WYOMING : BlueSelect Silver Classic Individuals

Coverage for: Single/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-442-2376 or visit https://shop.yourwyoblue.com/content/agreements/2021/WY/Individual/BlueSelectSilverClassicIXD.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-442-2376 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,500 / person, $5,000 / family. Out-of-network: $20,000 / person, $40,000 / family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, children's dental check-up, and services subject to a copayment are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $8,550 / person, $17,100 / family. Out-of-network: unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billing charges, sanctions, reductions and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://provider.bcbswy.com or call 1-800-442-2376 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copayment per visit. Deductible does not apply.	50% coinsurance	In-network subject to deductible and 40% coinsurance after 2 visits.
	Specialist visit	40% coinsurance	50% coinsurance	----------None----------
	Preventive care/ screening/immunization	No Charge. Deductible does not apply.	Not Covered	Benefits include but are not limited to those recommended by the USPSTF (A & B only), CDC Advisory Committee on Immunization Practices, and the HRSA for women's and children's preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbswy.com/rx21	Tier 1	$5 copayment per 30 day supply retail $10 copayment per 90 day supply mail order. Deductible does not apply.	Not Covered	Generally covers up to a 30 day supply, retail. Covers up to a 90 day supply of maintenance medications through pharmacies participating in Prime's Extended Supply Network or mail order.
	Tier 2	$50 copayment per 30 day supply retail $100 copayment per 90 day supply mail order. Deductible does not apply.	Not Covered	
	Tier 3	40% coinsurance retail and mail order	Not Covered	
	Tier 4	40% coinsurance	Not Covered	Must receive preauthorization from Blue Cross Blue Shield of Wyoming. Failure to obtain preauthorization may result in a denial or reduction in coverage. Covers up to a 30 day supply from Prime Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Obesity and weight loss, orthognathic, and reconstructive surgeries require preauthorization before receiving these services. Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Out-of-network non-medical emergencies will be covered at 50% coinsurance.
	Emergency medical transportation	40% coinsurance	50% coinsurance	----------None----------
	Urgent care	40% coinsurance	50% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Pre-admission review must be obtained prior to a non-maternity or non-emergency inpatient stay. Failure to obtain pre-admission review may result in a denial or reduction in coverage.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	50% coinsurance	Benefits are not available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are not available for the treatment of codependency.
	Inpatient services	40% coinsurance	50% coinsurance	Benefits are not available for therapy or counseling services for marital dysfunction or family dysfunction. Benefits are not available for the treatment of codependency. Failure to obtain pre-admission review may result in a denial or reduction in coverage.
If you are pregnant	Office visits	$45 copayment per visit. Deductible does not apply.	50% coinsurance	In-network subject to deductible and 40% coinsurance after 2 visits. Depending on the type of services, a coinsurance or deductible may apply. Cost-sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	Cost-sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	----------None----------
	Rehabilitation services	40% coinsurance	50% coinsurance	Physical, occupational and speech therapy benefits are provided for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery and must be preauthorized. Failure to obtain preauthorization may result in a denial or reduction in coverage. Inpatient is limited to 45 days per member per calendar year. Outpatient is limited to 20 visits per member per calendar year. Other physical therapy is limited to 40 visits per calendar year. Respiratory Therapy is covered when related to an accident, emergency, surgery or when medically necessary. Cardiac rehabilitation is not covered.
	Habilitation services	40% coinsurance	50% coinsurance	Inpatient physical, occupational and speech therapy benefits are limited to 45 days per member per calendar year. Outpatient limited to 20 visits per member per calendar year. Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Skilled nursing care	40% coinsurance	50% coinsurance	Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Durable medical equipment	40% coinsurance	50% coinsurance	Some items require preauthorization. Failure to obtain preauthorization may result in a denial or reduction in coverage.
	Hospice services	40% coinsurance	50% coinsurance	Must have preauthorization for inpatient hospice. Failure to obtain preauthorization may result in a denial or reduction in coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	40% coinsurance	50% coinsurance	Covers 1 exam per calendar year for individuals up to age 19.
	Children's glasses	40% coinsurance	50% coinsurance	Covers 1 pair of eyeglasses or 12 month supply of contacts per calendar year for individuals up to age 19.
	Children's dental check-up	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Limited to 1 every 6 months for individuals up to age 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion - except in cases of rape, incest, or when the life of the mother is endangered.
- Acupuncture
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - Requires prior approval, limited to 1 per lifetime.
- Chiropractic care - Limited to 15 visits per calendar year.
- Cosmetic surgery - Limited to pre-approved restorative surgery.
- Infertility treatment - Limited to the correction of the condition causing infertility.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Limited to inpatient services provided by an R.N.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Blue Cross Blue Shield of Wyoming at 1-800-442-2376, your state insurance department at 1-800-438-5768, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or Healthcare.gov www.HealthCare.gov or call 1-800-318-2596. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Wyoming Insurance Department at 1-800-438-5768 or doi.wyo.gov.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Not Applicable.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,500**
Specialist coinsurance	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$4,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,500**
Specialist coinsurance	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,500**
Specialist coinsurance	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,680**

The plan would be responsible for the other costs of these EXAMPLE covered services.

WYOMING

This Notice is Being Provided as Required by the Affordable Care Act

Translation Services

If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.	Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.
如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376.	Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.
Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-2376.	ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Wyoming についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.	यदि तपाई आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ,Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा नि:शुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.	اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Wyoming ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید.800-442-2376 تماس حاصل نمایید.
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-442-2376 로 전화하십시오.	જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે,આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.	Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídíłkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ́ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą́ doo bą́ą́h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnil 800-442-2376.

Non-Discrimination Notices

Blue Cross Blue Shield of Wyoming (BCBSWY) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

BCBSWY provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

BCBSWY provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

In order to obtain the interpretation services listed in paragraphs two (2) and three (3), Participants may call (800) 442-2376 or use BCBSWY's Telecommunications Device for the Deaf (TDD) at (800) 696-4710.

Participants have the right to file a grievance regarding potential discrimination. To file a grievance, please call BCBSWY at (307) 634-1393 or (800) 442-2376 and request the Grievance Officer in the Legal Department or mail a letter describing the grievance to 4000 House Avenue, Cheyenne, WY 82001 to the attention of the Legal Department.

If a Participant believes they have been discriminated against because of their race, color, national origin, disability, age, sex or religion, the Participant may file a discrimination complaint with the Office of Civil Rights. Please visit www.hhs.gov/ocr for directions to file a complaint.