for additional days	<b>In- and Out-of-Network</b> \$450 copayment per day for days 1 through 4  \$0 copayment for additional days	<b>In- and Out-of-Network</b> \$450 copayment per day for days 1 through 4  \$0 copayment for additional days
<b>Outpatient Hospital Coverage</b>	<i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i>		
	<b>In- and Out-of-Network</b> \$450 copayment, after deductible, for non-surgical and \$550 copayment, after deductible, for surgical outpatient hospital services	<b>In- and Out-of-Network</b> \$350 copayment for non-surgical and \$400 copayment for surgical outpatient hospital services	<b>In- and Out-of-Network</b> \$350 copayment for non-surgical and \$400 copayment for surgical outpatient hospital services
<b>Ambulatory Surgical Center (ASC) Services</b>	<i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i>		
	<b>In- and Out-of-Network</b> \$350 copayment, after deductible	<b>In- and Out-of-Network</b> \$200 copayment	<b>In- and Out-of-Network</b> \$200 copayment
<b>Doctor Visits</b> <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Specialists</li> </ul>	<b>In- and Out-of-Network</b> \$0 copayment  <b>In- and Out-of-Network</b> \$55 copayment	<b>In- and Out-of-Network</b> \$0 copayment  <b>In- and Out-of-Network</b> \$50 copayment	<b>In- and Out-of-Network</b> \$0 copayment  <b>In- and Out-of-Network</b> \$50 copayment

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<p><b>Preventive Care</b></p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p style="text-align: center;"><b>In- and Out-of-Network</b> \$0 copayment</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screening and counseling</li> <li>• Annual physical exam</li> <li>• Annual wellness visit</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease risk reduction visit</li> <li>• Cardiovascular disease testing</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (colonoscopy, flexible sigmoidoscopy, guaiac-based fecal occult blood test, fecal immunochemical test, or DNA based colorectal screening)</li> <li>• Depression screening</li> <li>• Diabetes screening</li> <li>• Diabetes self-management training</li> <li>• Glaucoma screening</li> <li>• HIV screening</li> <li>• COVID-19, flu, Hepatitis B, and pneumonia immunizations</li> <li>• Intensive behavioral therapy for obesity</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program</li> <li>• Prostate cancer screenings</li> <li>• Screening for lung cancer with low dose computed tomography</li> <li>• Screening for sexually transmitted infections and counseling to prevent STIs</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• “Welcome to Medicare” preventive visit (one-time)</li> </ul>		

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<b>Emergency Care</b>	<b>Note:</b> If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.		
	<b>In-Network</b> \$115 copayment	<b>In-Network</b> \$110 copayment	<b>In-Network</b> \$125 copayment
	<b>Outside the U.S. and its territories:</b> You have coverage for worldwide emergency care. See Worldwide Emergency Coverage later in this chart.		
<b>Urgently Needed Services</b>	<b>In-Network</b> \$40 copayment	<b>In-Network</b> \$50 copayment	<b>In-Network</b> \$50 copayment
	<b>In-Network</b> \$0 copayment for urgent care services delivered through Teladoc Health®, an independent company and telemedicine service, visit <b>www.TeladocHealth.com</b> or call <b>1-800-Teladoc (835-2362)</b> , available 24 hours a day, 7 days a week, 365 days a year. TTY users call <b>1-855-636-1578</b> .		
	<b>Outside the U.S. and its territories</b> You have coverage for worldwide urgently needed services. See Worldwide Emergency Coverage later in this chart.		

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<b>Diagnostic Services/ Labs/Imaging</b>	<i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i>		
Outpatient services, including: <ul style="list-style-type: none"> <li>• Diagnostic mammograms</li> <li>• Diagnostic colonoscopies</li> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> <li>• High-tech Medicare-covered diagnostic radiological services, such as CT, MRI, MRA, and PET</li> <li>• X-rays and low-tech diagnostic radiological services, such as ultrasounds</li> <li>• Therapeutic radiological services</li> </ul>	<b>In- and Out-of-Network</b>  \$0 copayment  \$0 copayment  \$350 copayment, after deductible  \$25 copayment  \$500 copayment, after deductible  \$40 copayment, after deductible  20% coinsurance, after deductible	<b>In- and Out-of-Network</b>  \$0 copayment  \$0 copayment  \$200 copayment  \$20 copayment  \$400 copayment  \$20 copayment  20% coinsurance	<b>In- and Out-of-Network</b>  \$0 copayment  \$0 copayment  \$200 copayment  \$20 copayment  \$500 copayment  \$30 copayment  20% coinsurance

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Hearing Services</b></p> <p><b>Original Medicare covers limited hearing services</b></p> <p>Hearing exam to diagnose and treat hearing and balance issues</p> <p><b>Enhanced hearing services, beyond Original Medicare</b></p> <ul style="list-style-type: none"> <li>• Routine hearing exam once every year</li> <li>• Supplemental Benefit Flex Card that can be used toward hearing aids</li> </ul>	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment for primary care provider visit</p> <p>\$55 copayment for specialist visit</p> <p><b>In-Network</b></p> <p>\$0 copayment through NationsHearing</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b></p> <p>Our plan provides up to \$600 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment for primary care provider visit</p> <p>\$50 copayment for specialist visit</p> <p><b>In-Network</b></p> <p>\$0 copayment through NationsHearing</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b></p> <p>Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment for primary care provider visit</p> <p>\$50 copayment for specialist visit</p> <p><b>In-Network</b></p> <p>\$0 copayment through NationsHearing</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b></p> <p>Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Dental Services</b></p> <p><b>Original Medicare covers limited dental services</b> (This does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</p> <p><b>Enhanced dental services (Preventive and Comprehensive)</b> Our plan provides an allowance via the Flex Supplemental Benefit Card, which can be used toward dental services, eyewear, or hearing aids.</p>	<p><b>In- and Out-of-Network</b> \$55 copayment for each Medicare-covered service</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$600 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In- and Out-of-Network</b> \$50 copayment for each Medicare-covered service</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In- and Out-of-Network</b> \$50 copayment for each Medicare-covered service</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>
<p><b>Vision Services</b></p> <p><b>Original Medicare covers limited vision services</b></p> <ul style="list-style-type: none"> <li>• Glaucoma screening, diabetic retinopathy screening, eyeglasses or contact lenses after cataract surgery</li> <li>• Exam to diagnose and treat diseases and conditions of the eye</li> </ul>	<p><b>In- and Out-of-Network</b> \$0 copayment</p> <p><b>In- and Out-of-Network</b> \$55 copayment</p>	<p><b>In- and Out-of-Network</b> \$0 copayment</p> <p><b>In- and Out-of-Network</b> \$50 copayment</p>	<p><b>In- and Out-of-Network</b> \$0 copayment</p> <p><b>In- and Out-of-Network</b> \$50 copayment</p>

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Enhanced vision benefits, beyond Original Medicare</b></p> <ul style="list-style-type: none"> <li>• Routine eye exam every 12 months</li> <li>• Our plan provides an allowance via the Flex Supplemental Benefit Card, which can be used toward dental services, eyewear, or hearing aids.</li> </ul>	<p><b>In-Network</b> \$0 copayment through a VSP provider</p> <p><b>Out-of-Network</b> 50% coinsurance</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$600 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In-Network</b> \$0 copayment through a VSP provider</p> <p><b>Out-of-Network</b> 50% coinsurance</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>	<p><b>In-Network</b> \$0 copayment through a VSP provider</p> <p><b>Out-of-Network</b> 50% coinsurance</p> <p><b>Supplemental Benefit Flex Card Maximum Allowance</b> Our plan provides up to \$650 maximum benefit per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p>

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>Inpatient mental health</li> <li>Outpatient mental health</li> </ul>	<p><i>Authorization rules may apply to inpatient stays; your plan provider will arrange for this prior authorization, if needed.</i></p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>If your psychiatric-hospital stay is longer than 90 days, our plan provides for up to 100 additional days of coverage, subject to the Medicare lifetime limit of 190 days. This limitation does not apply to inpatient psychiatric services furnished in a psychiatric unit of a general hospital.</p> <p>A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without inpatient psychiatric hospital care.</p> <p>No prior hospital stay is required. Copayments restart as new benefit period begins.</p> <p><b>In- and Out-of-Network</b> \$450 copayment, after deductible, per day for days 1 through 4 \$0 copayment, after deductible, per day for additional days until lifetime limitation is exhausted</p> <p><b>In- and Out-of-Network</b> \$50 copayment, after deductible, for outpatient individual or group therapy visit or psychiatric service</p>	<p><b>In- and Out-of-Network</b> \$450 copayment per day for days 1 through 4 \$0 copayment per day for additional days until lifetime limitation is exhausted</p> <p><b>In- and Out-of-Network</b> \$50 copayment for outpatient individual or group therapy visit or psychiatric service</p>	

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Mental Health Services</b> (continued)</p> <ul style="list-style-type: none"> <li>• Telemedicine visit</li> </ul> <p>Online behavioral health support from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists by appointment 7 days a week, 7 a.m. to 9 p.m. local time.</p>	<p><b>In-Network</b></p> <p>\$0 copayment for outpatient mental health care services delivered through Teladoc Health®, an independent company that provides telemedicine solutions for WyoBlue Advantage. For more information or to make an appointment, visit <a href="http://www.TeladocHealth.com">www.TeladocHealth.com</a> or call <b>1-800-Teladoc (835-2362)</b>, available 24 hours a day, 7 days a week, 365 days a year. TTY users call <b>1-855-636-1578</b>.</p>	<p><b>In-Network</b></p> <p>\$0 copayment for outpatient mental health care services delivered through Teladoc Health®, an independent company that provides telemedicine solutions for WyoBlue Advantage. For more information or to make an appointment, visit <a href="http://www.TeladocHealth.com">www.TeladocHealth.com</a> or call <b>1-800-Teladoc (835-2362)</b>, available 24 hours a day, 7 days a week, 365 days a year. TTY users call <b>1-855-636-1578</b>.</p>	<p><b>In-Network</b></p> <p>\$0 copayment for outpatient mental health care services delivered through Teladoc Health®, an independent company that provides telemedicine solutions for WyoBlue Advantage. For more information or to make an appointment, visit <a href="http://www.TeladocHealth.com">www.TeladocHealth.com</a> or call <b>1-800-Teladoc (835-2362)</b>, available 24 hours a day, 7 days a week, 365 days a year. TTY users call <b>1-855-636-1578</b>.</p>
<p><b>Skilled Nursing Facility (SNF)</b></p> <p>Our plan covers up to 100 days in a SNF.</p>	<p><i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i></p>		
	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment, after deductible, per day for days 1 through 20</p> <p>\$218 copayment, after deductible, per day for days 21 through 100</p>	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment per day for days 1 through 20</p> <p>\$200 copayment per day for days 21 through 55</p> <p>\$0 copayment per day for days 56 through 100</p>	<p><b>In- and Out-of-Network</b></p> <p>\$0 copayment per day for days 1 through 20</p> <p>\$218 copayment per day for days 21 through 100</p>
<p><b>Physical Therapy</b></p>	<p><b>In- and Out-of-Network</b></p> <p>\$55 copayment, after deductible</p>	<p><b>In- and Out-of-Network</b></p> <p>\$50 copayment</p>	<p><b>In- and Out-of-Network</b></p> <p>\$50 copayment</p>

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only									
<b>Ambulance</b>	<p><i>Authorization rules may apply for non-emergency air ambulance.</i></p> <p>Copayment is for each one-way trip for Medicare-covered services.</p> <p>Medicare-covered non-emergency ambulance transport must be medically required.</p> <table border="1" data-bbox="537 396 2007 607"> <thead> <tr> <th data-bbox="537 396 1031 444"><b>In- and Out-of-Network</b></th> <th data-bbox="1031 396 1524 444"><b>In- and Out-of-Network</b></th> <th data-bbox="1524 396 2007 444"><b>In- and Out-of-Network</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="537 444 1031 526">\$500 copayment for ground ambulance</td> <td data-bbox="1031 444 1524 526">\$400 copayment for ground ambulance</td> <td data-bbox="1524 444 2007 526">\$400 copayment for ground ambulance</td> </tr> <tr> <td data-bbox="537 526 1031 607">20% coinsurance for air ambulance</td> <td data-bbox="1031 526 1524 607">20% coinsurance for air ambulance</td> <td data-bbox="1524 526 2007 607">20% coinsurance for air ambulance</td> </tr> </tbody> </table> <p><b>Outside the U.S. and its territories:</b> You have coverage for worldwide emergency transportation. See Worldwide Emergency Coverage later in this chart.</p>			<b>In- and Out-of-Network</b>	<b>In- and Out-of-Network</b>	<b>In- and Out-of-Network</b>	\$500 copayment for ground ambulance	\$400 copayment for ground ambulance	\$400 copayment for ground ambulance	20% coinsurance for air ambulance	20% coinsurance for air ambulance	20% coinsurance for air ambulance
<b>In- and Out-of-Network</b>	<b>In- and Out-of-Network</b>	<b>In- and Out-of-Network</b>										
\$500 copayment for ground ambulance	\$400 copayment for ground ambulance	\$400 copayment for ground ambulance										
20% coinsurance for air ambulance	20% coinsurance for air ambulance	20% coinsurance for air ambulance										
<b>Transportation</b>	Non-emergency transportation is not covered.											
<b>Medicare Part B Drugs</b> <ul style="list-style-type: none"> <li>• Part B Insulin drugs</li> <li>• Chemotherapy drugs</li> <li>• Other Part B drugs</li> </ul>	<p><i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i></p> <p><b>In- and Out-of-Network</b> \$35 copayment maximum for a one-month supply of insulin</p> <p>20% coinsurance for each Medicare-covered Part B chemotherapy drug and the administration</p> <p><b>In-Network</b> 20% coinsurance for each Medicare-covered Part B drug</p> <p><b>Out-of-Network</b> 35% coinsurance for each Medicare-covered Part B drug</p>											
<b>Medicare Part B Immunizations</b>	<p><b>In-Network</b> 0% coinsurance for pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p> <p>0% coinsurance for other Medicare-covered Part B vaccines.</p> <p><b>Out-of-Network</b> 35% coinsurance for other Medicare-covered Part B vaccines.</p>											

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<p><b>Flex Supplemental Benefit Card</b></p> <p>Our Plan provides a pre-paid debit card with an annual allowance to help offset out-of-pocket expenses on the following services not covered by Medicare:</p> <ul style="list-style-type: none"> <li>• Dental services</li> <li>• Hearing aids</li> <li>• Eyewear</li> </ul> <p>With WyoBlue Enhanced PPO and WyoBlue Entrust PPO, you also have an allowance to be used toward health fitness programs through your Flex Supplemental Benefit Card.</p>	<p>There is no coinsurance, copayment, or deductible for the Flex Supplemental Benefit Card.</p> <p><b>Combined Flex Supplemental Benefit Card Allowance</b></p> <p>Our plan provides up to \$600 per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear. You can choose how and where to spend your annual allowance for any combination of dental services, hearing aids, or eyewear.</p> <p>You can use your Flex Supplemental Benefit Card at participating locations. To see the full list of approved retail stores, visit <b>WyoBlueAdvantage.NationsBenefits.com</b>.</p>	<p>There is no coinsurance, copayment, or deductible for the Flex Supplemental Benefit Card.</p> <p><b>Combined Flex Supplemental Benefit Card Allowance</b></p> <p>Our plan provides up to \$650 per year for non-Medicare covered supplemental services related to dental services, hearing aids, or eyewear.</p> <p>You can choose how and where to spend your annual allowance for any combination of dental services, hearing aids, or eyewear. You also have an \$100 allowance to use at participating health fitness locations.</p> <p>You can use your Flex Supplemental Benefit Card at participating locations. To see the full list of approved retail stores, visit <b>WyoBlueAdvantage.NationsBenefits.com</b>.</p>	
<p><b>Health Fitness Program</b></p>	<p>Not offered</p>	<p>Our plan provides up to \$100 per year toward health fitness programs through your Flex Supplemental Benefit Card. See <b>Flex Supplemental Benefit Card</b> within this benefits chart for details.</p>	

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation</li> <li>• Intensive cardiac rehabilitation services</li> <li>• Pulmonary rehabilitation</li> <li>• Occupational therapy visit</li> <li>• Speech and language therapy</li> </ul>	<b>In- and Out-of-Network</b> \$30 copayment, after deductible  <b>In- and Out-of-Network</b> \$40 copayment, after deductible  <b>In- and Out-of-Network</b> \$25 copayment, after deductible  <b>In- and Out-of-Network</b> \$35 copayment, after deductible  <b>In- and Out-of-Network</b> \$55 copayment, after deductible	<b>In- and Out-of-Network</b> \$30 copayment  <b>In- and Out-of-Network</b> \$45 copayment  <b>In- and Out-of-Network</b> \$25 copayment  <b>In- and Out-of-Network</b> \$40 copayment  <b>In- and Out-of-Network</b> \$50 copayment	<b>In- and Out-of-Network</b> \$40 copayment  <b>In- and Out-of-Network</b> \$50 copayment  <b>In- and Out-of-Network</b> \$35 copayment  <b>In- and Out-of-Network</b> \$50 copayment  <b>In- and Out-of-Network</b> \$50 copayment
<b>Foot Care (podiatry services)</b>  Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	<b>In- and Out-of-Network</b> \$55 copayment, after deductible	<b>In- and Out-of-Network</b> \$50 copayment	<b>In- and Out-of-Network</b> \$50 copayment

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Medical Equipment/Supplies</b></p> <ul style="list-style-type: none"> <li>Durable medical equipment (for example, wheelchairs, oxygen)</li> <li>Medical supplies (for example, bandages and catheter tips)</li> </ul>	<p><i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i></p> <p><b>In-Network</b> 20% coinsurance, after deductible, for Medicare-covered durable medical equipment</p> <p><b>Out-of-Network</b> 35% coinsurance, after deductible, for Medicare-covered durable medical equipment</p> <p><b>In-Network</b> 20% coinsurance, after deductible, of the cost for Medicare-covered medical supplies</p> <p><b>Out-of-Network</b> 50% coinsurance, after deductible, of the cost for Medicare-covered medical supplies</p>	<p><b>In-Network</b> 20% coinsurance for Medicare-covered durable medical equipment</p> <p><b>Out-of-Network</b> 30% coinsurance for Medicare-covered durable medical equipment</p> <p><b>In-Network</b> 20% coinsurance of the cost for Medicare-covered medical supplies</p> <p><b>Out-of-Network</b> 30% coinsurance of the cost for Medicare-covered medical supplies</p>	<p><b>In-Network</b> 20% coinsurance for Medicare-covered durable medical equipment</p> <p><b>Out-of-Network</b> 35% coinsurance for Medicare-covered durable medical equipment</p> <p><b>In-Network</b> 20% coinsurance of the cost for Medicare-covered medical supplies</p> <p><b>Out-of-Network</b> 50% coinsurance of the cost for Medicare-covered medical supplies</p>

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<p><b>Medical Equipment/Supplies</b> (continued)</p> <ul style="list-style-type: none"> <li>Prosthetics (for example, braces, artificial limbs)</li> <li>Diabetic monitoring supplies</li> </ul>	<p><i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed. Non-preferred diabetic supplies require prior authorization.</i></p> <p><b>In-Network</b> 20% coinsurance, after deductible, of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>Out-of-Network</b> 35% coinsurance, after deductible, of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>In-Network</b> \$0 copayment for select Medicare-covered continuous glucose monitors at an in-network pharmacy. 20% coinsurance, after deductible, for Medicare-covered insulin infusion pumps, tubing, and continuous glucose monitors at a DME provider</p>	<p><b>In-Network</b> 20% coinsurance of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>Out-of-Network</b> 30% coinsurance of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>In-Network</b> \$0 copayment for select Medicare-covered continuous glucose monitors at an in-network pharmacy. 20% coinsurance for Medicare-covered insulin infusion pumps, tubing, and continuous glucose monitors at a DME provider</p>	<p><b>In-Network</b> 20% coinsurance of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>Out-of-Network</b> 35% coinsurance of the approved amount for Medicare-covered prosthetic devices and related supplies</p> <p><b>In-Network</b> \$0 copayment for select Medicare-covered continuous glucose monitors at an in-network pharmacy. 20% coinsurance for Medicare-covered insulin infusion pumps, tubing, and continuous glucose monitors at a DME provider</p>

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Medical Equipment/Supplies</b> (continued)</p> <ul style="list-style-type: none"> <li>Diabetic shoes and inserts</li> <li>Diabetic supplies</li> </ul> <p>Preferred diabetic supplies brands are Accu-Chek and Contour.</p>	<p><b>Out-of-Network</b></p> <p>35% coinsurance for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors at an out-of-network pharmacy.</p> <p>35% coinsurance, after deductible, for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors from a DME provider.</p> <p><b>In- and Out-of-Network</b></p> <p>20% coinsurance, after deductible, for Medicare-covered diabetic shoes and inserts</p> <p><b>In-Network</b></p> <p>\$0 copayment for Medicare-covered preferred diabetic supplies</p> <p><b>Out-of-Network</b></p> <p>35% coinsurance for Medicare-covered preferred diabetic supplies</p>	<p><b>Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors at an out-of-network pharmacy.</p> <p>30% coinsurance for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors at a DME provider.</p> <p><b>In- and Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered diabetic shoes and inserts</p> <p><b>In-Network</b></p> <p>\$0 copayment for Medicare-covered preferred diabetic supplies</p> <p><b>Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered preferred diabetic supplies</p>	<p><b>Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors at an out-of-network pharmacy.</p> <p>35% coinsurance for Medicare-covered diabetic monitoring supplies, including continuous glucose monitors from a DME provider.</p> <p><b>In- and Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered diabetic shoes and inserts</p> <p><b>In-Network</b></p> <p>\$0 copayment for Medicare-covered preferred diabetic supplies</p> <p><b>Out-of-Network</b></p> <p>20% coinsurance for Medicare-covered preferred diabetic supplies</p>

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Unlimited manual manipulation of the spine to correct subluxation</li> <li>• Unlimited maintenance visits per year</li> <li>• One set of X-rays (up to 3 views)</li> </ul>	<p><b>In- and Out-of-Network</b> \$15 copayment, after deductible, for each Medicare-covered visit</p> <p><b>In- and Out-of-Network</b> \$45 copayment for each maintenance visit</p> <p><b>In- and Out-of-Network</b> \$0 copayment for one annual set of X-rays</p>		<p><b>In- and Out-of-Network</b> \$15 copayment for each Medicare-covered visit</p> <p><b>In- and Out-of-Network</b> \$45 copayment for each maintenance visit</p> <p><b>In- and Out-of-Network</b> \$0 copayment for one annual set of X-rays</p>
<p><b>Home Health Care</b></p> <p>Includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Custodial care is not a benefit.</p>	<p><i>Authorization rules may apply; your plan provider will arrange for this authorization, if needed.</i></p> <p><b>In- and Out-of-Network</b> \$0 copayment, after deductible</p>		<p><b>In- and Out-of-Network</b> \$0 copayment</p>
<p><b>Nurse Advice Line</b></p>	<p>Speak to a nurse anytime day or night by calling our 24-hour Nurse Line at <b>1-800-638-4304</b>. TTY users call <b>711</b>.</p> <p><b>In- and Out-of-Network</b> \$0 copayment</p>		

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Telemedicine</b></p> <p>Use your smartphone, computer, or tablet anywhere in the United States to meet with doctors and behavioral health care providers when it's convenient for you. Prescriptions can be sent to your local pharmacy.</p>	<p><b>In-Network</b></p> <p>\$0 copayment for telemedicine visits through Teladoc Health®, an independent company and our plan-approved vendor.</p> <p>This service is separate from any telehealth care your personal doctor might offer.</p> <p>Get urgent general medical services from U.S. board-certified doctors without an appointment for:</p> <ul style="list-style-type: none"> <li>• Sore throat, coughs, fevers</li> <li>• Ear and sinus infections</li> <li>• Pink eye</li> <li>• Bronchitis</li> <li>• Allergies</li> <li>• Headache</li> </ul> <p>Online behavioral health support from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists by appointment 7 days a week, 7 a.m. to 9 p.m. local time.</p> <p>Use Teladoc Health® to access telemedicine services at <b>www.TeladocHealth.com</b> for more information or call <b>1-800-Teladoc (835-2362)</b>, available 24 hours a day, 7 days a week, 365 days a year. TTY users call <b>1-855-636-1578</b>. Providers will contact members directly. Appointments are not conducted through the numbers above.</p>		
<p><b>Outpatient Substance Use Disorder Services</b></p> <p>Individual or group therapy visit</p>	<p><b>In- and Out-of-Network</b></p> <p>\$55 copayment, after deductible</p>	<p><b>In- and Out-of-Network</b></p> <p>\$50 copayment</p>	
<p><b>Renal Dialysis</b></p>	<p><b>In- and Out-of-Network</b></p> <p>20% coinsurance, after deductible</p>	<p><b>In- and Out-of-Network</b></p> <p>20% coinsurance</p>	

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<p><b>Supervised Exercise Therapy (SET)</b></p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p>	<p><b>In- and Out-of-Network</b></p> <p>\$20 copayment, after deductible, for each Medicare-covered service</p>	<p><b>In- and Out-of-Network</b></p> <p>\$25 copayment for each Medicare-covered service</p>	
<p><b>Over-the-Counter Items</b> (from authorized vendor only)</p> <p>We offer certain drugs and health related products that do not need a prescription. More than 300 OTC items are available under this benefit. Covered items include but are not limited to antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items.</p>	<p>Not covered</p>	<p>You get up to \$50 every quarter to spend on certain approved non-prescription over-the-counter drugs and health-related items.</p>	<p>You get up to \$50 every quarter to spend on certain approved non-prescription over-the-counter drugs and health-related items.</p>
<p>This benefit is built into the plan at no additional cost.</p> <p>Benefits are available each quarter (January, April, July, October). Unused OTC amounts do not roll over to the next quarter or to the next calendar year.</p> <p>There is a limit on the total dollar amount we contribute each quarter. However, you can order more than that amount, and you will be asked to pay the difference. All orders must be placed through the plan's approved vendor. Benefit can't be used on hearing aids. Items can't be obtained from any other vendor or retailer. Direct member reimbursement is not available.</p> <p>There are three ways to use your benefit:</p> <ol style="list-style-type: none"> <li><b>1. Online.</b> Beginning Jan. 1, 2026, you can go to <b>WyoBlueAdvantage.NationsBenefits.com</b> and follow the prompts to place the order using the online catalog.</li> <li><b>2. Phone.</b> Select items using the online NationsOTC catalog and place an order by calling <b>1-877-336-6009</b>, 8 a.m. to 8 p.m., 7 days a week. TTY users call <b>711</b>. Items will be mailed to you.</li> <li><b>3. Using the app.</b> Download the Benefits Pro™ app and enjoy access to shopping benefit information, transaction history, and more.</li> </ol>			

<b>Benefits</b>	<b>WyoBlue Essential PPO</b> Medical & Part D drug coverage	<b>WyoBlue Enhanced PPO</b> Medical & Part D drug coverage	<b>WyoBlue Entrust PPO</b> Medical coverage only
<p><b>Personal Emergency Response Services (PERS)</b></p> <p>WyoBlue Enhanced, Empower, and Entrust PPO cover Personal Emergency Response Services (PERS) to give you added security and protection with a medical alert system that offers two-way connectivity to a live agent and around-the-clock monitoring. For more information, visit <b>WyoBlueAdvantage.NationsBenefits.com/PERS</b> or call <b>1-877-336-6009</b> 8 a.m. to 8 p.m., 7 days a week. TTY users call <b>711</b>.</p>	<p>This benefit is built into the plan at no additional cost.</p>	<p>This benefit is built into the plan at no additional cost.</p>	<p>This benefit is built into the plan at no additional cost.</p>

Benefits	WyoBlue Essential PPO Medical & Part D drug coverage	WyoBlue Enhanced PPO Medical & Part D drug coverage	WyoBlue Entrust PPO Medical coverage only
<b>Worldwide Emergency Coverage</b> <ul style="list-style-type: none"> <li>• Worldwide emergency medical coverage</li> <li>• Worldwide emergency transportation (ambulance)</li> <li>• Worldwide urgent coverage</li> </ul>	<p style="text-align: center;">\$115 copayment</p> <p style="text-align: center;">\$115 copayment</p> <p style="text-align: center;">\$40 copayment</p>	<p style="text-align: center;">\$110 copayment</p> <p style="text-align: center;">\$110 copayment</p> <p style="text-align: center;">\$50 copayment</p>	<p style="text-align: center;">\$125 copayment</p> <p style="text-align: center;">\$125 copayment</p> <p style="text-align: center;">\$50 copayment</p>
<p>If you need care when you're outside of the U.S. you have coverage for emergency medical care, emergency transportation and urgently needed services.</p> <p>You are responsible for the difference between the approved amount and the provider's charge.</p> <p>Emergency medical care, emergency transportation, and urgent care are subject to a combined \$50,000 lifetime maximum benefit outside the U.S. and its territories.</p>			

A complete list of services is found in the *Evidence of Coverage*. For a copy of the *Evidence of Coverage*, go to [www.WyoBlueAdvantage.com/member-resources](http://www.WyoBlueAdvantage.com/member-resources) or contact Customer Service at **1-844-682-9966** from 8 a.m. to 8 p.m., local time, 7 days a week from October 1 through March 31; 8 a.m. to 8 p.m., local time, Monday through Friday from April 1 through September 30, for more information. TTY users call **711**.

## WyoBlue Essential PPO

<b>Stage 1: Deductible</b>	No deductible for Tier 1. \$615 total deductible per year for Tiers 2, 3, 4, and 5. Deductible does not apply to insulins.			
<b>Stage 2: Initial Coverage</b>	<b>Standard retail one-month supply</b>	<b>Preferred retail cost sharing (in network) (up to a 30-day supply)</b>	<b>Mail-order one-month supply</b>	<b>Long-term care 31-day supply</b>
Tier 1: Preferred Generic	\$9	\$4	\$4	\$4
Tier 2: Generic	\$14	\$9	\$9	\$9
Tier 3: Preferred Brand	20%	20%	20%	20%
Tier 4: Non-Preferred	35%	35%	35%	35%
Tier 5: Specialty	25%	25%	25%	25%
<b>Stage 2: Initial Coverage</b>	<b>Standard retail 100-day supply</b>	<b>Preferred retail 100-day supply</b>	<b>Mail-order 100-day supply</b>	<b>Long-term care 100-day supply</b>
Tier 1: Preferred Generic	\$27	\$12	\$0	Not offered
Tier 2: Generic	\$42	\$27	\$22.50	Not offered
Tier 3: Preferred Brand	20%	20%	20%	Not offered
Tier 4: Non-Preferred	35%	35%	35%	Not offered
Tier 5: Specialty	Not offered	Not offered	Not offered	Not offered
<b>Stage 3: Catastrophic Coverage</b>	Once your year-to-date out-of-pocket costs (your payments) total \$2,100, you move to Stage 3: Catastrophic Coverage. During this stage, you pay \$0.			

You won't pay more than \$35 for a one-month or \$105 for a 100-day supply of each insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **[www.WyoBlueAdvantage.com/member-resources](http://www.WyoBlueAdvantage.com/member-resources)**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website **[www.WyoBlueAdvantage.com/formularies](http://www.WyoBlueAdvantage.com/formularies)**.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website **[www.WyoBlueAdvantage.com/pharmacies](http://www.WyoBlueAdvantage.com/pharmacies)**.

## WyoBlue Enhanced PPO

<b>Stage 1: Deductible</b>	No deductible for Tier 1. \$615 total deductible per year for Tiers 2, 3, 4, and 5. Deductible does not apply to insulins.			
<b>Stage 2: Initial Coverage</b>	<b>Standard retail one-month supply</b>	<b>Preferred retail cost sharing (in network) (up to a 30-day supply)</b>	<b>Mail-order one-month supply</b>	<b>Long-term care 31-day supply</b>
Tier 1: Preferred Generic	\$9	\$4	\$4	\$4
Tier 2: Generic	\$14	\$9	\$9	\$9
Tier 3: Preferred Brand	20%	20%	20%	20%
Tier 4: Non-Preferred	35%	35%	35%	35%
Tier 5: Specialty	25%	25%	25%	25%
<b>Stage 2: Initial Coverage</b>	<b>Standard retail 100-day supply</b>	<b>Preferred retail 100-day supply</b>	<b>Mail-order 100-day supply</b>	<b>Long-term care 100-day supply</b>
Tier 1: Preferred Generic	\$27	\$12	\$0	Not offered
Tier 2: Generic	\$42	\$27	\$22.50	Not offered
Tier 3: Preferred Brand	20%	20%	20%	Not offered
Tier 4: Non-Preferred	35%	35%	35%	Not offered
Tier 5: Specialty	Not offered	Not offered	Not offered	Not offered
<b>Stage 3: Catastrophic Coverage</b>	Once your year-to-date out-of-pocket costs (your payments) total \$2,100, you move to Stage 3: Catastrophic Coverage. During this stage, you pay \$0.			

You won't pay more than \$35 for a one-month or \$105 for a 100-day supply of each insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online at **[www.WyoBlueAdvantage.com/member-resources](http://www.WyoBlueAdvantage.com/member-resources)**.

Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website **[www.WyoBlueAdvantage.com/formularies](http://www.WyoBlueAdvantage.com/formularies)**.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website **[www.WyoBlueAdvantage.com/pharmacies](http://www.WyoBlueAdvantage.com/pharmacies)**.

# WyoBlue Entrust PPO

## Outpatient Prescription Drugs

This plan does not cover Part D prescription drugs.

**For more information, or to enroll online, visit us at [www.WyoBlueAdvantage.com](http://www.WyoBlueAdvantage.com).**

If you are not a member of this plan, call toll-free 1-888-468-0179. TTY: 711.

If you are a member of this plan, call toll-free 1-844-682-9966. TTY: 711.

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Mountain time.

From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Mountain time.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at 1-844-682-9966. TTY: 711.

You can order a copy of the “Medicare & You” handbook at [www.medicare.gov](http://www.medicare.gov), or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048.

WyoBlue Advantage is a PPO plan with a Medicare contract. Enrollment in WyoBlue Advantage depends on contract renewal.

WyoBlue Advantage Inc. is an independent licensee of the Blue Cross Blue Shield Association.