



BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross
and Blue Shield Association

BLUESELECT PPO

A Silver Qualified Health Plan

THIS BENEFIT DOCUMENT CONTAINS THE EXPANDED WELLNESS BENEFITS PROVIDED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. THE EXPANDED WELLNESS BENEFITS UNDER THIS BENEFIT DOCUMENT REQUIRE THE USE OF AN IN-NETWORK PROVIDER. FOR A FURTHER DESCRIPTION OF THESE BENEFITS, PLEASE REFER TO SECTION 9 OF THIS DOCUMENT. THIS BENEFIT DOCUMENT DOES NOT MEET THE MINIMUM COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY THE WYOMING INSURANCE CODE.

IMPORTANT CONTACT INFORMATION

If You Need Information About.....	Contact.....
Blue Cross Blue Shield of Wyoming General Information and Questions	Street Address: 4000 House Avenue Cheyenne, Wyoming 82001 Mailing Address: PO Box 2266 Cheyenne, Wyoming 82003-2266 Phone Numbers: (307) 634-1393 (800) 442-2376 E-Rep: Log into the "Online Member Services" on www.wyomingblue.com Website: www.wyomingblue.com Business Hours: Monday through Friday 8:00 a.m. – 5:00 p.m. MST
BlueSelect PPO Directory	For PPO Providers Within the U.S.: (307) 634-1393 (800) 442-2376 www.wyomingblue.com For PPO Providers Outside of the U.S.: (877) 547-2903 if calling from within the U.S. (804) 673-1177 (collect call) if calling from outside U.S.
Pre-admission Review	(800) 251-1814
Pre-certification Requests	(800) 442-2376
Prescription Drug Program	(307) 634-1393 (800) 442-2376
Wyoming Insurance Department	106 East 6 th Ave Cheyenne, WY 82002 (800) 438-5768

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Section 1: Important Information About This Plan

A. ENTIRE AGREEMENT

This Benefit Document, including the application submitted to enroll in the health insurance coverage offered in this Benefit Document, the Schedule of Benefits, Participant's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card, and any amendments or endorsements that are or may become attached to this Benefit Document, constitute the entire Agreement between Applicant and Blue Cross Blue Shield of Wyoming, and supersedes and replaces all previous Agreements between Applicant and Blue Cross Blue Shield of Wyoming. This Agreement may also be referred to as the "Plan."

This Agreement describes the Benefits available to Applicant and Applicant's Dependents, if any, as Participants in this Blue Cross Blue Shield of Wyoming BlueSelect PPO Plan. The Benefits offered in this Plan are limited to the express written terms of this Agreement. If a Participant has questions about his or her coverage after reading this Benefit Document, the Participant should contact Blue Cross Blue Shield of Wyoming at the address or telephone numbers listed at the beginning of this Benefit Document and talk with a Blue Cross Blue Shield of Wyoming member services representative. Participants may also find answers to their questions on Blue Cross Blue Shield of Wyoming's website at www.wyomingblue.com.

B. AMENDMENTS TO THE AGREEMENT

All amendments to a Participant's Agreement with Blue Cross Blue Shield of Wyoming shall be made through a written endorsement signed by Blue Cross Blue Shield of Wyoming's President and Chief Executive Officer. Amendments to this Agreement will be delivered to the Applicant's last known address no less than fifteen (15) days prior to the Effective Date of the amendment. After this, the written endorsement will become part of the Participant's Agreement with Blue Cross Blue Shield of Wyoming.

No employee, agent or representative of Blue Cross Blue Shield of Wyoming may change, amend or waive a provision of this Agreement by giving incomplete or incorrect information, or by contradicting the terms of this Agreement. Any such situation will not prevent Blue Cross Blue Shield of Wyoming from administering this Agreement in strict accordance with its terms.

C. STATEMENTS AND REPRESENTATIONS

All statements contained in an application or other written document made by or on behalf of a Participant to obtain this Agreement shall be considered representations and not warranties. No such statements shall be used in any contest unless a copy of the document containing the statement is or has been furnished to the Participant or, in the event of the death or incapacity of the Participant, to the Participant's beneficiary or personal representative.

Misrepresentations, omissions, concealment of facts and incorrect or incomplete statements as provided in this subsection shall not prevent this Agreement from remaining in effect or prevent reimbursement for Covered Services under this Agreement unless Blue Cross Blue Shield of Wyoming determines that either:

1. The statements and/or representations are fraudulent;
2. The statements and/or representations are material to the acceptance of the risk or coverage of the Benefits provided under this Agreement; or
3. Blue Cross Blue Shield of Wyoming, in good faith, if it knew the true facts as required by the application or other document would not have entered into the Agreement with the Participant.

D. UNDERSTANDING REGARDING BLUE CROSS BLUE SHIELD OF WYOMING'S STATUS AS INDEPENDENT CORPORATION

Participants are hereby expressly advised, agree and acknowledge that Blue Cross Blue Shield of Wyoming is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Cross Blue Shield of Wyoming to use the Blue Cross and Blue Shield Service Marks in the State of Wyoming, and agree this legal Agreement was not entered into based upon representations by any person or entity other than Blue Cross Blue Shield of Wyoming and that no person, entity, or organization other than Blue Cross Blue Shield of Wyoming shall be held accountable or liable to the Participant for any of Blue Cross Blue Shield of Wyoming's obligations to the Participant created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross Blue Shield of Wyoming other than those obligations created under other provisions of this Agreement.

E. THE EFFECTIVE DATE OF THIS AGREEMENT

The Effective Date of this Agreement will be assigned after receipt and approval of the application. The Effective Date will be indicated on Applicant's Schedule of Benefits.

F. TERM OF THIS AGREEMENT

The term of this Agreement shall be one (1) month from its Effective Date. This Agreement will be renewed by Blue Cross Blue Shield of Wyoming from month to month, so long as Premiums are regularly and timely prepaid as scheduled and this Agreement has not otherwise been terminated as provided herein.

IN WITNESS WHEREOF, this Agreement is executed by Blue Cross Blue Shield of Wyoming through its duly authorized officer, undersigned, to take effect 12:01 a.m. Mountain Time on the Effective Date of this Agreement.

BLUE CROSS BLUE SHIELD OF WYOMING

Rick Schum
President & CEO

Section 2: Schedule of Benefits and Identification Cards

A. SCHEDULE OF BENEFITS

The Schedule of Benefits has been, or will be provided to the Participant separately in his/her Blue Cross Blue Shield of Wyoming Welcome Packet.

The Schedule of Benefits includes important information regarding the Plan's Effective Date, the selected Class of Coverage, Participant's Identification Card number, Benefits and Cost-Sharing Amounts. Upon Participant's receipt of the Schedule of Benefits, the Schedule of Benefits page should be inserted here and should remain with this Benefit Document at all times for easy reference.

B. IDENTIFICATION CARD

Attached to the Schedule of Benefits document is the Participant's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card(s). The Participant should remove his/her Identification Card from the Schedule of Benefits page and carry it with him/her at all times to ensure he/she has the BlueSelect PPO Benefit information and Blue Cross Blue Shield of Wyoming contact information available should Benefits be needed.

The Participant should:

1. Present the Identification Card to all Healthcare Providers whenever the Participant receives Healthcare Services.
2. Be sure to carry the most recent Identification Card the Participant has received from Blue Cross Blue Shield of Wyoming to ensure the Identification Card represents the most current Class of Coverage and Benefit and Cost-Sharing Amount information. Outdated Identification Cards should be destroyed.
3. Contact Blue Cross Blue Shield of Wyoming immediately in the event the Identification Card is lost or stolen.

Section 3: Participant's Bill of Rights and Responsibilities

A. PARTICIPANT'S RIGHTS

Blue Cross Blue Shield of Wyoming is committed to treating Participants in a manner that respects their rights. In this regard, Blue Cross Blue Shield of Wyoming recognizes that each Participant (or the Participant's parent, legal guardian or other legal representative if the Participant is a minor or incompetent) has the right to the following:

1. Participant has the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sex or sources of payment for care.
2. Participant has the right to considerate, respectful treatment at all times and under all circumstances with recognition of Participant's personal dignity.
3. Participant has the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Participant has the right, but is not required under this Agreement, to select a primary care physician (PCP) of Participant's choice. If a Participant is dissatisfied for any reason with the PCP initially chosen, the Participant has the right to choose another PCP.
5. Participant has the right to expect communications and other records pertaining to Participant's care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Federal and State law.
6. Participant has the right to know the identity and professional status of the individuals providing Healthcare Services to the Participant and to know which Healthcare Provider is primarily responsible for Participant's individual care. Participant also has the right to receive information about Blue Cross Blue Shield of Wyoming's clinical guidelines and protocols.
7. Participant has the right to a candid discussion with Participant's Healthcare Providers responsible for coordinating Participant's Medically Necessary treatment options for his/her Condition in a way that is understandable to Participant and is not dependent upon the cost or benefit coverage for those treatment options.
8. Participant shall have the right to participate with Healthcare Providers in decision making regarding Participant's treatment plan.

9. Participant has the right to give informed consent before the start of any procedure or treatment.
10. When Participant does not speak or understand the predominant language of the community, Blue Cross Blue Shield of Wyoming will make reasonable efforts to access an interpreter for purposes of communicating with the Participant about this Agreement.
11. Participant has the right to receive printed materials that describe important information about Blue Cross Blue Shield of Wyoming in a format that is easy to understand and easy to read.
12. Participant has the right to a clear appeals process for complaints and comments and to have Participant's issues resolved in a timely manner.
13. Participant has the right to appeal any decision regarding Medical Necessity made by Blue Cross Blue Shield of Wyoming and its BlueSelect PPO Providers.
14. Participant has the right to make recommendations regarding Blue Cross Blue Shield of Wyoming's Participant's rights and responsibilities policies.
15. Participant shall have the right to receive information about Blue Cross Blue Shield of Wyoming, its services, the Healthcare Providers in its networks and Participant's rights and responsibilities.

B. PARTICIPANT'S RESPONSIBILITIES

Each Participant (or the Participant's parent, legal guardian or other legal representative if the Participant is a minor or incompetent) is responsible for cooperating with Blue Cross Blue Shield of Wyoming and the Healthcare Providers providing Covered Services to the Participant, and shall have the following responsibilities:

1. Participant has the responsibility to provide to Participant's Healthcare Provider, to the best of Participant's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to Participant's health. Participant has the responsibility to report unexpected changes in Participant's Condition to the responsible Healthcare Provider. Participant is responsible for communicating whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.
2. Participant is responsible for carrying Participant's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card with him/her and for having his/her Identification Card numbers available when telephoning or contacting Blue Cross Blue Shield of Wyoming.

3. Participant is responsible for following all access and availability procedures including Pre-admission and Pre-certification requirements as described throughout this Benefit Document.
4. Participant is responsible for seeking services for a Medical Emergency at an In-Network emergency facility whenever possible. In the event an Ambulance is used, Participants should direct the Ambulance to the nearest In-Network emergency facility, unless that transport would put the Participant at serious risk of harm.
5. Participant is responsible for notifying Blue Cross Blue Shield of Wyoming of any emergency Hospital admission during the next business day or as soon thereafter as reasonably possible after becoming physically or mentally able to give notice.
6. Participant is responsible for keeping appointments and, when Participant is unable to do so for any reason, for notifying the responsible Healthcare Provider.
7. Participant is responsible for following his/her treatment plan as recommended by the Healthcare Provider primarily responsible for Participant's care. Participant is also responsible for participating, to the degree possible, in understanding his/her own healthcare problems including behavioral problems and developing mutually agreed upon treatment goals.
8. Participant is responsible for Participant's own actions if Participant refuses treatment or does not follow a Healthcare Provider's instructions.
9. Participant is responsible for notifying Blue Cross Blue Shield of Wyoming within thirty (30) days if Participant changes his/her name, address or phone number.

Section 4: Eligibility, Enrollment and Termination

A. EMPLOYER ELIGIBILITY

In order to be eligible for this BlueSelect PPO group health plan, an employer must meet and maintain the following eligibility requirements:

1. The employer must be actively engaged in business in Wyoming and provide, upon request, evidence to this effect satisfactory to Blue Cross Blue Shield of Wyoming.
2. The employer must maintain, at a minimum, the following numbers and percentages of total employees enrolling in this Plan, as determined by Blue Cross Blue Shield of Wyoming. The number of potential employees that must be enrolled will include employees of all affiliated companies as determined by Blue Cross Blue Shield of Wyoming.

<u>If the number of potential enrollees is:</u>	<u>Percentage of enrollment must be:</u>
1-4	100%
5-9	100% less one potential enrollee
10 or more	8 potential enrollees or 75%, whichever is greater

3. The employer must, upon request, provide documentation satisfactory to Blue Cross Blue Shield of Wyoming supporting the eligibility of all employees, directors, partners, and owners.
4. The employer is required to comply with the minimum contribution requirements as established by Blue Cross Blue Shield of Wyoming.

B. APPLICANT AND DEPENDENT ELIGIBILITY

1. Applicant

In order to be eligible for this BlueSelect PPO group health plan, Applicant must meet and maintain the following eligibility requirements:

- a. Unless otherwise specified, Applicant must be a regular (non-seasonal, non-temporary) full-time employee who is employed thirty (30) or more hours a week by the employer that has made application for this Plan (or any affiliated companies as determined by Blue Cross Blue Shield of Wyoming).
- b. Applicant must have deductions made for Federal Income Taxes and Social Security by the employer.

- c. Directors are eligible only if they are also employed thirty (30) or more hours per week by the employer that has made application for this Plan (or any affiliated companies as determined by Blue Cross Blue Shield of Wyoming).
- d. Partners and owners are eligible only if they are employed thirty (30) or more hours per week by the employer that has made application for this Plan (or any affiliated companies as determined by Blue Cross Blue Shield of Wyoming).

NOTE: The following individuals are not eligible for coverage under this Plan:

- (1) Retired employees.
- (2) Directors, partners, owners who do not work thirty (30) hours or more per week.
- (3) Independent contractors.
- (4) Volunteers or non-compensated employees.

2. Dependent(s)

The Dependents, as defined below, of an eligible Applicant will also be eligible for coverage under this Agreement if the Applicant has elected the appropriate Class of Coverage (as indicated on the Schedule of Benefits and Identification Card at the time of enrollment) to cover the Applicant's Dependent(s):

- a. Applicant's spouse. For purposes of this Agreement, Applicant's spouse is defined and limited to a legally recognized spouse who is a current and permanent resident in the Applicant's home.
- b. Applicant's child, stepchild, adopted child, or legal ward under the age of twenty-six (26).
- c. Applicant's child, stepchild, adopted child, or legal ward who has attained age twenty-six (26) may be eligible if the child is unmarried and is BOTH incapable of self-sustaining employment and chiefly dependent upon the Applicant or Applicant's Dependent Spouse for their support and maintenance by reason of physical or intellectual disability. Proof of disability and dependency must be furnished to Blue Cross Blue Shield of Wyoming upon request.

NOTE: Applicant's spouse, children, stepchildren, adopted children and legal wards will be referred to throughout this Benefit Document as "Dependents"

when referred to collectively. However, the terms “Dependent Spouse” or “Dependent Children” may be used when a differentiation between the Applicant’s spouse and the Applicant’s children, stepchildren, adopted children or legal wards is required.)

C. ENROLLMENT

An eligible Applicant and the Applicant’s eligible Dependents will be able to enroll for coverage under this Agreement according to the following guidelines, or as may be determined by applicable Federal and State law:

1. When To Enroll For Coverage

a. Timely Enrollment

The Applicant must submit an application for coverage to Blue Cross Blue Shield of Wyoming within thirty (30) days of the end of any applicable Waiting Period. If there is no Waiting Period, the application must be received by Blue Cross Blue Shield of Wyoming within thirty (30) days of the Applicant’s date of hire. Applicant may submit an application to enroll in this Plan individually, or may also enroll his or her eligible Dependents at this time. Based on the completeness and acceptability of the application, the Effective Date will be the first day of the month following receipt of the Applicant’s completed application.

b. Late Enrollment

If an application is not submitted as described above, the Applicant, and/or Applicant’s Dependent(s) will be considered to be late enrollees. Late enrollees are only eligible to apply for coverage as follows:

- (1) Late enrollees may apply for coverage during the employer’s annual open enrollment period. Provided the application is received by Blue Cross Blue Shield of Wyoming **during** the open enrollment period, a late enrollee will have coverage with an Effective Date under this Agreement of the first day of the first calendar month immediately following the employer’s open enrollment period.
- (2) Late enrollees may apply for coverage if a situation arises during the Plan Year that qualifies the late enrollee for a special enrollment period as described in this Agreement.

2. Annual Open Enrollment Periods

If an Applicant and/or Applicant’s Dependent(s) were not enrolled in this Plan within thirty (30) days of the end of the applicable Waiting Period or, where there is no Waiting Period, within thirty (30) days of the Applicant’s

date of hire, Applicant and/or Applicant's Dependent(s) are eligible to apply for coverage under this Plan during the employer's annual open enrollment period.

3. Special Enrollment Periods

a. Newly Gained Dependent(s)

If, during the Plan Year, Applicant gains a new Dependent(s) as a result of marriage, birth, adoption, placement for adoption, or court order, Applicant may be eligible for a special enrollment for himself/herself and his/her Dependents. Applicant must submit a completed special enrollment application to Blue Cross Blue Shield of Wyoming as specified below:

(1) New Spouse and/or Stepchild

The Effective Date of coverage for a new spouse or stepchild shall be on the first day of the month following the date of marriage provided an application for coverage is received by Blue Cross Blue Shield of Wyoming within thirty (30) days after the date of marriage.

(2) Newborn Child

A newborn child will automatically be covered under this Plan for the first thirty-one (31) days after the child's birth. However, a completed application for coverage for the newborn child is required before Claims for Benefits will be processed and paid. The Applicant may continue coverage for the newborn child beyond the thirty-one (31) day automatic coverage period provided that a properly completed application for coverage for the newborn child is received by Blue Cross Blue Shield of Wyoming within sixty-one (61) days of the child's date of birth.

(3) Adopted Child/Legal Ward

The Effective Date of coverage for an adopted child/legal ward will be the earlier of the date the petition for adoption was filed or the child's date of entry into the adoptive home (unless the child is in the custody of the State, in which case the Effective Date of coverage will be the date of entry of a final adoption decree by the court), for a period of thirty-one (31) days. However, a properly completed application for coverage for the adopted child/legal ward is required before Claims for Benefits will be processed and paid. The Applicant may continue coverage for the adopted child/legal ward beyond the thirty-one (31) day automatic coverage provided that the properly completed application for coverage for the adopted

child/legal ward is received by Blue Cross Blue Shield of Wyoming within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the Effective Date of coverage will be the date of entry of a final adoption decree by the court). If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

NOTE: The adoption or legal guardianship papers issued by the court must be submitted to Blue Cross Blue Shield of Wyoming with the application for coverage

b. Loss of Other Coverage

If at the time of initial eligibility the Applicant or Applicant's Dependent were not enrolled under this Agreement because of other health insurance coverage, the Applicant and/or Dependent may be eligible for a special enrollment. To qualify for this special enrollment, the Applicant and/or Dependent must have lost his/her other coverage due to either:

- (1) The termination of employer's contributions.
- (2) Loss of eligibility due to divorce, death, legal separation, termination of employment, reduction in work hours, or loss of eligibility for Kid Care CHIP or Medicaid.
- (3) The exhaustion of group continuation coverage if the Applicant and/or Dependent had been on group continuation coverage at the time of initial eligibility.

Note: Loss of other coverage does not include termination or loss due to failure to pay Premiums on a timely basis, including COBRA Premiums, or situations allowing for a rescission of coverage.

Applicant and/or Dependant must submit a completed special enrollment application to Blue Cross Blue Shield of Wyoming no later than thirty (30) days after the loss of other coverage due to termination of employer's contributions or exhaustion of group continuation coverage, and no later than sixty (60) days after the loss of other coverage due to divorce, death, legal separation, termination of employment, reduction in work hours or loss of eligibility for Kid Care CHIP or Medicaid. The Effective Date of coverage for the Dependent will be the first day of the month following receipt of the completed application by Blue Cross Blue Shield of Wyoming.

C. TERMINATION

1. Applicant

An Applicant's coverage under this Agreement terminates as a result of the following events:

- a. When the employer's Group Master Agreement for this coverage is terminated.
- b. When the Applicant leaves employment or otherwise becomes ineligible, coverage will terminate the first of the month following the last day of eligibility. The Applicant may apply to Blue Cross Blue Shield of Wyoming for continuation of coverage as described in this Agreement.

NOTE: Accrued vacation time and sick leave will not extend coverage beyond the first Billing Service Date following the last day of employment.

- c. When Blue Cross Blue Shield of Wyoming is notified within thirty (30) days of a leave of absence for an Applicant, the Applicant may remain on this Plan for ninety (90) days, providing the employer continues to contribute the same portion of the Premium for the Applicant, and Blue Cross Blue Shield of Wyoming receives the remittance of monthly Premiums from the employer. If, after the initial leave of absence, the Applicant does not return to work or is not maintained on the payroll, he or she will be removed from this Plan on the first Billing Service Date following the ninety (90) day leave of absence. The Applicant then has thirty-one (31) days to apply to Blue Cross Blue Shield of Wyoming for continuation of coverage as described in this Agreement.

NOTE: If the employer does not contribute the same amount toward the Applicant's Premium as it does for other employees, Blue Cross Blue Shield of Wyoming will consider that the Applicant has left employment and this coverage will no longer be available to the Applicant. Continuation of this coverage may be available to Applicant as described in this Agreement.

- d. Upon the death of the Applicant.
- e. Upon the Applicant's request. Coverage ends on the next Billing Service Date following receipt of the written request.
- f. When Applicant misuses this Agreement, or when there is fraud or material misrepresentation associated with the application for coverage, or with the filing of a Claim for Benefits by the Applicant.

The Applicant is liable for any payments made by Blue Cross Blue Shield of Wyoming to, or on behalf of, the Applicant as a result of such improper actions.

- g. When an Applicant age sixty-five (65) or over leaves employment the following options are available:
 - (1) Where Applicant's employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Applicant may select either coverage under COBRA as described below, or coverage under a senior healthcare product.
 - (2) Where Applicant's employer is not subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Applicant will have his or her coverage terminated under this Agreement. However, if Applicant wishes to apply for continuous coverage, the Applicant will be transferred to a senior healthcare product.
- h. When the Applicant is age sixty-five (65) and remains an active employee, and the Applicant's employer is subject to the Tax Equity And Fiscal Responsibility Act (TEFRA), the Applicant must chose a primary insurance carrier from the following:
 - (1) This employer coverage with Blue Cross Blue Shield of Wyoming; or
 - (2) Benefits of the Federal Medicare program.

NOTE: If the Federal Medicare program is chosen, the Applicant will not be allowed to remain covered under this Plan.

2. Dependent

A Dependent's coverage under this Agreement terminates upon the earliest of the following events:

- a. When the Applicant's employer's Group Master Agreement for this coverage is terminated.
- b. When the Applicant's coverage under this Agreement ends. Dependent(s) may apply for a continuation of coverage as described in this Agreement.

NOTE: Upon the death of the Applicant, the surviving Dependent(s) will remain covered under this Agreement until the next Billing

Service Date. Dependent(s) have the right to continue coverage as described in this Agreement. A written application for such continuation must be received by Blue Cross Blue Shield of Wyoming within thirty-one (31) days after the Applicant's death.

- c. When the Applicant notifies Blue Cross Blue Shield of Wyoming in writing to end coverage for a Dependent. Coverage ends on the next Billing Service Date following receipt of the written request.
- d. When Dependent no longer qualifies as a Dependent as defined in this Agreement.
- e. The end of the calendar year in which a Dependent Child attains age twenty-six (26).

NOTE: Eligibility may be continued past the end of the calendar year in which a Dependent Child attains age twenty-six (26) for unmarried Dependent Children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Applicant or Applicant's Dependent Spouse for their support and maintenance by reason of physical or intellectual disability. Continuous coverage will be established at the same level of benefits. Proof of disability and dependency must be furnished to Blue Cross Blue Shield of Wyoming within thirty-one (31) days of the end of the calendar year in which the Dependent Child attains age twenty-six (26). Disability and dependency upon the Applicant or Applicant's Dependent Spouse must both continue in order for the coverage to continue and Blue Cross Blue Shield of Wyoming may, from time to time, require continued proof of such disability and dependency. If the conditions of BOTH disability and dependency by reason of physical or intellectual disability are not continuously met, coverage will continue as required by Federal or State law as applicable.

- f. Where the Dependent is Applicant's spouse, on the next Billing Service Date following a final divorce decree or separation.
- g. For newborn and adopted children, at the end of the thirty-one (31) day automatic coverage period, unless a completed application for coverage of the child is received by Blue Cross Blue Shield of Wyoming no later than thirty (30) days after the end of that automatic coverage period.
- h. When the Dependent Spouse of an Applicant who is an active employee of an employer who is subject to the Tax Equity And Fiscal Responsibility Act (TEFRA) turns age sixty-five (65), the Dependent Spouse must choose a primary insurance carrier from the following:

- (1) This employer coverage with Blue Cross Blue Shield of Wyoming; or
- (2) Benefits of the Federal Medicare program.

NOTE: If the Federal Medicare program is chosen, the Dependent Spouse will not be allowed to remain covered under this Plan.

- i. When Dependent misuses this Agreement, or when there is fraud or material misrepresentation associated with the application for coverage, or with the filing of a Claim for Benefits by the Dependent. The Applicant and/or Dependent is liable for any payments made by Blue Cross Blue Shield of Wyoming to, or on behalf of, the Dependent as a result of such improper actions.

D. CONTINUATION OF COVERAGE

Applicants should consult with their employer to determine whether or not their employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA).

1. Where the Applicant's employer is subject to COBRA:

(a) Applicant's Options:

- (1) When the Applicant's employment is terminated (except for termination due to gross misconduct), or Applicant suffers a reduction in work hours resulting in loss of coverage, the Applicant is eligible for COBRA continuation of coverage under this Agreement at his or her own expense.
- (2) The employer must notify Blue Cross Blue Shield of Wyoming in writing within thirty (30) days after Applicant's employment is terminated or Applicant suffers a reduction in work hours resulting in the loss of eligibility for health coverage.
- (3) Blue Cross Blue Shield of Wyoming will notify the Applicant of his or her COBRA continuation of coverage rights within fourteen (14) days of receiving notification from the employer.
- (4) The Applicant must sign and return the COBRA continuation of coverage election form to Blue Cross Blue Shield of Wyoming within sixty (60) days of either the date of the letter containing the form or the effective date of the COBRA continuation coverage, whichever is later.

NOTE: Applicants who do not apply for COBRA continuation of coverage within sixty (60) days as described above are **not** later eligible to apply during the annual open enrollment period and will lose their COBRA continuation of coverage rights.

(5) The term of the Applicant's COBRA continuation coverage is:

- (a) Eighteen (18) months; or
- (b) Twenty-four (24) months if the Applicant left his or her employment to enter the Armed Forces on a full-time basis; or
- (c) Up to a maximum of twenty-nine (29) months if the Applicant is disabled at the time of termination.

However, the above stated terms will end prior to the time indicated above if Applicant obtains health insurance coverage under another health plan or becomes entitled to Medicare.

(6) COBRA continuation coverage can be canceled only upon:

- (a) Abolition of all health plans by the employer.
- (b) The Applicant's failure to pay Premiums.
- (c) The Applicant's coverage by any other health plan or entitlement to Medicare.

b. Dependent's Options

- (1) Where a Dependent's coverage under this Plan has been terminated, the Dependent is entitled to elect COBRA continuation coverage under this Agreement at his or her own expense.
- (2) The Applicant or covered Dependent must notify Blue Cross Blue Shield of Wyoming in writing within sixty (60) days of the date Dependent lost eligibility as a covered Dependent under this Plan.

NOTE: If the Applicant or covered Dependent fails to report the Dependent's loss of eligibility within sixty (60) days, the

Dependent will lose his or her COBRA continuation of coverage rights.

- (3) Blue Cross Blue Shield of Wyoming will notify the Dependent of his or her right to COBRA continuation of coverage within fourteen (14) days of receiving notification from the Applicant or Dependent.
- (4) The Dependent must sign and return the COBRA continuation of coverage election form to Blue Cross Blue Shield of Wyoming within sixty (60) days of either the date of the letter containing the form or the effective date of the COBRA continuation coverage, whichever is later.

NOTE: Dependents who do not apply for COBRA continuation of coverage within sixty (60) days as described above are **not** later eligible to apply during the annual open enrollment period and will lose their COBRA continuation of coverage rights.

- (5) The term of the Dependent's COBRA coverage is:
 - (a) Eighteen (18) months in the case of the Applicant's termination from employment or reduction in work hours resulting in loss of coverage; or
 - (b) Twenty-four (24) months if the Applicant left his or her employment to enter the Armed Forces on a full-time basis; or
 - (c) Thirty-six (36) months if the Dependent lost coverage due to the Applicant's death; or
 - (d) Thirty-six (36) months if the Dependent lost coverage due to separation, divorce or is a Medicare ineligible Dependent of an Applicant who remains a current active employee; or
 - (e) Thirty-six (36) months if the Dependent Child lost his or her Dependent Child status under the terms of this Agreement.

However, the above stated terms will end prior to the time indicated above if Dependent obtains health insurance coverage under another health plan or becomes entitled to Medicare.

(6) COBRA coverage can be canceled only upon:

- (a) Abolition of all health plans by the employer.
- (b) The Applicant and/or Dependent's failure to pay Premiums.
- (c) The Dependent's coverage by any other health plan or entitlement to Medicare.

2. Where the Applicant's employer is **not** subject to COBRA:

- a. When the Applicant's or a Dependent's coverage under this Plan is terminated due to loss of Applicant's employment or the Applicant's or Dependent's loss of eligibility, the Applicant and/or Dependent is eligible for continuation of coverage pursuant to Wyoming state law if the Applicant or Dependent was continuously insured under this Plan for at least three (3) full months before the event causing the termination of coverage under this Agreement.
- b. Continuation of coverage is not available for any Applicant or Dependent who obtains health insurance coverage under any other health plan or becomes entitled to Medicare (except in cases where only Applicant is eligible for Medicare, Applicant's Dependents will continue to be entitled to continuation of coverage under this Agreement).
- c. The Applicant or Dependent must notify Blue Cross Blue Shield of Wyoming in writing of his or her intent to continue coverage within thirty-one (31) days following the date of termination of coverage under this Plan.
- d. The Applicant or Dependent electing continuation of coverage is responsible for payment of the Premium, in advance, on a monthly basis.
- e. The term of the continuation of coverage is:
 - (1) Twelve (12) months; or
 - (2) Twenty-four (24) months where the Applicant has left his or her employment to enter the Armed Forces on a full-time basis.
- f. Continuation of coverage can be canceled only upon:

- (1) The date upon which the employer's group policy is terminated.
- (2) The Applicant's or Dependent's failure to pay Premiums.
- (3) The Applicant or Dependent obtains coverage under another health plan or becomes entitled to Medicare.

E. GROUP CONVERSION

Applicant's have the right to group conversion under this Agreement pursuant to Wyoming Statute 26-22-202. Blue Cross Blue Shield of Wyoming will offer Applicant's the full range of non-group BlueSelect products offered by Blue Cross Blue Shield of Wyoming pursuant to the provisions of Wyoming Statute 26-22-202.

F. CERTIFICATES OF CREDITABLE COVERAGE

When coverage for the Applicant and/or Dependent(s) under this Agreement is terminated, Blue Cross Blue Shield of Wyoming will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the affected Applicant and/or Dependent(s). Upon notification by the Applicant of the ineligibility of a Dependent, a Certificate of Creditable Coverage for the ineligible Dependent will be issued in a timely fashion thereafter. Certificates of Creditable Coverage may also be obtained from Blue Cross Blue Shield of Wyoming upon request within twenty-four (24) months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through Blue Cross Blue Shield of Wyoming.

Section 5: Premium Payments

A. PREMIUM PAYMENTS

1. How Premiums Are Established And Changed

The Premium for coverage may be established by Blue Cross Blue Shield of Wyoming according to any of the following:

- a. Factors such as age, tobacco usage, and geographical location as allowed by Federal and State law.
- b. Applicant's Class of Coverage.

The Premium may be changed from time to time by Blue Cross Blue Shield of Wyoming upon Blue Cross Blue Shield of Wyoming giving the Applicant fifteen (15) days written notice of a change in Premium. Payment of the Premium will be conclusive proof of Applicant's agreement to the change.

2. How And When To Pay Premiums

The initial Premium is due and payable on the Effective Date of this Agreement. Applicant's coverage (and Dependents' coverage where applicable) will not become effective until Blue Cross Blue Shield of Wyoming receives that first Premium payment.

3. Grace Period

A grace period of thirty-one (31) days from the Premium due date will be granted to the employer for the payment of that monthly Premium. During this grace period, the Agreement shall remain in force and Benefits will be paid so long as payment of the Premium is received by Blue Cross Blue Shield of Wyoming on or before the last day of the thirty-one (31) day grace period. (Where the Premium payment is mailed to Blue Cross Blue Shield of Wyoming, the envelope must be post-marked on or before the last day of the grace period). However, if the Premium is not paid by the end of the thirty-one (31) day grace period, this Benefit Document will be terminated as of the last day of the month that the last Premium was timely paid in full. Where coverage is terminated, any Benefits paid by Blue Cross Blue Shield of Wyoming to or on behalf of a Participant for Covered Services received during the thirty-one (31) day grace period will be the legal responsibility of the Applicant/Participant and must be reimbursed to Blue Cross Blue Shield of Wyoming.

Section 6: Cost-Sharing Amounts

Payments by Blue Cross Blue Shield of Wyoming for Covered Services under this Benefit Document are based on the Maximum Allowable Amount, less Cost-Sharing Amounts that are the Participant's responsibility.

A. COST-SHARING AMOUNTS

Cost-Sharing Amounts are those dollar amounts that a Participant is responsible for paying when Covered Services are received from a Healthcare Provider. Cost-Sharing Amounts include Copayment Amounts, Deductible Amounts and Coinsurance Amounts. Healthcare Providers may either bill a Participant directly for these amounts or request payment of these amounts from the Participant at the time the Covered Services are provided.

1. Copayment Amount

A specified dollar amount payable by the Participant to the Healthcare Provider for certain Covered Services. Healthcare Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not accumulate toward the Participant's satisfaction of the Deductible Amount or Coinsurance Amount, but will accumulate toward the Participant's satisfaction of the Out-of-Pocket Maximum.

2. Deductible Amount

A specified dollar amount that a Participant must pay to the Healthcare Provider for Covered Services within a calendar year before Benefits for Covered Services are provided under this Agreement.

How the Deductible Amount can be met during the calendar year depends upon the applicable Class of Coverage:

a. **Single Coverage:** If only the Applicant is covered under this Plan, the Applicant alone must meet the entire Deductible Amount.

b. **Applicant and Dependent Coverage, Two Adult Coverage, and Family Coverage:** The Deductible Amount for each calendar year will be satisfied when any of the following scenarios occurs:

(1) When one (1) Participant meets one-half of the Deductible Amount, that Participant will be eligible for Benefits. The remaining Participants will be eligible for Benefits when they have collectively satisfied the remaining balance of the Deductible Amount.

(2) When two (2) or more Participants each meet one-half of the Deductible Amount, the remaining Participants will then be eligible for Benefits without regard to that Deductible Amount.

- (3) When no one (1) Participant meets one-half of the Deductible Amount, but all the Participants collectively meet the Deductible Amount, then all Participants will be eligible for Benefits.

NOTE: A Participant may not apply more than the individual deductible expenses per Participant to satisfy the Deductible Amount.

NOTE: The Deductible Amount does not apply to PREVENTIVE CARE.

3. Coinsurance Amount

A percentage of the cost of Covered Services that is a Participant's responsibility after the Deductible has been met.

Blue Cross Blue Shield of Wyoming calculates a Participant's Coinsurance Amount, when Participant obtains the Covered Services from Healthcare Providers in Blue Cross Blue Shield of Wyoming's service area, off of the Maximum Allowable Amount.

However, if the Participant obtains Covered Services outside of the Blue Cross Blue Shield of Wyoming service area, the local Blue Cross Blue Shield Plan's (Host Plan's) contract with the Healthcare Provider may require that the Coinsurance Amount be based on the full amount of the Healthcare Provider's billed charges rather than the Maximum Allowable Amount. This may result in a significantly higher Coinsurance Amount to the Participant for these Covered Services. It is not possible for Blue Cross Blue Shield of Wyoming to detail the specific information for each out-of-area Healthcare Provider in this Benefit Document because of the many different arrangements the various Host Plans have with their local Healthcare Providers. However, if a Participant contacts Blue Cross Blue Shield of Wyoming prior to incurring out-of-area Healthcare Services, a Blue Cross Blue Shield of Wyoming member services representative may be able to provide the Participant with more specific information on the applicable Coinsurance Amount.

NOTE: The Coinsurance Amount does not apply to PREVENTIVE CARE.

4. Out-of-Pocket Maximum Amount

The Out-of-Pocket Maximum Amount is the total Copayment, Deductible and Coinsurance Amounts for Covered Services that are the Participants' responsibility during a single calendar year. When the Participants' Out-of-Pocket Maximum Amount is met by any combination of Copayment, Deductible or Coinsurance Amounts during a single calendar year, Blue Cross Blue Shield of Wyoming will reimburse one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services for the remainder of that

calendar year.

There are separate Out-of-Pocket Maximum Amounts for In-Network and Out-of-Network Cost Sharing Amounts. Satisfaction toward one type of Out-of-Pocket Maximum Amounts (i.e. In-Network Out-of-Pocket Maximum Amounts) will not work to satisfy the other type of Out-of-Pocket Maximum Amount (i.e. Out-of-Network Out-of-Pocket Maximum Amounts).

The calculation of the total Copayment, Deductible and Coinsurance Amounts toward the Out-of-Pocket Maximum Amount begins new on January 1 of each calendar year.

5. Schedule of Benefits/Summary of Benefits

The Cost-Sharing Amounts applicable to this Plan are set out in Participant's Schedule of Benefits and Summary of Benefits herein.

Section 7: The BlueSelect PPO Network

A. WHEN YOU RECEIVE HEALTHCARE IN WYOMING

1. BlueSelect PPO Network

The Blue Cross Blue Shield of Wyoming BlueSelect PPO Network is a preferred provider organization network comprised of independent Healthcare Providers in the State of Wyoming (or in some circumstances from contiguous counties of neighboring states) that have entered into agreements with Blue Cross Blue Shield of Wyoming to provide Healthcare Services to BlueSelect Participants. The BlueSelect PPO Network includes Healthcare Providers offering a broad range of medical services, such as family practice, internal medicine, obstetrics, gynecology and pediatrics.

In an effort to contain healthcare costs and keep Premiums down, Blue Cross Blue Shield of Wyoming has negotiated with these BlueSelect Providers to provide Healthcare Services to BlueSelect Participants for reduced charges. Regardless of the total amount of charges the BlueSelect Provider's billing statement to the Participant may indicate, a BlueSelect Provider has agreed to accept the Maximum Allowable Amount as full reimbursement for the Covered Services that the BlueSelect Provider provided to the Participant. Blue Cross Blue Shield of Wyoming will pay the Maximum Allowable Amount directly to the BlueSelect Provider on behalf of the Participant. A BlueSelect Provider may still bill the Participant for Participant's Cost-Sharing Amounts and for any Non-Covered Services. However, the BlueSelect Provider may not bill the Participant for the difference between the amount of the total charges that may have been reflected on the BlueSelect Provider's billing statement to the Participant and the Maximum Allowable Amount the BlueSelect Provider has agreed to accept as reimbursement from Blue Cross Blue Shield of Wyoming for the Covered Services.

However, where a Participant obtains Healthcare Services from a Healthcare Provider that has elected not to become part of the BlueSelect PPO Network, that Healthcare Provider may bill the Participant for the total charges reflected in the Healthcare Provider's billing statement to the Participant. Blue Cross Blue Shield of Wyoming will reimburse the Maximum Allowable Amount for the Covered Services directly to the Participant. It will be the Participant's responsibility to pay this Maximum Allowable Amount to the Healthcare Provider. However, in addition to any Cost-Sharing Amounts and charges for Non-Covered Services that are Participant's responsibility, Participant will also be responsible for paying the Healthcare Provider for the difference between the full amount of charges reflected in the Healthcare Provider's billing statement and the Maximum Allowable Amount Blue Cross Blue Shield of Wyoming reimbursed the Participant for the Covered Services. The difference may be a considerable amount of money.

Participant is free to select his or her Healthcare Providers. Blue Cross Blue Shield of Wyoming makes no guarantee as to the availability of any Healthcare Provider. Blue Cross Blue Shield of Wyoming's responsibility to Participant is solely to make payment for the Benefits described in this Benefit Document. However, in order to receive the best value under this Benefit Document, the Participant should use BlueSelect Providers whenever possible.

2. How to Find BlueSelect Providers

The BlueSelect PPO Network Directory can be accessed as follows:

For BlueSelect Providers within the U.S.:

(307) 634-1393

(800) 442-2376

www.wyomingblue.com

For PPO Providers outside of the U.S.:

(877) 547-2903 if calling from within the U.S.

(804) 673-1177 (collect call) if calling from outside U.S.

NOTE: A Healthcare Provider's network status may change at any time without notice. Participant is responsible for confirming a Healthcare Provider's BlueSelect PPO Network status prior to receiving any treatment or services from the provider.

B. WHEN YOU RECEIVE HEALTHCARE OUTSIDE OF WYOMING

Blue Cross Blue Shield of Wyoming has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Participant obtains Covered Services outside of Blue Cross Blue Shield of Wyoming's service area, the claims for these Covered Services may be processed through one of these Inter-Plan Programs, which includes the BlueCard® Program.

Typically, when accessing Covered Services outside Blue Cross Blue Shield of Wyoming's service area, a Participant will obtain Covered Services from Healthcare Providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue") (hereinafter referred to collectively for purposes of this provision as "Participating Providers"). In some instances, a Participant may obtain Covered Services from Healthcare Providers that do not have a contractual agreement with a Host Blue (hereinafter referred to collectively for purposes of this provision as "Non-participating Providers"). Blue Cross Blue Shield of Wyoming's payment practices in both instances are described below.

1. BlueCard® Program

Under the BlueCard® Program, when a Participant accesses Covered Services within the geographic area served by a Host Blue, Blue Cross Blue

Shield of Wyoming will remain responsible for fulfilling its contractual obligations with the Participant. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever a Participant accesses Covered Services outside Blue Cross Blue Shield of Wyoming's service area and the Claim for Benefits is processed through the BlueCard® Program, the amount the Participant pays for Covered Services is calculated based on the lower of:

- a. The billed charges for the Participant's Covered Services; or
- b. The negotiated price that the Host Blue makes available to Blue Cross Blue Shield of Wyoming.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Participating Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Participating Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross Blue Shield of Wyoming uses for the Participant's Claim for Benefits because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Participant's liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, Blue Cross Blue Shield of Wyoming would then calculate the Participant's liability for any Covered Services according to applicable law.

2. Non-Participating Providers Outside of Blue Cross Blue Shield of Wyoming's Service Area

a. Participant's Liability Calculation

When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by Non-participating Providers, the amount the Participant pays for Covered Services will generally be based on either the Host Blue's Non-participating Provider local payment or the pricing arrangements required by applicable state law. In these

situations, the Participant may be liable for the difference between the amount that the Non-participating Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

b. Exceptions

In certain situations, Blue Cross Blue Shield of Wyoming may use other payment bases, such as billed charges, the payment Blue Cross Blue Shield of Wyoming would make if the Covered Services had been obtained within Blue Cross Blue Shield's service area, or a special negotiated payment, as permitted under Inter-Plan Programs' policies, to determine the amount Blue Cross Blue Shield of Wyoming will pay for Covered Services rendered by Non-participating Providers. In these situations, the Participant may be liable for the difference between the amount that the Non-participating Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

C. DISCLAIMER OF LIABILITY

Blue Cross Blue Shield of Wyoming has no control over any diagnosis, treatment, care, or other Healthcare Service provided to a Participant by any Healthcare Provider, and is not liable to the Participant for any loss or injury the Participant may incur as the result of any negligent or intentional act or omission on the part of the Healthcare Provider.

Section 8: Summary of Benefits

This summary provides an overview of some of the Benefits available under the BlueSelect PPO Silver Plan. For further information on the Benefits, as well as the applicable Limitations and Exclusions, please refer to Sections 9: Benefits (Covered Services) and Section 10, Limitations and Exclusions of this Benefit Document.

Participant's Calendar Year Cost-Sharing Amounts		
Cost-Sharing Amounts	In Network	Out of Network
Deductible:		
Single Coverage	\$2,000	\$4,500
Two Adult Coverage	\$4,000	\$9,000
Applicant & Dependent Coverage	\$4,000	\$9,000
Family Coverage	\$4,000	\$9,000
Coinsurance Amount – All Classes of Coverage:	25%	25%
Copayment Amounts - All Classes of Coverage:		
Primary Care:	\$45 per visit for first six (6) office visits per Participant per calendar year	No Copayment Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Generic Prescription Drugs:	\$5.00 – Retail \$10.00 - Mail	Not Covered
Preferred Brand Prescription Drugs:	\$50.00 – Retail \$100.00 – Mail	Not Covered
All Other Prescription Drugs:	No Copayment Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Not Covered
Out-of-Pocket Maximum Amount:		
Single Coverage:	\$6,350	\$12,700
Two Adult Coverage:	\$12,700	\$25,400
Applicant and Dependent Coverage:	\$12,700	\$25,400
Family Coverage:	\$12,700	\$25,400

BlueSelect PPO Summary of Benefits

Benefit Description	In Network Cost-Sharing	Out of Network Cost-Sharing
Hospital Services		
Room and Board (semi-private) *Pre-Admission Review Required)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Intensive/Progressive Care *Pre-Admission Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Emergency Room	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Outpatient Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Physician Services		
Emergency Room	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Hospital Visit	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Office Visit – Primary Care	Subject to \$45.00 Copayment Amount per visit for first six (6) Primary Care visits per Participant per calendar year. After first six (6) visits, subject to Deductible and Coinsurance Amount of 25% up to Out-of- Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Office Visit – Speciality	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Outpatient Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Preventive Care – Adult	Paid at 100%	Not Covered
Preventive Care – Child	Paid at 100%	Not Covered
Surgery (Inpatient/Outpatient) *Pre-Admission Review Required for Inpatient Hospitalization *Some Surgical Procedures may require Pre-Certification, refer to Section 9: Benefits under SURGERY for details.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Urgent Care Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Other Covered Facility Services		
Ambulatory Surgical Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum

Birthing Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Home Healthcare *Pre-Certification Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Hospice (Inpatient)	Not Covered except when approved by Case Management	Not Covered except when approved by Case Management
Hospice (Outpatient) *Pre-Certification Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Osteopathic Hospital (Inpatient) *Pre-Admission Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Outpatient Facility	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Rehabilitation/Habilitation (Inpatient) *Pre-Admission Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 45 days per calendar year.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 45 days per calendar year.
Rehabilitation/Habilitation (Outpatient)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 20 visits per calendar year.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 20 visits per calendar year.
Skilled Nursing Facility *Pre-Certification Required and subject to approval by Case Benefit Management.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Specialty Facility (Inpatient) *Pre-Admission Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Specialty Facility (Outpatient)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Other Services & Conditions		
Acupuncture	Not Covered	Not Covered
Alternative Medicine	Not Covered	Not Covered
Ambulance	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Anesthesia	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Artificial Conception/Fertilization	Not Covered	Not Covered
Autism	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Autopsies	Not Covered	Not Covered
Biofeedback	Not Covered	Not Covered
Blood Transfusions	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum

Cardiac Rehabilitation	Not Covered	Not Covered
Cleft Lip and Cleft Palate *Pre-Certification Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Consultations	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Contraceptives, Supplies and related services	Generic and Preferred Brand Prescription Drugs are paid at 100%, all other Prescription Drugs subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Not Covered
Convalescent Care	Not Covered	Not Covered
Custodial Care	Not Covered	Not Covered
Dental Services (Pediatric and limited other Benefits) *Some Dental Services require Pre-Certification.	Pediatric Preventive Dental paid at 100%. All other Pediatric Dental and other dental services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Dental Benefits are limited to Dependent Children through the end of the calendar year in which they turn age 19.	Pediatric Preventive Dental paid at 100%. All other subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Dental Benefits are limited to Dependent Children through the end of the calendar year in which they turn age 19.
Diabetes Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Domiciliary Care	Not Covered	Not Covered
Durable Medical Equipment(DME)/Supplies/Prosthetics and Orthotics *Some items require Pre-Certification	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Environmental Medicine	Not Covered	Not Covered
Experimental/Investigational Procedures	Not Covered	Not Covered
Fertility Testing and Treatment (Excludes artificial methods of fertilization)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Foot Care Services (Routine)	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered
Hearing Tests (Only Medically Necessary testing is covered.)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Hemodialysis and Peritoneal Dialysis	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Hypnosis	Not Covered	Not Covered
Laboratory, Pathology, X-Ray, Radiology and MRI	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Learning Disabilities	Not Covered	Not Covered
Mammograms	Preventive paid at 100%. Medically Necessary services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Preventive not covered Out-of-Network. Medically Necessary services subject to Deductible and Coinsurance Amount of 25% up to Out-of-

		Pocket Maximum
Manipulative Services (Limited to 15 Spinal Manipulations per calendar year)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Mastectomy and Reconstructive Surgery *Pre-Certification Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Maternity Care	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Midwife Services (licensed)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Phenylketonuria	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Physical Therapy	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Outpatient services are limited to a maximum of 40 visits per calendar year.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Outpatient services are limited to a maximum of 40 visits per calendar year.
Prescription Drugs	See above under Cost-Sharing Amounts	Not Covered
Private Nursing Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Subluxation	Not Covered	Not Covered
Surgical Sterilization	Female sterilization services paid at 100% Male sterilization services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Female sterilization services not covered Out-of-Network Male sterilization services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Transplants *Pre-Admission Review and Pre-Certification Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum
Temporomandibular Joint Dysfunction (TMJ)	Not Covered	Not Covered
Vision Services (Pediatric) *Some Pediatric Vision Procedures require Pre-Certification,	Pediatric Preventive Vision paid at 100%. All other Pediatric Vision subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Vision Benefits are limited to Dependent Children through the end of the calendar year in which they turn age 19.	Preventive not covered Out-of-Network. All other subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Vision Benefits are limited to Dependent Children through the end of the calendar year in which they turn age 19.
Weight Loss Services	Not Covered	Not Covered
Wigs	Not Covered	Not Covered

Section 9: Benefits (Covered Services)

The following pages describe the various Healthcare Services that Blue Cross Blue Shield of Wyoming covers as Benefits under this Agreement, and to what extent these Benefits are covered.

Benefits are only provided for Healthcare Services related to and required for the treatment of a Participant's Condition.

All Benefits are subject to all other provisions in this Agreement including, but not limited to Section 10: Limitations and Exclusions on Benefits.

A. ACCIDENTS

1. Covered Services

Unexpected traumatic incidents which are identified by time and place of occurrence, identifiable by body member or part of the body affected, and caused by a specific event on a single day will be covered as accidents under this Plan. Examples include a blow or fall, animal bites, allergic reactions to insect bites or medication, or poisoning. Accidental Benefits include:

- a. Medical or surgical treatment by a Healthcare Provider or by a doctor of dental Surgery in connection with treatment for injury to sound, natural teeth.
- b. Confinement and covered care in a Hospital.
- c. Laboratory and x-ray examinations.
- d. Ambulance service.
- e. Any Medically Necessary supply or service.

2. Limitations and Exclusions

- a. Accidents are not the result of either services received (e.g. a massage), physical training (e.g. a strain from an exercise routine), an activity of daily living not resulting from a blow or fall, an intentionally self-inflicted injury (unless the injury is the result of a medical condition [either physical or mental] or the result of domestic violence.)
- b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

B. AMBULANCE SERVICES

1. Covered Services

Ambulance services are covered when the Participant, due to his or her Condition, cannot be safely transported by any other means:

- a. From Participant's home or site of an emergency.
- b. Between Hospitals.
- c. Between a Hospital and Skilled Nursing Facility.

2. Limitations and Exclusions

- a. Air Ambulance is a Covered Service only when terrain, distance, or the Participant's Condition warrants air Ambulance services.
- b. If Participant could have been transported by automobile or public transportation without danger to Participant's health or safety, Ambulance services will not be a Covered Service, even if other means of transportation were not available to the Participant.
- c. Ambulance service provided for the convenience of the Participant or the Participant's family is not a Covered Service. (Example: Transportation of an infant to be closer to the family's home.)
- d. Transportation services, such as private automobile or wheelchair Ambulance charges, which have not specifically been listed as a Benefit are not a Covered Service.
- e. As otherwise limited or excluded by SECTION 10: Limitations and Exclusions on Benefits.

B. ANESTHESIA SERVICES

1. Covered Services

Anesthesia services provided by specially trained Healthcare Providers are Covered Services when Medically Necessary for a covered Surgery. The Maximum Allowable Amount is determined by the type of Surgery and the amount of time necessary for Anesthesia services.

2. Limitations and Exclusions

- a. Hypnosis for Anesthesia purposes is not a Covered Service.
- b. The "Limitations and Exclusions" that apply to SURGERY Benefits also apply to Anesthesia Benefits.
- c. As otherwise limited or excluded by SECTION 10: Limitations and Exclusions on Benefits.

c. **BLOOD EXPENSES**

1. Covered Services

The following blood related services are Covered Services:

- a. Blood transfusions.
- b. Blood, blood plasma and blood derivatives, except when donated or replaced.
- c. The processing, transportation, handling and administration of blood.

2. Limitations and Exclusions

- a. The "Limitations and Exclusions" that apply to SURGERY Benefits also apply to Blood Expense Benefits.
- b. As otherwise limited or excluded by SECTION 10: Limitations and Exclusions on Benefits.

D. CONSULTATIONS

1. Covered Services

a. Physician Consultations

Physician Consultations are Covered Services.

b. Second Surgical Opinions

Physician's services, as well as any charges for tests necessary to receive a second surgical opinion before undergoing any Surgery are Covered Services. If possible, a Participant should provide any medical records and test results created or obtain by Participant's initial treating Physician to the Physician giving the second surgical opinion.

c. Third Surgical Opinions

If the first and second surgical opinions differ, Physician's services, as well as any charges for tests necessary to receive a third surgical opinion before undergoing any Surgery are Covered Services. If possible, a Participant should provide any medical records and test results created or obtain by Participant's first two treating Physicians to the Physician giving the third surgical opinion.

2. Limitations and Exclusions

a. Staff Consultations that are required by rules and regulations of a Hospital are not covered.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions of Benefits.

E. DENTAL SERVICES

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Dental Services or any Medically Necessary Orthodontia Services. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

1. Covered Services

a. Treatment of Condition

Dental services performed for treatment of Conditions related to the teeth or structures supporting the teeth are Covered Services.

b. Accident-Related Dental Expenses

Accident-related dental expenses are Covered Services, but only under the following conditions:

- (1) Services, supplies, and appliances must be required due to an accidental injury.
- (2) Treatment must be for injuries to sound natural teeth.
- (3) Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
- (4) The first services must be performed within ninety (90) days after the accident.
- (5) Related services must be performed within one (1) year after the accident.
- (6) All services must be performed while the Participant's coverage under this Agreement is still in effect.

c. Dental Related Hospital Expenses

(1) Inpatient

If a Participant is hospitalized for one of the following reasons, HOSPITALIZATION Benefits as defined in this Benefit Document will be Covered Services:

- (a) Excision of exostoses of the jaw, hard palate, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a Prosthesis).
- (b) Surgical correction of accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a Prosthesis).
- (c) Treatment of fractures of facial bones.
- (d) Incision and drainage of cellulitis not originating in the teeth or gums.
- (e) Incision of accessory sinuses, salivary glands or ducts.
- (f) Reduction of dislocations of the temporomandibular joints.
- (g) Accidental injury (provided the procedure is not done in preparation for a Prosthesis).
- (h) If a Participant has a hazardous medical condition (such as heart condition) which makes it necessary for the Participant to have an otherwise non-covered dental procedure performed in the Hospital.

Benefits will be provided for general Anesthesia if the hospitalization is covered.

(2) Outpatient

The initial services provided by a Hospital or other facility for any one of the procedures specifically listed above under Dental Related Hospital Expenses - Inpatient Benefits are Covered Services.

e. Dental Related Physician Expenses

Inpatient and Outpatient services provided for the specific procedures listed above under the Dental Related Hospital Expenses - Inpatient Benefits, when provided by a Physician, dentist, or oral surgeon, are Covered Services. The Benefit allowance for Surgery includes payment for pre-operative visits, local infiltration of Anesthesia, and follow-up care.

f. Pediatric Dental Services

See PEDIATRIC DENTAL for coverage.

g. Preventive Care

Pediatric dental screenings as indicated under PREVENTIVE CARE are Covered Services.

2. Limitations and Exclusions

- a. Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances to be appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement or serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
- b. Accidental-related dental expenses for restoring the mouth, tooth, or jaw because of injuries from biting or chewing are not Covered Services.
- c. If, due to a hazardous medical condition (e.g. a heart condition), a Participant must be hospitalized for a non-covered dental procedure, the Participant may receive Benefits for Inpatient Hospital charges as indicated under Covered Services. However, the services provided by the dentist or oral surgeon for these procedures are not Covered Services.
- d. Before dental benefits will be allowed for hazardous medical conditions, the Participant must receive from Blue Cross Blue Shield of Wyoming ***in advance*** of the date the Participant is hospitalized, a written authorization that such services will be Covered Services. A Physician other than a dentist or oral surgeon must certify to Blue Cross Blue Shield of Wyoming that hospitalization is necessary to safeguard the life or health of the Participant. Psychiatric reasons for admissions will not be considered hazardous medical conditions.
- e. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, the Participant must receive from Blue Cross Blue Shield of Wyoming ***in advance*** of the date the Participant is to receive the dental procedure, a written authorization that such services will be Covered Services.
- f. Orthodontic procedures, services and supplies, except as provided in PEDIATRIC DENTAL, are not Covered Services.
- g. Mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible are not Covered Services.
- h. Physician services for dentistry or services related to dental care are not Covered Services.

- i. Dental services not specifically detailed above, or in PEDIATRIC DENTAL are not Covered Services.
- j. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

G. DIABETES SERVICES

1. Covered Services

Diabetes services, including equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin using diabetes, if prescribed by certified, registered or licensed Healthcare Provider with expertise in diabetes and who is legally authorized to prescribe such items under law are Covered Services when provided on an Outpatient basis.

2. Limitations and Exclusions

- a. Inpatient diabetes services are not covered.
- b. Covered Outpatient self-management training and education are limited to a one-time evaluation and training program when Medically Necessary, within one (1) year of diagnosis. Any additional Medically Necessary self-management training shall be provided upon a significant change in symptoms, condition, or treatment. This additional training shall be limited to three (3) hours per year.
- c. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

H. HEMODIALYSIS AND PERITONEAL DIALYSIS

1. Covered Services

a. Hemodialysis

Hemodialysis for the treatment of a kidney disorder by removal of blood impurities with dialysis equipment is a Covered Service when a Healthcare Provider treats a Participant as an Inpatient, in the Outpatient department of a Hospital, or in the Participant's home. Blue Cross Blue Shield of Wyoming will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Healthcare Provider and required for therapeutic use.

b. Peritoneal Dialysis

Peritoneal dialysis as a treatment, where blood impurities are removed by using the lining of the peritoneal cavity as the filter, is a Covered Service when a Healthcare Provider treats a Participant as an Inpatient, in the Outpatient department of a Hospital, or in the Participant's home. Blue Cross Blue Shield of Wyoming will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Healthcare Provider and required for therapeutic use.

2. Limitations and Exclusions

- a. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

I. HOME HEALTHCARE

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Home Healthcare Services. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

1. Conditions That Must Be Met Before Benefits Are Available

To obtain Home Healthcare Benefits, the Participant must meet all of the following conditions:

- a. The Benefit must be Pre-certified.
- b. The need for Home Healthcare must be directly related to the Condition for which the Participant's hospitalization was required.
- c. The Participant would have to be admitted to a Hospital or Skilled Nursing Facility if he or she did not receive Home Healthcare.
- d. The Participant's Home Healthcare is ordered by a Healthcare Provider.
- e. The Participant's Home Healthcare must be provided by a licensed Home Healthcare Agency.
- f. The Participant's Home Healthcare program must begin within fourteen (14) days of Participant's discharge from a Hospital or Skilled Nursing Facility.

2. Covered Services

If the conditions listed above are met, the following Outpatient Home Health Care services are Covered Services:

a. Nursing Care

Part-time or periodic home nursing care by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed public nurse, or licensed vocational nurse under the supervision of a registered nurse.

b. Home Health Aide Care

Part-time or periodic home nursing care by home health aides.

c. Therapy

Physical, occupational, or speech therapy if provided by the Home Healthcare Agency.

d. Medical Supplies

Medical supplies ordered by a Healthcare Provider and provided by the Home Healthcare Agency.

2. Limitations and Exclusions

- a. Pre-Certification is required.
- b. Inpatient Home Healthcare is not a Covered Service.
- c. Custodial care such as the provision of meals, housekeeping or other non-medical assistance or for services provided by a member of the Participant's immediate family or a person ordinarily residing in the Participant's home are not Covered Services.
- d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

J. HOSPICE SERVICES

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Hospice Services. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

1. Conditions That Must Be Met Before Benefits Are Available

To obtain Hospice Services, the Participant must meet all of the following conditions:

- a. The Benefit must be Pre-certified.
- b. The Participant must be diagnosed with a terminal illness for which the attending Physician's prognosis for life expectancy is estimated to be six (6) months or less.
- c. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
- d. The attending Physician must refer the Participant to the program and must be in agreement with the plan for treatment of the Participant's condition.

2. Covered Services

If the conditions listed above are met, the following Outpatient Hospice Services will be Covered Services:

- a. Periodic nursing care by registered or practical nurses.
- b. Home health aides.
- c. Homemaker services.
- d. Physical, occupational and respiratory therapy.
- e. Medical social workers.
- f. Bereavement counseling sessions for covered family members during the twelve (12) months following the death of the terminally ill Participant. Blue Cross Blue Shield of Wyoming will provide benefits up to \$25.00 for each bereavement counseling session for covered family members up to a limit of twelve (12) sessions.

3. Limitations and Exclusions

- a. Inpatient Hospice Benefits are not Covered Services.
- b. Pre-Certification is required.
- c. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

K. HOSPITALIZATION

IMPORTANT NOTICE: If a Physician recommends that a Participant be hospitalized for any non-maternity or non-emergency Condition, Pre-Admission Review by Blue Cross Blue Shield of Wyoming is required before these hospital benefits are payable as a Covered Service to the Participant under this Agreement. Participant must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Pre-admission Review before being admitted as an Inpatient to a Hospital for non-maternity or non-emergency Conditions. The failure to obtain Pre-admission Review may result in a denial or reduction in coverage for this Benefit.

1. Covered Services

a. Room Expenses

Room expenses, including such items as the cost of a room, general nursing services, meal services for the Participant, and routine laundry service are Covered Services.

b. Ancillary Services

Ancillary services that Hospitals bill for and regularly make available to Participants when Covered Services are provided for the treatment of Participant's Condition are Covered Services. Ancillary services include, but are not limited to:

- (1) Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
- (2) Drugs and medicines, biologicals, and pharmaceuticals.
- (3) Dressings and supplies, sterile trays, casts, and splints.
- (4) Diagnostic and therapeutic services.
- (5) Blood administration.
- (6) Intensive and coronary care units.

2. Limitations and Exclusions

- a. Pre-Admission Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospital services. Participant's Inpatient Hospital Benefits will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not obtained. The additional \$200.00/\$500.00 a Participant must pay for failing to obtain a Pre-

admission Review **cannot** be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.

- b. If Participant has a private room in a Hospital, the Maximum Allowable Amount for this HOSPITALIZATION Benefit will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
- c. Hospitalizations, or portions thereof, which do not require twenty-four (24) hour continuous bedside nursing care, or hospitalizations for services which could be safely provided on an Outpatient basis, are not Covered Services.
- d. Benefits will not be provided for services and supplies provided for Participant's personal convenience which are not related to the treatment of the Participant's Condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)
- e. Services or supplies provided by Skilled Nursing Facilities, extended care facilities, or similar facilities are not covered except as expressly provided in this Benefit Document.
- f. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

L. HUMAN ORGAN TRANSPLANTS

IMPORTANT NOTICE: Pre-admission Review and Pre-certification by Blue Cross Blue Shield of Wyoming are required for Human Organ Transplant Benefits. Participant must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Pre-admission Review and at (800) 442-2376 to obtain Pre-certification before receiving Human Organ Transplant services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-admission Review or Pre-certification may result in a denial or reduction in coverage for this Healthcare Service.

1. Covered Services

Human organ transplant services required in connection with the replacement of a diseased human organ by transplantation of a healthy human organ from a donor are a Covered Service under this Agreement. Those transplants covered under this Benefit include, but are not limited to, the following:

- a. Heart Transplants
- b. Liver Transplants
- c. Heart-Lung Transplants
- d. Pancreas Transplants
- e. Kidney Transplants
- f. Corneal Transplants
- g. High dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support.

Where the Participant is the organ recipient, Benefits will be provided for Participant's expenses directly related to the transplant procedure including pre-operative and post-operative care. Benefits will also be provided for surgical costs directly related to the donation of the organ used in a covered organ transplant procedure.

2. Limitations and Exclusions

- a. Pre-Admission Review is required prior to obtaining non-maternity and non-emergency Inpatient Human Organ Transplant services. Participant's Inpatient Human Organ Transplant Benefits will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not

obtained. The additional \$200.00/\$500.00 a Participant must pay for failing to obtain a Pre-admission Review **cannot** be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.

- b. Pre-Certification is required.
- c. Donor expenses are not Covered Services if the donor is a Participant but the recipient is not.
- d. Donor expenses for which Benefits are available from another source are not Covered Services.
- e. The cost of transportation, meals, and lodging related to a Human Organ Transplant are not Covered Services.
- f. Services and supplies for which government funding of any kind is available are not Covered Services.
- g. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

M. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, MAGNETIC RESONANCE SERVICES & RELATED TESTING SERVICES

1. Covered Services

a. Laboratory, Pathology, X-ray, Radiology and Magnetic Resonance Services

Laboratory and pathology, x-ray, radiology and Magnetic Resonance Services provided by a Hospital, Healthcare Provider, independent pathology laboratory, or independent radiology laboratory are Covered Services.

- (1) Laboratory and pathology services include testing procedures required for the diagnosis or treatment of a Condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures which require the use of technical equipment for evaluation of body systems are also allowed as laboratory services. (Examples: electrocardiograms and electroencephalograms).
- (2) X-ray, radiology and Magnetic Resonance Services include services which involve the use of radiology, nuclear medicine, and ultrasound equipment for the purpose of obtaining a visual image of internal body organs or structures, and the interpretation of these images.

b. Pre-Admission Testing

Pre-admission testing ordered by the Participant's surgeon leading up to Surgery is a Covered Service if:

- (1) Proper diagnosis and treatment require the tests;
- (2) An operating room has been reserved before the tests are given; and
- (3) The Surgery actually takes place within seven (7) days after the tests are given.

c. Routine Pap Smears

Routine Pap Smears will be paid as indicated under PREVENTIVE CARE.

2. Limitations and Exclusions

- a. Laboratory, pathology, X-ray, radiology and Magnetic Resonance Services which are not related to Participant's specific Condition are not Covered Services.
- b. Pre-admission testing that is repeated in the Hospital will not be paid as a Covered Service unless Medically Necessary.
- c. Laboratory or X-ray services related to weight loss programs are not Covered Services.
- d. When more than one Magnetic Resonance Services is performed on the same day, payment for the technical component for each Magnetic Resonance Services after the first will be limited to fifty percent (50%) of the Maximum Allowable Amount. The fifty percent (50%) reduction does not apply to any Cost-Sharing Amounts or the Out-of-Pocket Maximum and is the Participant's payment responsibility.
- e. Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.
- f. As otherwise limited or excluded in Section 10: Limitations and Exclusions on Benefits.

N. MATERNITY AND NEWBORN CARE

1. Covered Services

a. Maternity Services

Maternity services required by female Participants for the diagnosis and care of a pregnancy and for delivery services are Covered Services. Maternity services include services related to the following conditions:

- (1) Complications of pregnancy.
- (2) Spontaneous termination of pregnancy prior to full term.
- (3) Ectopic pregnancies.
- (4) Therapeutic or elective termination of pregnancy prior to full term.
- (5) Normal vaginal delivery.
- (6) Caesarean section.

b. Newborn Services

Newborn services include the following:

- (1) Routine nursery charges for a newborn billed by a Hospital.
- (2) Routine care of a newborn billed by a Physician.

c. Hospitalization

Subject to HOSPITALIZATION Benefits, Blue Cross Blue Shield of Wyoming will not restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, nor will Blue Cross Blue Shield of Wyoming require that a Healthcare Provider obtain authorization for prescribing a length of stay not in excess of the above periods.

2. Limitations and Exclusions

- a. Benefits will not be provided for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.
- b. Genetic molecular testing is not a Covered Service except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed. As used herein, "genetic molecular testing"

means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

- c. Newborn services are Covered Services meant to cover **only** the newborn child of the Applicant or Applicant's Dependent Spouse. Where the newborn child is the child of Applicant's Dependent Child, newborn services are not Covered Services.
- d. As otherwise limited and excluded in Section 10: Limitations and Exclusions on Benefits.

O. MEDICAL CARE FOR GENERAL CONDITIONS

IMPORTANT NOTICE: If a Physician recommends that a Participant be hospitalized for any non-maternity or non-emergency Condition, Pre-Admission Review by Blue Cross Blue Shield of Wyoming is required before hospital benefits are payable as a Covered Service to the Participant under this Agreement. Participant must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Pre-admission Review before being admitted as an Inpatient to a Hospital for non-maternity or non-emergency Conditions. The failure to obtain Pre-admission Review may result in a denial or reduction in coverage for this Benefit.

1. Covered Services

Medical Care services rendered by the appropriate Healthcare Provider for the Medically Necessary treatment of a Participant's Condition are Covered Services as follows.

a. Inpatient

Medical Care provided by a Healthcare Provider in a Hospital for:

- (1) A condition requiring only Medical Care, or
- (2) A condition that, during an admission for Surgery, requires Medical Care not normally related to surgical care. This is only payable after approval by Blue Cross Blue Shield of Wyoming's Medical Review Department.

b. Outpatient

Medical Care provided by a Healthcare Provider when required for the treatment of a Participant's specific Condition.

2. Limitations and Exclusions

- a. Pre-Admission Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospitalization Services. Participant's Inpatient Hospitalization will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not obtained. The additional \$200.00/\$500.00 a Participant must pay for failing to obtain a Pre-admission Review **cannot** be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.
- b. Inpatient Medical Care Benefits are limited to one Physician per covered hospitalization unless services performed by other Physicians are CONSULTATION Services as defined in this Benefit Document.

- c. Inpatient Medical Care Benefits are limited to one Medical Care visit per day when charged by the same Physician.
- d. If Participant has a private room in a Hospital, the Maximum Allowable Amount for this HOSPITALIZATION Benefit will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
- e. The first six (6) In-Network Primary Care office visits are subject to a \$45.00 Copayment Amount per visit, per Participant, per calendar year. After the first six (6) In-Network Primary Care visits by the Participant during the calendar year, the visits are subject to the applicable Deductible and Coinsurance Amounts up to the Out-of-Pocket Maximum Amount.
- f. Services related to routine examinations and immunizations (such as yearly physicals or screening examinations for school, camp or other activities) are not Covered Services except as described under PREVENTIVE CARE.
- g. Except as indicated under PREVENTIVE CARE and PEDIATRIC VISION, services for the condition of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia are **not** Covered Services. Benefits will not be provided for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.
- h. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

P. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

1. Covered Services

Mental Health Services and Substance Use Disorder Services for Conditions requiring psychotherapeutic treatment, rehabilitation from a substance use disorder or both are Covered Services.

2. Limitations and Exclusions

- a.** Services must be for the diagnosis and/or treatment of manifest mental disorders. These disorders are described in two publications:
 - (1) The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693).
 - (2) The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
- b.** Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Participant's education or training. (It makes no difference what the diagnosis is or what symptoms may be present.)
- c.** Benefits will not be paid for marital counseling or related services.
- d.** Mental Health Services and Substance Use Disorder Services must be provided by a properly licensed or certified Healthcare Provider.
- e.** Benefits will not be paid for services, supplies, or drugs related to tobacco dependency except as described under PREVENTIVE CARE.
- f.** Services related to the treatment of the family of a person receiving treatment for nicotine, chemical, or alcohol dependence are not covered.
- g.** As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Q. PEDIATRIC DENTAL SERVICES

IMPORTANT NOTE: If the estimated charges for Pediatric Dental Services exceed five hundred dollars (\$500.00), a Pre-certification estimate of charges is required and should be handled as follows:

The dentist should complete a claims form outlining the services to be performed, including the charges to be made, and forward it to Blue Cross Blue Shield of Wyoming at the address shown on the claim form.

After review by Blue Cross Blue Shield of Wyoming, the claim form will be returned to the dentist indicating the coverage available.

When the work is completed the dentist should indicate on the claim form:

- a. The specific service performed.
- b. Identify the tooth, or teeth, involved in the procedure.
- c. The date the specific service was completed.
- d. The actual charges for the service or supply.

The claim form should be forwarded to Blue Cross Blue Shield of Wyoming for processing.

1. Covered Services

The following Pediatric Dental Services are Covered Services for Dependent Children through the end of the calendar year in which they turn age nineteen (19):

a. Preventive and Diagnostic

Except as indicated below, the following preventive and diagnostic pediatric dental services are Covered Services payable at one-hundred percent (100%) of the Maximum Allowable Amount:

- (1) Oral examination (but not more than twice per calendar year).
- (2) Prophylaxis - Teeth cleaning and scaling (but not more than twice per calendar year).
- (3) Bite wing x-rays (but not more than two sets per calendar year).
- (4) Emergency palliative treatment.
- (5) Fluoride treatments.

- (6) Space maintainers.
- (7) Sealant – One (1) per un-restored permanent molar every thirty-six (36) months subject to Cost Sharing Amounts.

b. Restorative Procedures

The following restorative pediatric dental services are Covered Services:

- (1) X-rays as follows:
 - (a) Full mouth x-rays (but not more than one (1) set in thirty-six (36) consecutive months).
 - (b) X-rays required in connection with diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic procedures and treatment.
- (2) Extractions (except extractions for orthodontics).
- (3) Oral Surgery (excluding procedures covered under the Dental Services portion of this Benefit Document).
- (4) Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).
- (5) General Anesthetics.
- (6) Periodontal treatment, diseases of gums.
- (7) Endodontic treatment (Pulp infection and root canal therapy).
- (8) Injection of antibiotic drugs.

c. Prosthodontic Treatment

The following prosthodontic pediatric dental services are Covered Services:

- (1) Initial installation of fixed bridgework.
- (2) Initial installation of partial or full removable dentures.
- (3) Inlays, onlays, crowns.
- (4) Gold fillings.

- (5) Repair or replacement or addition to bridgework, dentures, crowns, inlays including re-cementing where necessary because of:
 - (a) One (1) or more teeth extracted after existing denture or bridgework was installed.
 - (b) Existing denture or bridgework was installed five (5) years prior to its replacement and cannot be made serviceable.
- (6) Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth) when determined to be a dental necessity and Pre-certification is obtained.

d. Treatment in Progress

Benefits are not provided for treatment received prior to the Participant's Effective Date of coverage. If a course of treatment is started prior to, and completed after, the Effective Date of this Pediatric Dental Services Benefit, Blue Cross Blue Shield of Wyoming will reimburse a pro-rated portion of the Maximum Allowable Amount for the Covered Service provided after the Effective Date.

In the event a Participant transfers from the care of one dentist to that of another during the course of treatment, or if more than one dentist provides service for the same dental procedure, Covered Services will be determined and paid as if only one dentist had provided the service.

2. Limitations and Exclusions

- a. Pre-certification for services over \$500.00 is required as described above.
- b. Before benefits will be allowed for hazardous medical conditions, Blue Cross Blue Shield of Wyoming must give written authorization of such Benefits in advance of the date the Participant is hospitalized. A Physician other than a dentist or oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. Psychiatric reasons for admissions will not be considered hazardous medical conditions. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, Benefits will be allowed only if written authorization is given by Blue Cross Blue Shield of Wyoming in advance of the date services are performed.
- c. Often there are several ways to treat a particular dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in decisions about the use of precious metals versus amalgam. Before the alternate procedures provision is used, dental consultants for Blue Cross Blue Shield of Wyoming will review the

claim to verify that an alternate method of treatment would meet professional standards. If so, the payment is based on the less costly procedure if the result meets the accepted standards of dental practice. If the more costly procedure is performed, the Subscriber will be responsible for the excess amount over the benefits allowed for the less costly procedure.

- d. Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
- e. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
- f. Dentures and Bridgework: Benefits will not be provided for replacement of existing dentures or bridgework, except in the following cases:
 - 1. When existing partial dentures, full removable dentures or fixed bridgework cannot be made serviceable and were installed five years before replacement, and/or
 - 2. When replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while individual is covered.
- h. Gold or other precious metals used in restorative or prosthodontic procedures will be payable at the semi-precious allowance.
- i. Replacement of stolen or lost prosthetic devices.
- j. Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.
- k. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.
- l. To be eligible for any Medically Necessary orthodontia Benefits covered under this Plan, the Dependent Child receiving the orthodontia Benefits must have been enrolled in this Plan for an entire and continuous twenty-four (24) month period prior to receiving the Medically Necessary orthodontia Benefits.

- m. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.
 - (1) Extra sets of dentures or other prosthetic devices or appliances.
 - (2) Temporary or treatment dentures.
- n. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

R. PEDIATRIC VISION SERVICES

1. Covered Services

The following Pediatric Vision Services are Covered Services for Dependent Children through the end of the calendar year in which they turn age nineteen (19):

a. Vision Examinations

Benefits will be provided for one (1) vision exam for each Participant per calendar year. **Frames**

Benefits will be provided for one (1) frame for each Participant per calendar year. Covered Services include but are not limited to facial measurements, determination of interpupillary distances, and assistance in frame selection, fitting and adjustment.

b. Lenses

Benefits will be provided for one (1) pair of lenses for each Participant per calendar year, providing there were no Benefits paid for contact lenses during the same calendar year.

c. Contact Lenses

Contact lenses are covered as a substitute for conventional lenses and frames as indicated above. Benefits will be provided for contact lenses for each Participant per calendar year, providing there were no Benefits paid for contact lenses during the same calendar year.

2. Limitations and Exclusions

a. Services for the conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia, and presbyopia will be covered only as described under Covered Services above. In addition, benefits for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, the servicing of corrective lenses, and consultations related to such services will also be limited only to those Benefits, if any, described above.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

S. PHENYLKETONURIA

1. Covered Services

The equipment, supplies and Outpatient self-management training and education, including medical nutrition therapy for the treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids, as prescribed by a Healthcare Provider, are Covered Services.

Inherited Enzymatic Disorders include, but are not limited to, phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic academia and propionic academia.

2. Limitations and Exclusions

- a. Outpatient self-management training and education must be provided by a certified, registered or licensed Healthcare Provider with expertise in Inherited Enzymatic Disorders.
- b. Outpatient self-management training and education is limited to:
 - (1) A one (1) time evaluation and training program when Medically Necessary, within one (1) year of diagnosis;
 - (2) Additional Medically Necessary self-management training shall only be provided upon a significant change in symptoms, condition or treatment.

T. PRESCRIPTION DRUGS

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for high cost Prescription Drugs. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification ***before*** receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

1. Covered Services

Prescription Drugs are covered under this BlueSelect PPO Plan when purchased from a Pharmacy participating in the BlueSelect Network ("BlueSelect Pharmacy"). When a Participant needs a prescription filled, the Participant should go to a BlueSelect Pharmacy and present his or her BlueSelect PPO Identification Card. The BlueSelect Pharmacy will only charge the Participant for the Cost-Sharing Amounts as shown below.

a. When Purchased at a Retail BlueSelect Pharmacy

Tier 1 Drugs: Covered Generic Drugs require a \$5.00 Copayment Amount for each thirty (30) day supply of the Generic Drugs purchased (when taken in the quantity prescribed).

Tier 2 Drugs: Covered Formulary* (Preferred) Brand Drugs require a \$50.00 Copayment Amount for each thirty (30) day supply of the Formulary* (Preferred) Brand Drugs purchased (when taken in the quantity prescribed).

Tier 3 Drugs: Covered Non-Formulary* (Non-Preferred) Brand Drugs are subject to the Participant's Deductible and Coinsurance Amounts.

Participants may not purchase more than a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed).

b. When Purchased by Mail through a BlueSelect Pharmacy

Tier 1 Drugs: Covered Generic Drugs require a \$10.00 Copayment Amount for each ninety (90) day supply of the Generic Drugs purchased (when taken in the quantity prescribed).

Tier 2 Drugs: Covered Formulary* (Preferred) Brand Drugs require a \$100.00 Copayment Amount for each ninety (90) day supply of the Formulary* (Preferred) Brand Drugs purchased (when taken in the quantity prescribed).

Tier 3 Drugs: Covered Non-Formulary* (Non-Preferred) Brand Drugs are subject to the Participant's Deductible and Coinsurance Amounts.

Participants may not purchase more than a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed).

c. When Specialty Drugs are Purchased Through Prime Specialty Pharmacy

Specialty Medications are generally prescribed for people with complex or ongoing Conditions and have one or more of the following characteristics: (i) they may be injected or infused; (ii) they have unique storage or shipping requirements; (iii) additional education and support is required from a Healthcare Provider; (iv) they are usually not stocked at retail pharmacies.

Specialty Medications are only a Covered Service when the prescriptions are filled through Prime Specialty Pharmacy, when available. A small number of limited distribution drugs may not be available at Prime Specialty Pharmacy. In this instance, Blue Cross Blue Shield of Wyoming will make accommodations for prescription fulfillment at an alternative pharmacy that carries the limited distribution drug.

Specialty medication prescriptions can be filled through Prime Specialty Pharmacy by calling (800) 627-6337.

Tier 1 Drugs: Covered Generic Specialty Medications require a \$5.00 Copayment Amount for each thirty (30) day supply of the Generic Specialty Medication purchased (when taken in the quantity prescribed).

Tier 2 Drugs: Covered Formulary* (Preferred) Brand Specialty Medications require a \$50.00 Copayment Amount for each thirty (30) day supply of the Formulary* (Preferred) Brand Specialty Medication purchased (when taken in the quantity prescribed).

Tier 3 Drugs: Covered Non-Formulary* (Non-Preferred) Brand Specialty Medications are subject to the Participant's Deductible and Coinsurance Amounts.

Participants may not purchase more than a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed).

For a current list of Specialty Medications, go to:
<https://www.bcbswy.com/specialtydruglist>.

NOTE: *Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. The Formulary's (Preferred Drug List's) name is "BCBSWY BlueSelect." Formulary exceptions and Copayment tier exception requests are not allowed.

2. Limitations and Exclusions

- a. **Prescription Drugs purchased from a Pharmacy that is not in the BlueSelect PPO Network are not Covered Services under this Agreement. Payment for Prescription Drugs from a Pharmacy not participating in the BlueSelect PPO Network will be the sole responsibility of the Applicant/Participant.**
- b. **Specialty Medications purchased from a Pharmacy other than Prime Specialty Pharmacy (unless the medication is not available through Prime Specialty Pharmacy) are not Covered Services under this Agreement.**
- c. Prescription Drug and Specialty Medication Benefits may be subject to Utilization Management. Utilization Management policies, in collaboration with Prime Therapeutics, are used by Blue Cross Blue Shield of Wyoming to manage the clinical appropriateness and the cost of healthcare decision-making. These Utilization Management policies are applied prior the delivery of the Prescription Drug or Specialty Medication to the Participant and decisions are made on a case-by-case assessment of appropriateness. The following Utilization Management policies are in effect:
 - (1) **Prior Authorization**
Prescription Drugs and Specialty Medications are selected for Prior Authorization because of actual or potential misuse or overuse that may be of clinical and/or economic concern. Prescription Drugs and Specialty Medications selected for Prior Authorization require that specific clinical criteria be met before the drugs will be a Covered Service. Clinical criteria are based on product labeling, clinical studies and clinical practice standards. The lists of Prescription Drugs and Specialty Medications that require Prior Authorization are published on Blue Cross Blue Shield of Wyoming's Preferred Drug List found on www.wyomingblue.com.

(2) Quantity Level Limits

The Quality Level Limits program limits certain Prescription Drugs and Specialty Medications to a maximum number (or amount) within a certain time period. These limits are in place to encourage appropriate prescribing quantities and are typically based on the Federal Drug Administration's approved product labeling.

(3) Step Therapy

Step Therapy programs are focused on the use of cost-effective Prescription Drugs and Specialty Medications as first-line treatment when they are clinically appropriate based on current medical guidelines and best practice standards. First-line Prescription Drugs and Specialty Medications are usually Generic Drugs. Most costly Prescription Drugs and Specialty Medications are covered for Participants who have tried and failed a first-line Prescription Drug or Specialty Medication. The lists of Prescription Drug and Specialty Medication categories subject to Step Therapy are published on Blue Cross Blue Shield of Wyoming's website at www.wyomingblue.com.

- d. If the Participant chooses a Formulary* (Preferred) or Non-Formulary* (Non-Preferred) Brand Drug or Specialty Medication (Tier 2 or Tier 3) when a Generic Drug or Generic Specialty Medication is available and authorized by the Healthcare Provider, the Participant must pay the appropriate Cost-Sharing Amounts for the Formulary* (Preferred) or Non-Formulary* (Non-Preferred) Brand Drug or Specialty Medication selected, as well as the difference in cost between the Formulary* (Preferred) or Non-Formulary* (Non-Preferred) Brand Drug or Specialty Medication and the Generic Drug or Generic Specialty Medication. When the Out-of-Pocket Maximum has been reached, the Participant still pays the difference in cost between the Formulary* (Preferred) or Non-Formulary* (Non-Preferred) Brand Drug or Specialty Medication and the Generic Drug or Generic Specialty Medication, even though the Participant is no longer responsible for Cost-Sharing Amounts.
- e. Drugs that can be purchased without a written prescription, even if the Healthcare Provider has prescribed such "over-the-counter" medications are not Covered Services, except as described under PREVENTIVE CARE.
- f. Drugs and medicines which are provided as "take-home supply" by a Hospital are not Covered Services.

- g. Prescription Drugs related to weight loss programs are not Covered Services.
- h. Prescription Drugs related to hair loss are not Covered Services.
- i. Prescription Drugs related to tobacco dependency are not Covered Services, except as described under PREVENTIVE CARE.
- j. Prescription Drugs used for cosmetic purposes are not Covered Services.
- k. Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not a Covered Service.
- l. Blue Cross Blue Shield of Wyoming may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain covered Prescription Drugs. Such discounts are the sole property of Blue Cross Blue Shield of Wyoming and will not be considered in calculating any Participant's Cost-Sharing Amounts. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the BlueSelect PPO Network program.
- m. As otherwise limited and excluded in Section 10: Limitations and Exclusions on Benefits.

U. PREVENTIVE CARE

1. Covered Services

Preventive Care includes the preventive health services recommended by:

- a. United States Preventive Services Task Force (USPSTF) recommendations - Grade A and B only.
- b. Center for Disease Control and Prevention's (CDC) and Prevention's Advisory Committee on Immunization Practices' (ACIP) recommendations for immunizations.
- c. Health Resources and Services Administrations' (HRSA) recommendations for children and women preventive care and screenings.

Preventive Care also includes the following testing procedures:

- a. Testing procedures and examinations for cervical cancer and diabetes.
- b. Testing procedures and examinations for Applicant and Applicant's covered Spouse for breast cancer and/or prostate cancer.

When Preventive Care is provided by a BlueSelect Provider or by a licensed health fair, Preventive Care Covered Services will be provided at one-hundred percent (100%) of the Maximum Allowable Amount, without regard to any Cost-Sharing Amounts that might otherwise apply.

2. Limitations and Exclusions

- a. Preventive Care provided by Healthcare Providers who are not BlueSelect Providers will not be Preventive Care Covered Services under this Agreement and will only be Covered Services if the Healthcare Services provided by the Healthcare Provider fall under another covered Benefit in this Benefit Document. Any such Covered Services will be subject to Participant's Cost-Sharing Amounts and those additional amounts Participant is responsible for when receiving services from a Healthcare Provider not participating in the BlueSelect PPO Network as described in Section 7: The BlueSelect PPO Network.
- b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

V. PRIVATE DUTY NURSING SERVICES

1. Covered Services

Inpatient Private Duty Nursing Services are Covered Services only when:

- a. The Participant's Condition would ordinarily require that the Participant be placed in an intensive or coronary care unit, but the Hospital does not have such facilities; or
- b. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Participant's Condition; and
- c. The private duty nurse is not employed by the Hospital or Healthcare Provider and is not a resident of the household or a relative of the Participant.

2. Limitations and Exclusions

- a. Outpatient Private Duty Nursing Services are not Covered Services.
- b. Benefits will not be provided for nursing services which ordinarily would be provided by Hospital staff or its intensive care or coronary care units.
- c. Benefits will not be provided for services which are requested by or for the convenience of the Participant or the Participant's family and which do not require the training, judgment, or technical skills of a nurse, whether or not another person is available to perform such services. (Examples: bathing, feeding, exercising, homemaking, moving the Participant, giving medication, or acting as a companion or sitter.)
- d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

W. REHABILITATIVE AND HABILITATIVE SERVICES

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Rehabilitative and Habilitative Services. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

1. Covered Services

a. Rehabilitative Services

Healthcare Services primarily for the purpose of therapeutic or rehabilitative treatment of the Participant (such as physical, occupational, speech, or oxygen therapy, etc.) are Covered Services.

b. Habilitative Services

Healthcare Services primarily for the purpose of therapeutic or habilitative treatment of the Participant for Conditions which have limited the normal age appropriate motor, sensory or communications development of the Participant are Covered Services if through the Habilitative Services, functional improvement and measureable progress is made toward achieving functional goals within a predictable period of time to reach the Participant's maximum potential development.

2. Limitations and Exclusions

- a. Inpatient Rehabilitative Benefits are limited to a maximum of forty-five (45) days per calendar year per Participant. Outpatient Rehabilitative Benefits are limited to a maximum of twenty (20) visits per calendar year per Participant.
- b. Inpatient Habilitative Benefits are limited to a maximum of forty-five (45) days per calendar year per Participant. Outpatient Habilitative Benefits are limited to a maximum of twenty (20) visits per calendar year per Participant.
- c. Rehabilitative Benefits are only provided for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.
- d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

X. SUPPLIES, EQUIPMENT AND APPLIANCES

1. Covered Services

a. Durable Medical Equipment

The rental or the purchase of durable medical equipment, whichever is less expensive, is a Covered Service. When a purchase is authorized, Benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment.

b. Medical Supplies

Medical Supplies including, but not limited to, the following are Covered Services:

- (1) Colostomy bags and other supplies for their use.
- (2) Catheters.
- (3) Dressings for cancer, diabetic and decubitus ulcers and burns.
- (4) Syringes and needles for administering covered drugs, medicines, or insulin.

c. Prosthesis and Orthopedic Appliances

The following Prosthesis and Orthopedic Appliances are Covered Services, as well as fitting, adjusting, repairing, and replacement of an appliance due to wear, or a change in the Participant's condition which makes a new appliance necessary:

- (1) Artificial arms or legs.
- (2) Leg braces, including attached shoes.
- (3) Arm and back braces.
- (4) Cervical collars.
- (5) Surgical implants.
- (6) Artificial eyes.
- (7) Pacemakers.
- (8) Breast prosthesis and special bras.

d. Prescription Glasses/Lenses

One set of prescription glasses, intraocular lenses or contact lenses is covered when necessary to replace the human lens lost through intraocular Surgery or ocular injury. Replacement is covered if the Participant's Physician recommends a change in prescription.

e. Oxygen

Oxygen and the equipment needed to administer it are Covered Services.

f. Breast pumps

Breast pumps as indicated under PREVENTIVE CARE are Covered Services. **Pre-Certification is required for any Hospital-grade breast pumps.**

2. Limitations and Exclusions

- a. If the supply, equipment, or appliance which the Participant orders includes more features than are warranted for the Participant's Condition, Blue Cross Blue Shield of Wyoming will allow only up to the Maximum Allowable Amount for the item that would have met the Participant's medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars.")
- b. Deluxe equipment is covered only when additional features are required for effective medical treatment, or to allow the Participant to operate the equipment without assistance.
- c. Durable Medical Equipment such as air conditioners, purifiers, humidifiers, dehumidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical condition.
- d. Hearing aids and related services and supplies are not Covered Services.
- e. Benefits will not be provided for Hospital beds (including waterbeds or other floatation mattresses).
- f. Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics.)
- g. Benefits will not be provided for special braces or special equipment.

- h. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Y. **SURGERY**

IMPORTANT NOTICE: If a Physician recommends that a Participant be hospitalized for any non-maternity or non-emergency Condition, Pre-Admission Review by Blue Cross Blue Shield of Wyoming is required before hospital benefits are payable as a Covered Service to the Participant under this Agreement. Participant must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Pre-admission Review *before* being admitted as an Inpatient to a Hospital for non-maternity or non-emergency Conditions. The failure to obtain Pre-admission Review may result in a denial or reduction in coverage for this Benefit.

1. Covered Services

a. General Surgical Treatment

Surgery for the treatment of diseases or injuries, including specialized instrumentations, endoscopic examinations and other invasive procedures, the correction of fractures and dislocations, usual and related pre-operative and post-operative care are Covered Services.

b. Obesity and Weight Loss

Surgery for obesity will be a Covered Service only when required due to morbid obesity. Benefits will only be paid when:

The participant meets the current NIH (National Institutes of Health) surgical criteria.**IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Surgery for obesity. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification *before* receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.**

c. Orthognathic Surgery

Orthognathic Surgery will be a Covered Service only where Participant has a congenital defect or restoration due to accidental injury as follows:

- (1) Upper or lower jaw augmentation or reduction procedures.
- (2) Reconstructive procedures which correct deformities of the jaw.

- (3) Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and re-contouring of the facial bones).

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Orthognathic Surgery. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

d. Reconstructive Surgery

Reconstructive Surgery is a Covered Service only where Participant's Surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Coverage for any reconstructive Surgery will only be provided for the diseased body part except that any Participant who receives Benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

- (1) Reconstruction of the breast on which the mastectomy has been performed.
- (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- (3) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

IMPORTANT NOTE: Pre-certification by Blue Cross Blue Shield of Wyoming is required for Reconstructive Surgery. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification before receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service.

e. Sterilization Procedures

Sterilization procedures and related expenses are Covered Services. See section on PREVENTIVE CARE for certain Sterilization Procedures

covered at one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services without regard to Participant's Cost-Sharing Amounts that might otherwise apply.

2. Limitations and Exclusions

- a. Pre-Admission Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospitalization Services. Participant's Inpatient Hospitalization will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not obtained. The additional \$200.00/\$500.00 a Participant must pay for failing to obtain a Pre-admission Review cannot be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.
- b. More than one Surgery performed by the same Physician during the course of only one (1) operative period is called a "multiple Surgery." Since allowances for Surgery include Benefits for pre- and post-surgical care, total Benefits for multiple surgeries are reduced as pre- and post-Surgery allowances do not duplicate those of the primary Surgery. The reduced Benefit varies, depending upon the circumstances of the multiple surgeries.
- c. Surgical Assistant Benefits are available only for surgical procedures which are of such complexity that they require a Surgical Assistant as specified in the Medicare Correct Coding Initiative. When available, Benefits for Surgical Assistant services performed by another Physician will be based on twenty percent (20%) of the Surgery allowance. Benefits for Covered Services performed by a Healthcare Provider other than another Physician will be based on ten percent (10%) of the Surgery allowance.
- d. Cosmetic Surgery for purposes of beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic is not a Covered Service. Cosmetic Surgery does not become reconstructive Surgery because of psychiatric or psychological reasons.
- e. The number of gastric bypass procedures covered under this Benefit Document is limited to a lifetime maximum of one (1) per Participant.
- f. Reversals of sterilization procedures are not Covered Services.
- g. Sex change operations and related expenses are not Covered Services.

- h. Incidental procedures which are routinely performed during the course of the primary Surgery are not Covered Services.
- i. For a description of benefits allowed for dental Surgery, see section on DENTAL SERVICES.
- j. For a description of benefits related to Human Organ Transplants see section on HUMAN ORGAN TRANSPLANTS.
- k. For a description of benefits related to Participant's Hospitalization for a Surgery, see section on HOSPITALIZATION.
- l. As otherwise limited by Section 10: Limitations and Exclusions on Benefits.

Z. THERAPY (CHEMOTHERAPY, RADIATION, OCCUPATIONAL, PHYSICAL, SPEECH)

1. Covered Services

a. Hospital

The following therapies are Covered Services when performed in a Hospital:

- (1) Chemotherapy.
- (2) Radiation therapy.
- (3) Physical therapy.
- (4) Respiratory therapy.

b. Healthcare Provider

The following therapies are Covered Services when provided and/or prescribed by a Healthcare Provider:

- (1) Inpatient
 - (a) Chemotherapy.
 - (b) Radiation therapy.
 - (c) Respiratory therapy.
- (2) Outpatient
 - (a) Chemotherapy (drug and administration charges).
 - (b) Radiation therapy.
 - (c) Physical therapy provided by a Physician or by a registered physical therapist
 - (d) Respiratory therapy.

2. Limitations and Exclusions

- a. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year.
- b. Spinal manipulations are limited to fifteen (15) visits per Participant per calendar year.
- c. Benefits will not be provided for occupational or speech therapy services (except as described under the section on REHABILITATION and HABILITATION).

- d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

SECTION 10: Limitations and Exclusions on Benefits

The limitations and exclusions listed in this section apply to all Covered Services described in this Benefit Document. Benefits will not be provided for any of the following Healthcare Services, supplies, situations, hospitalizations or related expenses, or will be limited as specifically indicated below:

A. ACUPUNCTURE

Services related to acupuncture, whether for medical or Anesthesia purposes, are not Covered Services.

B. ALTERNATIVE MEDICINE

Treatments and services for alternative medicine are not Covered Services under this Benefit Document. Alternative medical therapies include, but are not limited to: interventions, services or procedures not commonly accepted as part of allopathic or osteopathic curriculums and practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, massage therapy, and aromatherapy.

C. ARTIFICIAL CONCEPTION

Artificial insemination, "test tube" fertilization or other artificial methods of conception are not Covered Services.

D. AUTOPSIES

Services related to autopsies are not Covered Services.

E. BIOFEEDBACK

Services related to biofeedback are not Covered Services.

F. CARDIAC REHABILITATION

Services designed to assist Participants recovering from recent heart problems are not Covered Services.

G. CLINICAL TRIALS

Benefits for approved clinical trials are only Covered Services to the extent required by Federal and State law. Approved clinical trials are defined as Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or other life-threatening diseases. A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

H. COMPLICATIONS OF NON-COVERED SERVICES

Services or supplies that a Participant receives for complications resulting from services that are not allowed (such as non-covered cosmetic Surgery and experimental procedures) are not Covered Services.

I. CONVALESCENT CARE

Benefits for convalescent care provided during the period of recovery from illness or the effects of injury and Surgery are limited to those Medically Necessary Covered Services normally received for a specific Condition.

J. COSMETIC SURGERY/RECONSTRUCTIVE SURGERY

Cosmetic Surgery for beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic are not Covered Services and do not become reconstructive Surgery because of Participant's psychiatric or psychological reasons.

Benefits for a cosmetic Surgery procedure and related expenses are allowed only when reconstructive Surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive Surgery will only be provided for the diseased body part except as noted below. Pre-certification is required before Benefits for cosmetic Surgery are payable.

NOTE: Any Participant who receives Benefits in connection with a mastectomy and who elects breast reconstruction Surgery in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

K. CUSTODIAL CARE

Services furnished to help a Participant in the activities of daily living which do not require the continuing attention of skilled medical or paramedical personnel are not Covered Services regardless of where they are furnished.

L. DIAGNOSTIC ADMISSIONS

If a Participant is admitted as an Inpatient to a Hospital for Diagnostic Services, and could have received these services as an Outpatient without danger to his or her health, benefits will not be provided for Hospital room charges or other charges that would not be paid if the Participant had received Diagnostic Services as an Outpatient.

M. DOMICILIARY CARE

This type of care is provided in a residential institution, treatment center, or school because a Participant's own home arrangement is not appropriate. Such care consists chiefly of room and board and is not a Covered Service, even if therapy is included.

N. EDUCATIONAL PROGRAMS

Educational, vocational, or training services and supplies are not Covered Services except as explicitly described in this Benefit Document.

O. ENVIRONMENTAL MEDICINE AND CLINICAL ECOLOGY

Treatment and services for environmental medicine and clinical ecology are not Covered Services under this Benefit Document. Environmental medicine and clinical ecology encompass the diagnosis or treatment of environmental illness, including, but not limited to: chemical sensitivity or toxicity from past or continued exposure to atmospheric contaminants, pesticides, herbicides, fungi, molds, or foods exposed to atmospheric or environmental contaminants.

P. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Except as explicitly described in this Benefit Document, procedures which are experimental or investigational in nature are not Covered Services.

Q. EYE CARE

Except as indicated under PREVENTIVE CARE and PEDIATRIC VISION, there are no Covered Services for the conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

R. FOOT CARE SERVICES

Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not Covered Services.

S. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Except as indicated under PREVENTIVE CARE, Genetic Molecular Testing is not a Covered Service except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed. As used herein, "genetic molecular testing" means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

T. GOVERNMENT INSTITUTIONS AND FACILITIES

Services and supplies furnished by a facility operated by, for, or at the expense of a federal, state, or local government or their agencies are not Covered Services except as required by the federal, state, or local government. Benefits shall not be excluded when provided by, and when charges are made for such services by, a Wyoming tax-

supported institution, providing the institution establishes and actively utilizes appropriate professional standard review organizations according to Section 35-17-101, Wyoming Statutes, 1977, as amended, or comparable peer review programs, and the operation of the institution is subject to review according to Federal and State laws.

U. HAIR LOSS

Wigs or artificial hairpieces, or hair transplants or implants, regardless of whether there is a medical reason for hair loss, are not Covered Services.

V. HOSPITALIZATIONS

Hospitalizations, or portions thereof, which do not require twenty-four (24) hour continuous bedside nursing care, or hospitalizations for services which could be safely provided on an Outpatient basis, are not Covered Services.

W. HYPNOSIS

Services related to hypnosis, whether for medical or anesthesia purposes, are not Covered Services.

X. LEARNING DISABILITIES

Treatment for the reduction or elimination of learning disabilities is not Covered Services.

Y. LEGAL PAYMENT OBLIGATIONS

Services for which legally a Participant does not have to pay, or charges that are made only because benefits are available under this Benefit Document are not Covered Services except as required by the federal, state, or local law. This includes services provided by any person related to the Participant or residing in the Participant's household.

Z. MEDICAL SERVICES RECEIVED AS A RESULT OF CONTRACTUAL OBLIGATIONS OR A THIRD PARTY'S GUARANTEE TO PAY

Benefits will not be paid for any claims related to medical services or supplies that a Participant receives in relation to a third party's offer of any form of compensation or promise to pay any part or all of the costs of the medical services or supplies, as an inducement for the Participant to seek, request, undergo or otherwise receive those medical services or supplies. This exclusion includes, but is not limited to, surrogate parenting, donation of body parts or organs, testing of medical procedures or supplies, gestational carrier services, pharmaceutical product testing and trials, and similar arrangements and agreements wherein the Participant receives compensation, directly or indirectly, in cash or any other form of consideration (including a promise to pay any part or all of the costs of such medical services or supplies), in exchange for the Participant's agreement to seek or receive such medical services or supplies.

AA. MISSED APPOINTMENTS

Charges for missed appointments are not Covered Services.

BB. NON-MEDICALLY NECESSARY SERVICES OR SUPPLIES

No Benefits will be provided for services or supplies that are not Medically Necessary.

CC. OBESITY AND WEIGHT LOSS

Benefits are not allowed for the evaluation and treatment of obesity alone. The only situation under which Benefits will be allowed for obesity is when a surgical procedure is required due to morbid obesity. Benefits will only be paid when:

The participant meets the current NIH (National Institutes of Health) surgical criteria.

DD. ORTHOGNATHIC SURGERY

The following types of procedures are not covered except in the case of a congenital defect or restoration due to accidental injury:

1. Upper or lower jaw augmentation or reduction procedures;
2. Reconstructive procedures which correct deformities of the jaw;
3. Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and re-contouring of the facial bones).

Pre-certification by Blue Cross Blue Shield of Wyoming is required before benefits will be paid.

EE. PERSONAL COMFORT OR CONVENIENCE

Services and supplies that are primarily for the Participant's personal comfort or convenience are not Covered Services.

FF. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Services rendered by a physician's assistant or nurse practitioner when the sponsoring Physician sees the patient or becomes directly involved in the medical service being provided are not Covered Services. (A sponsoring Physician is a licensed Physician approved to sponsor a physician assistant by the State Board of Medical Examiners.)

GG. PRE-ADMISSION REVIEW

Pre-Admission Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospitalization Services. Participant must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Pre-admission Review. Participant's Inpatient Hospitalization will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not obtained. The additional \$200.00/\$500.00 a Participant must pay for

failing to obtain a Pre-admission Review cannot be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.

HH. PRE-CERTIFICATION

Certain Covered Services require Pre-certification by Blue Cross Blue Shield of Wyoming. A Participant must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Pre-certification *before* receiving these Healthcare Services. Pre-certification may include the required use of designated Healthcare Providers who have demonstrated high quality, cost efficient care. The failure to obtain Pre-certification may result in a denial or reduction in coverage for the Healthcare Service. A list of Covered Services requiring Pre-Certification can be found at <https://www.bcbswy.com/precertification>.

II. PROPHYLAXIS/PROPHYLACTIC MEDICINE

Except as explicitly allowed as a Covered Service in this Benefit Document, Healthcare Services and supplies that are of a preventive or prophylactic nature are not Covered Services. Preventive or prophylactic treatments and services are those which are rendered to a person for purposes other than treating a present and existing Condition in that person including, but not limited to, immunizations or Surgery on otherwise healthy body organs and/or parts.

JJ. REPORT PREPARATION

Charges for preparing medical reports or itemized bills or claim forms are not Covered Services.

KK. ROUTINE HEARING EXAMINATIONS

Except as indicated under PREVENTIVE CARE, services will not be covered for the testing of hearing acuity. Services will not be covered for the prescription or fitting of a hearing aid.

LL. SERVICES AFTER COVERAGE ENDS

No Benefits are provided after this Agreement is terminated. (EXAMPLE: If the Participant is hospitalized on July 30th and had terminated coverage effective August 1st, no Benefits are provided for any services received on or after August 1st.).

MM. SERVICES NOT IDENTIFIED

Any Healthcare Service or supply not specifically identified as a Benefit in this Benefit Document is not a Covered Service.

NN. SERVICES PRIOR TO THE EFFECTIVE DATE

Charges incurred for supplies and services received prior to the Effective Date of coverage are not Covered Services.

OO. SEX CHANGE OPERATIONS

Services related to sex change operations and reversals of such procedures are not Covered Services.

PP. SUBLUXATION

Services for the detection and correction by manual or mechanical means (including incidental X-rays) of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column, unless requiring Surgery, are not Covered Services.

QQ. SUBROGATION

If another person or entity, through an act or omission, has caused a Participant to suffer a Condition, and if Blue Cross Blue Shield of Wyoming has paid Benefits for that Condition, the Participant agrees that Blue Cross Blue Shield of Wyoming shall be subrogated and succeed to any of Participant's rights of recovery for expenses incurred against such person or entity. In addition, if a Participant is injured and no other person or entity is responsible but Participant receives, or is entitled to receive, a recovery from any other source, and if Blue Cross Blue Shield of Wyoming has paid Benefits for that injury, the Participant agrees that Blue Cross Blue Shield of Wyoming shall be subrogated and succeed to any of Participant's rights of recovery for expenses incurred. Blue Cross Blue Shield of Wyoming's subrogation rights are as follows:

1. All recoveries the Participant obtains (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse Blue Cross Blue Shield of Wyoming in full for benefits Blue Cross Blue Shield of Wyoming has paid to or on behalf of the Participant. Blue Cross Blue Shield of Wyoming's share of any recovery extends only to the amount of Benefits Blue Cross Blue Shield of Wyoming has paid or will pay to or on behalf of the Participant or Participant's heirs, administrators, legal representatives, parents (if Participant is a minor), successors, or assignees. This is Blue Cross Blue Shield of Wyoming's right of recovery.
2. Blue Cross Blue Shield of Wyoming is entitled under its right of recovery to be reimbursed for the Benefit payments it has made to or on behalf of the Participant even if the Participant has not been "made whole" for all of his or her damages in the recoveries that the Participant has received. Blue Cross Blue Shield of Wyoming's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3. Blue Cross Blue Shield of Wyoming will not reduce its share of any recovery unless, in the exercise of its discretion, it agrees in writing to a reduction (a) because the Participant did not receive the full amount of damages that Participant claimed or (b) because the Participant had to pay attorneys' fees.
4. The Participant must cooperate in doing what is reasonably necessary to assist Blue Cross Blue Shield of Wyoming with its right of recovery. The

Participant must not take any action that may prejudice Blue Cross Blue Shield of Wyoming's right of recovery.

5. If the Participant does not seek damages for his or her Condition, the Participant must permit Blue Cross Blue Shield of Wyoming to initiate recovery on Participant's half (including the right to bring suit in Participant's name). This is called subrogation.

If Participant does seek damages for his/her Condition, the Participant must inform Blue Cross Blue Shield of Wyoming promptly that the Participant has made a claim against another party for a Condition that Blue Cross Blue Shield of Wyoming has paid or may pay Benefits. Participant must also seek recovery for Blue Cross Blue Shield of Wyoming's Benefit payments and liabilities, and the Participant must tell Blue Cross Blue Shield of Wyoming about any recoveries the Participant obtains, whether in or out of court. Blue Cross Blue Shield of Wyoming may seek a first priority lien on the proceeds of the Participant's claim in order to reimburse itself to the full amount of Benefits it has paid or will pay.

Blue Cross Blue Shield of Wyoming may request that the Participant sign a reimbursement agreement and/or assign to Blue Cross Blue Shield of Wyoming (a) Participant's right to bring an action, or (b) Participant's right to the proceeds of a claim for Participant's Condition. Blue Cross Blue Shield of Wyoming may delay processing of a Participant's Claim for Benefits until Participant provides the signed reimbursement agreement and/or assignment, and Blue Cross Blue Shield of Wyoming may enforce its right of recovery by offsetting future Benefits.

NOTE: Blue Cross Blue Shield of Wyoming will pay the costs of any Covered Services the Participant receives that are in excess of any recoveries made.

Among the other situations covered by this provision, the circumstances in which Blue Cross Blue Shield of Wyoming may subrogate or assert a right of recovery shall also include:

1. When a third party injures the Participant, for example, in an automobile accident or through medical malpractice.
2. When the Participant is injured on a premises owned by a third party.
3. When the Participant is injured and Benefits are available to Participant or Participant's dependents, under any law or under any type of insurance, including, but not limited to:
 - a. No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by the Participant to treat those benefits as secondary to this Plan.

- b. Uninsured and underinsured motorist coverage.
- c. Workers' Compensation benefits.
- d. Medical reimbursement coverage.

RR. TAXES

Income, sales, service, mailing charges or other taxes imposed by law that apply to Benefits covered under this Benefit Document are not Covered Services.

SS. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Except as explicitly allowed as a Covered Service in this Benefit Document, Benefits are not provided for the treatment of temporomandibular joint disorders and myofascial pain-dysfunction syndrome.

TT. THERAPIES

Except as explicitly allowed as a Covered Service in this Benefit Document, special therapies are not Covered Services. Such non-covered services include (but are not limited to): recreational and sex therapies, Z therapy, self-help programs, transactional analysis, sensitivity training, assertiveness training, encounter groups, transcendental meditation (TM), religious counseling, rolfing, primal scream therapy, and stress management programs.

UU. TOBACCO DEPENDENCY

Except as indicated under PREVENTIVE CARE, Benefits will not be provided for services, supplies or drugs related to tobacco dependency.

VV. TRAVEL EXPENSES

Travel expenses are not Covered Services.

WW. UNRELATED SERVICES

Services and supplies which are not related to a specific Condition are not Covered Services.

XX. WAR

Services or supplies required as the result of disease or injuries due to war, civil war, insurrection, rebellion, or revolution are not Covered Services.

YY. WEIGHT LOSS PROGRAMS

Services and supplies related to weight loss programs are not Covered Services.

ZZ. WORKERS' COMPENSATION

No Benefits will be provided for Covered Services for any Condition which occurs in the course of Participant's employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit.

This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.

Section 11: How to File a Claim for Benefits

A. WRITTEN CLAIM FOR BENEFITS

A Claim for Benefits must be furnished to Blue Cross Blue Shield of Wyoming at its office at 4000 House Avenue, Cheyenne, Wyoming 82003-2266.

Blue Cross Blue Shield of Wyoming will not be liable under this Benefit Document unless a proper Claim for Benefits is furnished to Blue Cross Blue Shield of Wyoming demonstrating that Covered Services have been rendered to a Participant. The Claim for Benefits must be given within ninety (90) days after completion of the Covered Service. The Claim for Benefits must include all of the information necessary for Blue Cross Blue Shield of Wyoming to determine whether or not the Healthcare Service was a Covered Service and the Maximum Allowable Amount of the benefit.

Failure to submit a Claim for Benefits to Blue Cross Blue Shield of Wyoming within the time specified above will not invalidate nor reduce any Claim for Benefits if it is shown it was not reasonably possible to submit the Claim for Benefits within the time specified above and that the Claim for Benefits was submitted as soon as it was reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the date the Claim for Benefits was first due.

B. CLAIM FORMS

Blue Cross Blue Shield of Wyoming shall furnish to the person making a claim (claimant) the forms it usually furnishes for filing Claims for Benefits. If such forms are not furnished within fifteen (15) days of the filing of a notice of claim, the claimant shall be deemed to have complied with the requirements of this Agreement as to Claims for Benefits upon submitting, within the time fixed in the Agreement for filing Claims for Benefits, written proof regarding the date(s) Healthcare Services were rendered, and the character and extent of Healthcare Services for which a claim is made.

Section 12: How Claims For Benefits Will Be Paid

A. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Agreement not more than forty-five (45) days after receipt of a Claim for Benefits and supporting evidence. Such supporting evidence may include, but not be limited to, medical records required for claim analysis and payment in accordance with this Agreement. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Agreement, the forty-five (45) day claim payment time will not commence until all such necessary records are received by Blue Cross Blue Shield of Wyoming from any source.

B. COORDINATION OF BENEFITS

Participants often have other coverage providing duplicate benefits. In the event of other coverage, Blue Cross Blue Shield of Wyoming will not duplicate benefits if otherwise provided for (or should have been provided had the Participant elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one (1) coverage shall be applicable to any Benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage. If the Agreement is determined to be secondary payor, the sum of the benefits payable by the primary payor plus the sum of the benefits payable under this Agreement shall not exceed the amount payable under this Agreement had this Agreement been determined to be the primary payor.

Determination of primary and secondary payor will be based on the following:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision.
2. Group coverage will be primary over an individual policy with a non-duplication provision.
3. Coverage of a plan, which covers the patient as a Subscriber will be primary over a plan covering the patient as a Dependent.
4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payor. If a plan does not have this provision, the primary payor will be determined by the provision of the plan not having this paragraph.
5. The above applies for children, except in situations where the parents are separated or divorced.
 - a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering

the child as a Dependent of the parent with custody shall be primary over the plan covering the child as a Dependent of the parent without custody.

- b. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the parent without custody.
 - c. Notwithstanding paragraphs a and b herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.
6. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the patient for a longer period of time shall be primary payor.

Except in situations of a laid-off or retired employee, or a Dependent of such employee, the plan covering the person as an active employee will be primary, over the coverage as a laid-off or retired employee, unless either coverage does not contain a provision for laid-off or retired employees, then this subparagraph shall not apply.

C. EXPLANATION OF BENEFITS

Blue Cross Blue Shield of Wyoming will provide an Explanation of Benefits (EOB) document to Participant after a Claim for Benefits has been processed. The EOB will include the Participant's name, claim number, type of Healthcare Services received, the identity of the Healthcare Provider rendering the Healthcare Services, the Covered Services and the Healthcare Services not covered, the amount of the Healthcare Provider's charges, the Maximum Allowable Amount paid, and the Participant's Cost-Sharing Amounts. Participants should carefully review each EOB they receive and keep them with other important records.

D. PAYMENT IN ERROR

If Blue Cross Blue Shield of Wyoming makes a payment in error, it may require the Healthcare Provider, the Participant, or the ineligible person to refund the amount paid in error. Blue Cross Blue Shield of Wyoming reserves the right to correct payments made in error by deducting against subsequent claims or by taking legal action, if necessary.

Section 13: Appealing a Denied Claim for Benefits

A. INTERNAL CLAIMS REVIEW PROCEDURE

If a Participant is not satisfied with the results of the processing of his or her Claim for Benefits, request for Pre-Admission Review, or request for Pre-Certification, the Participant may make a written appeal. When making the request for review or reconsideration, Participant should include his or her Identification Card numbers and claim numbers.

1. Medical Emergency Services

The Participant and/or the Participant's authorized legal representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's denial of a Claim for Benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized legal representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized legal representative of its determination within a reasonable period of time, but no later than seventy-two (72) hours after receiving the request.

NOTE: In order to be eligible for an external review, the timelines above must be followed.

2. Pre-Admission Review, Pre-Certification and Non-Emergency Medical Services

The Participant and/or the Participant's authorized legal representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's denial of a Hospital admission, Pre-certification of services, or Claim for Benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized legal representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized legal representative of its determination within a reasonable period of time, but no later than forty-five (45) days after receiving the request.

NOTE: In order to be eligible for an external review, the timelines above must be followed.

Participants should mail or hand-deliver their requests for an Internal Claims Review to:

BLUE CROSS BLUE SHIELD OF WYOMING
4000 House Avenue
PO Box 2266
Cheyenne, WY 82003-2266

Participants have the right to be represented by an attorney or other duly authorized legal representative at any stage of their appeal. Participants or their

authorized legal representative have the right to review documents that pertain to their appeal. These documents are on file in the office of Blue Cross Blue Shield of Wyoming at the above address. Blue Cross Blue Shield of Wyoming will need at least seventy-two (72) hours notice to assemble the documents pertaining to an appeal.

The adjudication committee of Blue Cross Blue Shield of Wyoming will review the appealed claim(s) and consider all information available pertaining to the appeal. Whether or not the initial decision is changed, Participants will receive a written response and explanation within forty-five (45) days of Blue Cross Blue Shield of Wyoming's receiving their request for review.

B. EXTERNAL CLAIMS REVIEW PROCEDURE

If Blue Cross Blue Shield of Wyoming denies the Participant's request for the provision of, or payment for, a Healthcare Service or course of treatment on the basis that it is not Medically Necessary, or on another similar basis, the Participant may have a right to have the adverse determination reviewed by healthcare professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending healthcare professional or the healthcare professional's partner by following the procedures outlined in this notice.

The Participant must submit a request for external review within one-hundred twenty (120) days after receipt of the claims denial to Blue Cross Blue Shield of Wyoming's appeals office. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.

When filing a request for an external review, the Participant will be required to authorize the release of any medical records of the Participant that may be required to be reviewed for the purpose of reaching a decision on the external review.

1. Medical Necessity Denials

Expedited Review: The Participant may be entitled to an expedited review when his or her Condition or circumstances require, and in any event within seventy-two (72) hours, where:

- a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Participant's claim concerns a request for an admission, availability of care, continued stay or Healthcare Service for which he or she received Medical Emergency services, but has not been discharged from a healthcare facility.

To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial: Request form, release for records, a healthcare professional's

statement of medical necessity and any other documents necessary. The State of Wyoming requires a fee to be submitted with all external review requests as noted in the Notice of Appeal Rights.

The Participant's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Avenue, PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

2. All Other Denials

Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances require it, and in any event within seventy-two (72) hours, where:

- a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Participant's claim concerns a request for an admission, availability of care, continued stay or Healthcare Service for which he or she received Medical Emergency services, but has not been discharged from a healthcare facility.

The Participant's request must be made in writing and sent to Blue Cross Blue Shield of Wyoming, 4000 House Ave, PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date of the internal appeal denial. A fee will be required with submission of an external review request as noted in the Notice of Appeal Rights.

Section 14: Additional Provisions

The following general provisions apply to all Benefits (Covered Services) and Limitations and Exclusions described in this Agreement.

A. APPLICANT'S LEGAL OBLIGATIONS

The Applicant and Applicant's Dependents are liable for any actions which may prejudice Blue Cross Blue Shield of Wyoming's rights under this Agreement. If Blue Cross Blue Shield of Wyoming must take legal action to uphold its rights, then it can require the Applicant and Applicant's Dependents to pay its legal expenses, including attorney's fees and court costs.

B. ASSIGNMENT OF BENEFITS

This Agreement, and all Benefits stated in this Agreement, is personal to the Participant. This Agreement, the Benefits stated in this Agreement, and Blue Cross Blue Shield of Wyoming's payments to the Participant pursuant to this Agreement may not be assigned to any person, corporation, or entity. Any attempted assignment shall be void.

C. CONTESTING AGREEMENT VALIDITY

The validity of this Agreement shall not be contested, except for nonpayment of Premiums, after it has been in force for two (2) years from the Effective Date. No statement made by any Participant covered under this Agreement relating to insurability shall be used in contesting the validity of the Agreement with respect to which the statement was made after the Agreement has been in force prior to such contest for a period of two (2) years during the Participant's lifetime unless the statement is contained in a written instrument signed by the Participant who made the statement.

D. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION

All Protected Health Information (PHI) maintained by Blue Cross Blue Shield of Wyoming under this Agreement is confidential. Any PHI about a Participant that is obtained by Blue Cross Blue Shield of Wyoming from that Participant or from a Healthcare Provider may not be disclosed to any person except:

1. Upon a written, dated, and signed authorization by the Participant or prospective Participant or by a person authorized to provide consent for a minor or an incapacitated person;
2. If the data or information does not identify either the Participant or prospective Participant or the Healthcare Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
3. Pursuant to statute or court order for the production or discovery of evidence; or

4. In the event of a claim or litigation between the Participant or prospective Participant and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for Blue Cross Blue Shield of Wyoming to conduct healthcare operations, including but not limited to utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or healthcare records data, to conduct disease management programs with Healthcare Providers, or to reconcile or verify claims. This section does not apply to PHI disclosed by Blue Cross Blue Shield of Wyoming to the Wyoming Department of Insurance for access to records of Blue Cross Blue Shield of Wyoming for purposes of enforcement or other activities related to compliance with state or federal laws.

E. EXECUTION OF PAPERS

On behalf of the Applicant and the Applicant's Dependents, the Applicant must, upon request, execute and deliver any instruments and papers to Blue Cross Blue Shield of Wyoming that are necessary to carry out the provisions of this Agreement.

F. LIMITATION OF ACTIONS

No action at law or equity may be brought to recover benefits against Blue Cross Blue Shield of Wyoming prior to the expiration of sixty (60) days after a written Claim for Benefits is furnished. No such action shall be brought later than three (3) years after the time the written Claim for Benefits is required by Blue Cross Blue Shield of Wyoming to be furnished.

G. PHYSICAL EXAMINATION AND AUTOPSY

Blue Cross Blue Shield of Wyoming, at its own expense, has the right to examine the person of the Applicant, or any Dependent, when and as often as it may reasonably require during the pendency or review of a Claim for Benefits under this Agreement or, upon death, require an autopsy where it is not otherwise prohibited by law.

H. RESERVE FUNDS

No Participant is entitled to share in any reserve or other funds that may be accumulated or established by Blue Cross Blue Shield of Wyoming, unless a right to share in such funds is granted by Blue Cross Blue Shield of Wyoming's Board of Directors.

I. SENDING NOTICES

All notices to the Participant are considered to be sent to and received by the Participant when deposited in the United States Mail with postage prepaid and addressed to the Applicant at the last known address appearing on Blue Cross Blue Shield of Wyoming's membership records, or where email is used, upon the sending of the email.

Section 15: Participants' Rights Under The Employee Retirement Income Security Act Of 1974 (ERISA)

The following explanation is provided as an overview and is not intended to be legal advice or provide other specific information to the Participant as to all their rights under ERISA. Participants should consult their employer to determine whether their employer is subject to ERISA.

A. PLAN DOCUMENTS AND FINANCIAL REPORTS

Participants in an employee benefit plan are entitled to certain rights and protection under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all benefits or plan Participants shall be entitled to:

1. Examine, without charge, at the plan Administrator's, or Employer's, offices, as applicable, and at other specified locations, such as union halls or worksites, all benefit (plan) documents including insurance contracts, and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and benefit (plan) descriptions.
2. Obtain copies of all benefit documents and other information upon written request to the plan Administrator, or Employer, as appropriate. A reasonable charge may be made for these copies.
3. Receive a summary of a benefit financial report. The plan Administrator is required by law to furnish each Participant with a copy of this summary annual report upon request.

B. FIDUCIARIES AND THEIR OBLIGATIONS

In addition to creating rights for employment benefit Participants, ERISA imposes duties upon the people who are responsible for the operation of the employment benefit plan (fiduciaries). These people have a duty to operate and/or administer Participants' employment benefits prudently and in the best interests of the Participants.

C. LEGAL RIGHTS TO BENEFITS

1. No person, including an employer, or any other person, may fire Participants or otherwise discriminate against Participants in any way to prevent Participants from obtaining an employment benefit or exercising their rights under ERISA.
2. If any claim for a benefit that Participants are legally entitled to is denied or ignored, in whole or in part, Participants must receive a written explanation of the reason for the denial. This explanation may come in various formats. Participants have the right to have Blue Cross Blue Shield of Wyoming review and reconsider their claim in accordance with the steps below.

3. Under the provisions of ERISA, there are various steps Participants can take to enforce the above rights. For instance, if Participants request materials and do not receive them within thirty (30) days, Participants may seek assistance from the U.S. Department of Labor, or they may file a lawsuit in Federal Court. In such a case the court may require the entity from whom the Participants requested materials to provide the materials and pay the Participants up to \$110.00 a day until they receive the materials, unless the materials the Participants requested were not sent because of reasons beyond the control of the entity from whom materials were requested.
4. If Participants have a claim for benefits that is denied or ignored, in whole or in part, the Participants may file a lawsuit in a state or Federal Court. If it should happen that fiduciaries misuse the plan's money, or if the Participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Participants are successful the court may order the person being sued to pay these costs and fees. If the Participants lose, the court may order them to pay these costs and fees; for example, if the court finds the Participants' claim is frivolous.

D. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

Upon receipt of a Claim for Benefits under this Agreement from a Participant and/or Participant's authorized representative that is conditioned on a Participant's obtaining approval in advance of obtaining the Benefit or Covered Service, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than fifteen (15) days from receiving the Claim for Benefits. Blue Cross Blue Shield of Wyoming may extend this initial time period an additional fifteen (15) days if it is unable to make a determination due to circumstances beyond its control after giving the Participant and/or the Participant's authorized representative notice of the need for additional time prior to the expiration of the initial fifteen (15) day time period.

If the Participant and/or the Participant's authorized representative improperly submits a Claim for Benefits, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative as soon as possible, but no later than five (5) days after receipt of the Claim for Benefits and provide the Participant and/or the Participant's authorized representative with the proper procedures to be followed when filing a Claim for Benefits. Blue Cross Blue Shield of Wyoming may also request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial fifteen (15) day time period after receiving the Claim for Benefits. Upon receiving notice of an improperly filed claim for benefits or a request for additional or specified information, the Participant and/or the Participant's authorized

representative has forty-five (45) days in which to properly file the Claim for Benefits and submit the requested information. After receiving the properly filed Claim for Benefits or additional or specified information, Blue Cross Blue Shield of Wyoming shall notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than fifteen (15) days after receipt of the properly filed Claim for Benefits and additional information.

E. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For services or benefits requiring Pre-admission Review or Pre-certification and involving an ongoing course of treatment taking place over a period of time or number of treatments, Blue Cross Blue Shield of Wyoming will provide the Participant and/or the Participant's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Participant and/or the Participant's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

Upon receipt of a Claim for Benefits for emergency services from a Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible but no later than seventy-two (72) hours after receiving the Claim for Benefits.

If the Participant and/or the Participant's authorized representative improperly submits a Claim for Benefits or the Claim for Benefits is incomplete and Blue Cross Blue Shield of Wyoming requests additional or specified information, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative as soon as possible, but no later than twenty-four (24) hours after receipt of the Claim for Benefits. Upon receiving notice of an improperly filed Claim of Benefits or the request from Blue Cross Blue Shield of Wyoming for additional or specified information, the Participant and/or the Participant's authorized representative has forty-eight (48) hours to properly file the Claim for Benefits or to provide the requested information. After receiving the properly filed Claim for Benefits or requested information, Blue Cross Blue Shield of Wyoming shall notify the Participant and/or the Participant's authorized representative of its determination as soon as possible, but no later than forty-eight (48) hours after receipt of the additional or specified information requested by Blue Cross Blue

Shield of Wyoming, or within forty-eight (48) hours after expiration of the Participant's time period to respond.

G. CLAIMS FOR BENEFITS NOT REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For a Claim for Benefits that does not require Pre-admission Review or Pre-certification, but involves services or benefits involving an ongoing course of treatment taking place over a period of time or a number of treatments, Blue Cross Blue Shield of Wyoming will provide the Participant and/or the Participant's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Participant and/or the Participant's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

Upon receipt of a Claim for Benefits under the Agreement from a Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than thirty (30) days from receiving the Claim for Benefits and only if the determination is adverse to the Participant. Blue Cross Blue Shield of Wyoming may extend this initial time period in reviewing a Claim for Benefits an additional fifteen (15) days if Blue Cross Blue Shield of Wyoming is unable to make a determination due to circumstances beyond its control after giving the Participant and/or the Participant's authorized representative notice of the need for additional time prior to the expiration of the initial thirty (30) day time period.

Blue Cross Blue Shield of Wyoming may request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial thirty (30) day time period after receiving the Claim for Benefits. Upon receiving a request for additional or specified information, the Participant and/or the Participant's authorized representative has forty-five (45) days in which to submit the requested information. After receiving the additional or specified information, Blue Cross Blue Shield of Wyoming shall notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but not later than thirty (30) days after receipt of the additional information.

I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

The Participant and/or the Participant's authorized representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a Claim for Benefits requiring preauthorization or prior approval of benefits or services. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than thirty (30) days after receiving the Participant's and/or the Participant's authorized representative's request for review.

NOTE: In order to be eligible for an external review, the timelines above must be followed.

J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

The Participant and/or the Participant's authorized representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a Claim for Benefits for emergency services. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receiving the Participant and/or the Participant's authorized representative request for a review.

A Participant and/or the Participant's authorized representative may request an appeal from a determination involving a Claim for Benefits for emergency services orally or in writing, and Blue Cross Blue Shield of Wyoming will accept needed materials by telephone or facsimile.

NOTE: In order to be eligible for an external review, the timelines above must be followed.

K. INTERNAL APPEALS OF CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

The Participant and/or the Participant's authorized representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than sixty (60) days after receiving the Participant and/or the Participant's authorized representative request for review.

NOTE: In order to be eligible for an external review, the timelines above must be followed.

L. EXTERNAL CLAIMS REVIEW PROCEDURE

If Blue Cross Blue Shield of Wyoming denies the Participant's request for the provision of, or payment for, a healthcare service or course of treatment on the basis

that it is not Medically Necessary, or on another similar basis, the Participant may have a right to have the adverse determination reviewed by healthcare professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending healthcare professional or the healthcare professional's partner by following the procedures outlined in this notice. The Participant must submit a request for external review within one-hundred twenty (120) days after receipt of the claims denial to Blue Cross Blue Shield of Wyoming's appeals office. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.

When filing a request for an external review, the Participant will be required to authorize the release of any medical records of the Participant that may be required to be reviewed for the purpose of reaching a decision on the external review.

1. Medical Necessity Denials:

Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances required, and in any event within seventy-two (72) hours, where:

- a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Participant's claim concerns a request for an admission, availability of care, continued stay or healthcare service for which he or she received emergency services, but has not been discharged from a healthcare facility.

To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial:

Request form, release for records, a healthcare professional's statement of medical necessity and any other documents necessary. The State of Wyoming requires a fee to be submitted with all external review requests as noted in the Notice of Appeal Rights.

The Participant's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Ave, PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

2. All Other Denials:

Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances require it, and in any event within seventy-two (72) hours, where:

- a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Participant's claim concerns a request for an admission, availability of care, continued stay or healthcare service for which he or she received emergency services, but has not been discharged from a healthcare facility.

The Participant's request must be made in writing and sent to Blue Cross Blue Shield of Wyoming, 4000 House Ave, PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date of the internal appeal denial. A fee will be required with submission of an external review request as noted in the Notice of Appeal Rights.

M. WYOMING INSURANCE DEPARTMENT

Participants may also have rights under Wyoming Insurance law. For more information about those rights, Participants may call or write the following telephone number or address:

Wyoming Insurance Department
106 East 6th Ave
Cheyenne, WY 82002
(800) 438-5768

N. BLUE CROSS BLUE SHIELD OF WYOMING AS A FIDUCIARY

In accordance with the appropriate provisions of ERISA, Blue Cross Blue Shield of Wyoming, as a fiduciary or plan administrator of this health insurance agreement, may exercise in good faith any authority or control respecting the management of the operation and administration of this health insurance plan in accordance with the provisions of this Agreement.

O. ANSWERS TO QUESTIONS

1. If Participants have any questions about any of the Benefits associated with this Agreement or their rights under this agreement, they should contact their employer or Blue Cross Blue Shield of Wyoming at (307) 634-1393. They can also call Blue Cross Blue Shield of Wyoming toll free at 1-800-442-2376
2. If Participants have any questions about their rights under ERISA, they should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

Section 16: Definitions

This section defines many of the terms and words that are found throughout this Benefit Document. The terms and words defined here are capitalized wherever they are used in the Benefit Document.

A. ACCIDENT

An unexpected traumatic incident which is identified by time and place of occurrence, identifiable by body member or part of the body affected, and caused by a specific event on a single day. Examples include a blow or fall, animal bites, allergic reactions to insect bites or medication, or poisoning.

B. AGREEMENT

This Benefit Document, including the application submitted to enroll in the health insurance coverage offered in this Benefit Document, the Schedule of Benefits, Participant's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card, and any amendments or endorsements that are or may become attached to this Benefit Document, constitute the entire Agreement between Applicant and Blue Cross Blue Shield of Wyoming, and supersedes and replaces all previous Agreements between Applicant and Blue Cross Blue Shield of Wyoming. This Agreement may also be referred to as the "Plan." This Agreement describes the Benefits available to Applicant and Applicant's Dependents, if any, as Participants in this Blue Cross Blue Shield of Wyoming BlueSelect PPO Plan. The Benefits offered in this Plan are limited to the express written terms of this Agreement.

C. ANESTHESIA

Services performed by a Healthcare Provider specially trained in Anesthesia. Anesthesia includes general Anesthesia that produces unconsciousness in varying degrees with muscular relaxation and reduced or absent pain sensation and regional or local Anesthesia that produces similar muscular and pain effects in a limited area with no loss of consciousness.

D. APPLICANT

The person who applies for coverage under this Agreement and whose name appears on the BlueSelect PPO Identification Card.

E. BENEFIT

The reimbursement to or on behalf of a Participant by Blue Cross Blue Shield of Wyoming for Covered Services received under this Plan

F. BENEFIT DOCUMENT

This document.

G. BILLING SERVICE DATE

The date used by Blue Cross Blue Shield of Wyoming in assigning Effective Dates and issuing billings. This date will always be the 1st of the month.

H. BLUECARD® PROGRAM

A nationwide program coordinated by the Blue Cross Blue Shield Association that enables Participants to reduce claims filing paperwork and to take advantage of available local provider networks, medical discounts, and cost saving measures when they receive Covered Services in states other than Wyoming.

I. BLUESELECT PHARMACY

A Pharmacy that has entered into an agreement with Blue Cross Blue Shield of Wyoming's Pharmacy Benefits Manager to provide Covered Services at an agreed upon reimbursement methodology for Participants in the BlueSelect PPO network. Covered Services are not available from a Pharmacy that is not a BlueSelect Pharmacy.

J. BLUESELECT PPO

The BlueSelect Preferred Provider Organization (PPO) is a comprehensive network of BlueSelect Pharmacies and BlueSelect Providers who have agreed to provide Covered Services to Participants with BlueSelect PPO Plans and participants of health plans issued or administered by other Blue Cross and/or Blue Shield licensees that have PPO network benefit documents comparable to the BlueSelect PPO Benefit Documents and who are receiving Covered Services in Blue Cross Blue Shield of Wyoming's service area, in compliance with the BlueCard® Program.

K. BLUESELECT PROVIDER

A Healthcare Provider that has entered into an agreement with Blue Cross Blue Shield of Wyoming to provide Covered Services at an agreed upon reimbursement methodology for Participants in the BlueSelect PPO network.

L. CHEMOTHERAPY

Drug therapy administered as treatment for Conditions of certain body systems.

M. CLAIM FOR BENEFITS

A request by a Participant (or a request by a BlueSelect Provider on behalf of the Participant) for reimbursement for Covered Services in accordance with the terms of this Agreement.

N. CLASS OF COVERAGE

The type of coverage an Applicant has enrolled for under this Agreement, identifying who is eligible to receive Benefits for Covered Services under this Plan. Classes of Coverage are as follows:

1. **Single Coverage:** Coverage under this Plan for the Applicant only.
2. **Applicant and Dependent Coverage:** Coverage under this Plan for the Applicant and one or more eligible Dependent Children.

3. **Two Adult Coverage:** Coverage under this Plan for Applicant and the Applicant's Dependent Spouse.

4. **Family Coverage:** Coverage under this Plan for the Applicant, the Applicant's Dependent Spouse, and one or more eligible Dependent Children.

O. COINSURANCE AMOUNT

A percentage of the cost of Covered Services that is a Participant's responsibility after the Deductible has been met.

Blue Cross Blue Shield of Wyoming calculates a Participant's Coinsurance Amount, when Participant obtains the Covered Services from Healthcare Providers in Blue Cross Blue Shield of Wyoming's service area, off of the Maximum Allowable Amount.

However, if the Participant obtains Covered Services outside of the Blue Cross Blue Shield of Wyoming service area, the local Blue Cross Blue Shield Plan's (Host Plan's) contract with the Healthcare Provider may require that the Coinsurance Amount be based on the full amount of the Healthcare Provider's billed charges rather than the Maximum Allowable Amount. This may result in a significantly higher Coinsurance Amount to the Participant for these Covered Services. It is not possible for Blue Cross Blue Shield of Wyoming to detail the specific information for each out-of-area Healthcare Provider in this Benefit Document because of the many different arrangements the various Host Plans have with their local Healthcare Providers. However, if a Participant contacts Blue Cross Blue Shield of Wyoming prior to incurring out-of-area Healthcare Services, a Blue Cross Blue Shield of Wyoming member services representative may be able to provide the Participant with more specific information on the applicable Coinsurance Amount.

NOTE: The Coinsurance Amount does not apply to PREVENTIVE CARE.

P. CONDITION

Any Accident, bodily dysfunction, illness, injury, mental health disorder, pregnancy or substance use disorder.

Q. CONSULTATION

The service of one Physician, at the request of another Physician, to provide advice in the diagnosis or treatment of a Condition which requires the consulted Physician's special skill or knowledge.

R. COPAYMENT AMOUNT

A specified dollar amount payable by the Participant to the Healthcare Provider for certain Covered Services. Healthcare Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not accumulate toward the Participant's satisfaction of the Deductible Amount or Coinsurance Amount, but will accumulate toward the Participant's satisfaction of the Out-of-

Pocket Maximum.

S. COST-SHARING AMOUNTS

Cost-Sharing Amounts are those dollar amounts that a Participant is responsible for paying when Covered Services are received from a Healthcare Provider. Cost-Sharing Amounts include Copayment Amounts, Deductible Amounts and Coinsurance Amounts. Healthcare Providers may either bill a Participant directly for these amounts or request payment of these amounts from the Participant at the time the Covered Services are provided.

T. COVERED SERVICE

Healthcare Services, including Prescription Drugs, for which reimbursement will be made by Blue Cross Blue Shield of Wyoming under this Plan.

U. CREDITABLE COVERAGE

Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 as amended, 42 U.S.C. Section 300 gg et seq.

V. DEDUCTIBLE AMOUNT

A specified dollar amount that a Participant must pay to the Healthcare Provider for Covered Services within a calendar year before Benefits for Covered Services are provided under this Agreement.

How the Deductible Amount can be met during the calendar year depends upon the applicable Class of Coverage:

1. **Single Coverage:** If only the Applicant is covered under this Plan, the Applicant alone must meet the entire Deductible Amount.
2. **Applicant and Dependent, Two-Adult, and Family Coverage:** The Deductible Amount for each calendar year will be satisfied when any of the following scenarios occurs:
 - a. When one (1) Participant meets one-half of the Deductible Amount, that Participant will be eligible for Benefits. The remaining Participants will be eligible for Benefits when they have collectively satisfied the remaining balance of the Deductible Amount.
 - b. When two (2) or more Participants each meet one-half of the Deductible Amount, the remaining Participants will then be eligible for Benefits without regard to that Deductible Amount.
 - c. When no one (1) Participant meets one-half of the Deductible Amount, but all the Participants collectively meet the Deductible Amount, then all Participants will be eligible for Benefits.

NOTE: A Participant may not apply more than the individual deductible expenses per Participant to satisfy the Deductible Amount.

NOTE: The Deductible Amount does not apply to PREVENTIVE CARE.

W. DEPENDENT

An Applicant's Dependents are the following:

1. Dependent Spouse: Applicant's legal spouse who is currently a permanent resident in the home of the Applicant.
2. Dependent Children: The children, stepchildren, adopted children and legal wards of the Applicant. Dependent Children are eligible to be Dependents under this Agreement until the end of the calendar year in which they turn age twenty-six (26).

However, eligibility will be continued past the end of the calendar year in which a Dependent Child turns age twenty-six (26) if the Dependent Child is unmarried and is BOTH incapable of self-sustaining employment and chiefly dependent upon the Applicant or the Applicant's Dependent Spouse for their support and maintenance by reason of intellectual disability or physical handicap. Continuous coverage will be established at the same level of benefits. Premiums may be adjusted accordingly. Proof of incapacity and dependency must be furnished to Blue Cross Blue Shield of Wyoming within thirty-one (31) days of the end of the year in which the Dependent Child turned age twenty-six (26). Incapacity and dependency upon the Applicant or Applicant's covered Spouse must both continue in order for the coverage to continue and Blue Cross Blue Shield of Wyoming may, from time to time, require continued proof of such incapacity and dependency. If the conditions of BOTH incapacity and dependency by reason of intellectual disability or physical handicap are not continuously met, coverage will continue as required by Federal or State law as applicable.

X. DIAGNOSTIC SERVICE

A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite Condition. A Diagnostic Service must be ordered by a Healthcare Provider. Diagnostic Services include, but are not limited to, x-rays and other imaging services and laboratory and pathology Services.

Y. DURABLE MEDICAL EQUIPMENT

Equipment that can with stand repeated use, is made to serve a medical purpose and is useless to a person who is not suffering from a Condition, and is appropriate for use in the home.

Z. EFFECTIVE DATE

The calendar date coverage under this Agreement begins.

AA. EXPERIMENTAL/INVESTIGATIONAL

A drug, device, or medical treatment or procedure is experimental or investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. If reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

BB. FORMULARY

A continually updated list of medications and related information, representing the clinical judgment of Physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health, as determined by Blue Cross Blue Shield of Wyoming.

CC. HEALTHCARE PROVIDER

Healthcare Providers, for purposes of this Agreement can mean professional physicians or other types of individuals who provide Healthcare Services (Professional Healthcare Providers), or it can mean the Hospitals, institutions, facilities or other entities (Institutional Healthcare Providers) where Healthcare Services are performed. Healthcare Providers must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed.

Where there is no appropriate state agency, the Healthcare Provider must be registered or certified by the appropriate professional body. Benefits will only be provided under this Agreement where the Covered Services were performed by a Healthcare Provider acting within the scope of the Healthcare Provider's license as provided by law. Healthcare Providers include, but are not limited to:

1. **Advanced Practice Registered Nurse:** A Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner or Psychiatric Nurse.
2. **Ambulance:** A specially designed or equipped vehicle used only for transporting the critically ill or injured to a healthcare facility. The ambulance service must meet state and local requirements for providing transportation for the sick and injured and must be operated by qualified personnel who are trained in the application of basic life support.
3. **Ambulatory Surgical Facility:** A facility with an organized staff of Professional Healthcare Providers that:
 - a. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 - b. Provides treatment by or under the direct supervision of a Professional Healthcare Provider;
 - c. Does not provide Inpatient accommodations; and
 - d. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Healthcare Provider.
4. **Audiologist:** A trained professional who measures hearing loss and can fit hearing aids.
5. **Certified Diabetes Educator (C.D.E.):** A healthcare professional who is specialized and certified to teach people with diabetes how to manage their condition.
6. **Chiropractor:** A Board Qualified and licensed Doctor of Chiropractic who treats disease by manipulation of the joints of the body.
7. **Clinical Psychologist:** A licensed clinical psychologist, or where there is no licensure law, a psychologist must be certified by the appropriate professional body.
8. **Dentist:** A Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

9. **Dialysis Facility (freestanding):** A facility that is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
10. **Home Health Agency:** A private or public organization certified by the U.S. Department of Health and Human Services, providing, under the direction of a Professional Healthcare Provider, skilled nursing services and other therapeutic services to patients in their homes.
11. **Home Infusion Therapy Provider:** A provider who administers infusion drug therapies in the home.
12. **Home Medical Equipment Supplier:** Supplier of Durable Medical Equipment.
13. **Hospice:** A coordinated program of Home Healthcare for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social, and economic stresses which are often experienced during the final stages of terminal illness and during dying and bereavement.
14. **Hospital:** A duly licensed institution that is engaged in providing short-term acute Inpatient and Outpatient Diagnostic Services and Therapeutic Services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Professional Healthcare Providers. A Hospital has organized departments of medicine and Surgery and provides twenty-four (24) hour nursing care by or under the supervision of a registered nurse which is physically present and on duty. Hospitals are not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Mental Illness, place for the treatment of alcoholism or drug abuse, place for the provision of hospice care, place for the provision of rehabilitative and habilitative care, or a place for the treatment of pulmonary tuberculosis.
15. **Independent Clinical Laboratory:** A medical laboratory providing Diagnostic Services that is approved for reimbursement by Blue Cross Blue Shield of Wyoming and is not affiliated or associated with a Hospital or Professional Healthcare Provider otherwise providing patient services.
16. **Licensed Addiction Counselor:** A licensed counselor who assists patients with Substance Use Disorders.
17. **Licensed Clinical Psychologist:** A licensed psychologist with a doctorate degree in psychology who is eligible for listing in the National Register of

Health Service Providers in Psychology.

18. **Licensed Independent Clinical Social Worker:** An individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the appropriate state agency for third party reimbursement.
19. **Licensed Professional Clinical Counselor:** A licensed counselor who assists patients in a clinic for Mental Health or Substance Use Disorders.
20. **Licensed Registered Dietician:** A licensed food and nutrition expert.
21. **Long Term Acute Care Facility:** A facility that provides long-term acute Hospital care for medically complex conditions or specialized treatment programs.
22. **Nurse Practitioner:** A registered nurse who performs primary care patient services such as acts of medical diagnosis or prescription of medical therapeutic or corrective measures and is licensed and certified by the state.
23. **Occupational Therapist:** A licensed Occupational Therapist who treats patients with injuries, illnesses, or disabilities through the therapeutic use of everyday activities.
24. **Ophthalmologist:** A specialist in medical and surgical eye Conditions.
25. **Optometrist:** A Doctor of Optometry (O.D.) who measures the eye's refractive powers, performs medical eye examinations and fits glasses to correct ocular defects.
26. **Oral Pathologist:** A Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Pathologists.
27. **Oral Surgeon:** A Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Surgery.
28. **Outpatient Psychiatric Facility:** A facility primarily engaged in providing Diagnostic Services and therapeutic services for the treatment of Mental Illness on an outpatient basis.
29. **Pain Treatment Facility:** A facility that has satisfied the CARF accreditation requirement of a chronic pain management program.
30. **Pharmacist:** A person who is professionally qualified to prepare and dispense Prescription Drugs.

31. **Pharmacy:** A licensed establishment where Prescription Drugs are dispensed by a licensed Pharmacist.
32. **Physical Therapist:** A licensed Physical Therapist, or where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.
33. **Physician:** A doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).
34. **Physician Assistant:** An individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a licensed Physician and must be certified by the state to practice.
35. **Podiatrist:** A Doctor of Podiatry (D.P.), a Doctor of Surgical Chiropody (D.S.C.), a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Podiatry (D.S.P.).
36. **Psychiatric Care Facility:** An institution or a distinct part of an institution providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness under the direct supervision of a Professional Healthcare Provider. Continuous nursing services are provided under the supervision of a registered nurse.
37. **Psychiatric Residential Treatment Center:** A facility or distinct part of a facility for psychiatric care that provides a total twenty-four (24) hour therapeutically planned and professionally staffed group living and learning environment.
38. **Rehabilitation Facility:** An institution or a distinct part of an institution providing rehabilitative services.
39. **Residential Treatment Center:** A healthcare facility providing therapy for Mental Health and Substance Use Disorders or other behavioral problems.
40. **Respiratory Therapist:** A licensed provider who assists patients with respiratory disease such as asthma or emphysema.
41. **Skilled Nursing Facility:** An institution or a distinct part of an institution providing Skilled Nursing Services and related services to persons on an Inpatient basis under the direct supervision of a Professional Healthcare Provider. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or part-time care services, or care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

- 42. Sleep Lab:** A medical lab in which sleep specialists study patient's sleep disorders and sleep disturbances.
- 43. Speech Therapist:** A therapist who treats speech defects and disorders.
- 44. Substance Abuse Facility:** An institution or a distinct part of an institution with nursing and medical Professional Healthcare Providers providing medically managed Inpatient detoxification, medically monitored Inpatient detoxification, medically managed intensive Inpatient treatment or medically monitored intensive Inpatient treatment at an appropriately licensed and credentialed facility.
- 45. Transitional Care Unit:** A sub-acute unit of a Hospital that provides skilled services necessary for the transition between Hospital and home or to a lower level of care.

DD. HEALTHCARE SERVICES

Medical Care provided by a Healthcare Provider for the treatment of a Condition.

EE. HOME HEALTHCARE

Medical Care provided in the Participant's home in lieu of Inpatient hospitalization.

FF. IDENTIFICATION CARD

A card issued in the Applicant's name identifying the Plan and Class of Coverage selected by the Applicant under this Agreement.

GG. IN-NETWORK

A term meant to include all Healthcare Providers who are in the BlueSelect PPO network.

HH. INPATIENT

A Participant who is treated as a registered bed patient in a Institutional Healthcare Provider and for whom a room and board charge is made. In computing days, a stay up to and including midnight of the date of admission shall be considered one day, and an additional day will be counted at each midnight census after the first day that the Participant is still a patient.

II. MAXIMUM ALLOWABLE AMOUNT

The maximum amount Blue Cross Blue Shield of Wyoming will reimburse for Covered Services under this Agreement. The Maximum Allowable Amount is the lesser of (1) the Healthcare Provider's billed charges for the Covered Service, or (2) the maximum reimbursement rate Blue Cross Blue Shield of Wyoming has negotiated with BlueSelect Providers for the Covered Service as determined by the Blue Cross Blue Shield of Wyoming payment system in effect at the time the Covered Services are provided.

JJ. MEDICAL CARE

Healthcare Services rendered by a Healthcare Provider for the treatment of a Condition.

KK. MEDICAL EMERGENCY

A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part, or
4. With respect to a pregnant woman who is having contractions if there is inadequate time to affect a safe transfer to another hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.

LL. MEDICAL NECESSITY

1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
 - a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
 - b. Provides for the diagnosis, direct care and treatment of the Participant's condition, illness, disease or injury;
 - c. Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care;
 - d. Is not primarily for the convenience of the Participant, Physician or other Healthcare Provider; and
2. A medical service, procedure or supply shall not be excluded from being a Medical Necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
 - a. Peer reviewed medical literature, including literature relating to

therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

- b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act.

MM. MEDICAL SUPPLIES

Expendable items (except Prescription Drugs) which are required for the treatment of a Condition.

NN. MENTAL HEALTH OR SUBSTANCE-USE DISORDER

A condition requiring specific treatment primarily because the Participant requires psychotherapeutic treatment, rehabilitation from a Mental Illness and/or Substance Use Disorder.

OO. MENTAL ILLNESS

Those conditions listed in the International Classification of Diseases as psychoses, neuroses, personality disorders and other non-psychotic mental disorders.

PP. OCCUPATIONAL THERAPY

Educational, vocational, and rehabilitative techniques used in order to improve a Participant's functional ability to achieve independence in daily living.

QQ. ORTHOPEDIC APPLIANCE

A rigid or semi-rigid support used to eliminate, restrict or support motions in a part of the body that is diseased, injured, weak or deformed.

RR. OUT-OF-NETWORK

A term meant to include all Healthcare Providers who are not included in the BlueSelect PPO network.

SS. OUT-OF-POCKET MAXIMUM AMOUNT

The total Copayment, Deductible and Coinsurance Amounts for Covered Services that are a Participant's responsibility during a single calendar year. When the Participant's Out-of-Pocket Maximum Amount is met by any combination of Copayment, Deductible or Coinsurance Amounts during a single calendar year, Blue Cross Blue Shield of Wyoming will reimburse one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services for the remainder of that calendar year.

There are separate Cost-Sharing Amounts and Out-of-Pocket Maximum Amounts for In-Network and Out-of-Network Covered Services. Satisfaction toward one type of Out-of-Pocket Maximum Amounts (i.e. In-Network Out-of-Pocket Maximum

Amounts) will not work to satisfy the other type of Out-of-Pocket Maximum Amount (i.e. Out-of-Network Out-of-Pocket Maximum Amounts).

The calculation of the total Copayment, Deductible and Coinsurance Amounts toward the Out-of-Pocket Maximum Amount begins new on January 1 of each calendar year.

TT. OUTPATIENT

A Participant who receives Healthcare Services while not an Inpatient.

UU. PARTICIPANTS

The Applicant and the Applicant's covered Dependents.

VV. PHYSICAL THERAPY

The use of physical agents for the treatment of disability resulting from a Condition. Physical Therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries.

WW. PLAN YEAR

For purposes of this Agreement, the twelve (12) month period following the employer's enrollment in (or renewal of) this Plan, unless otherwise defined by the employer under ERISA.

XX. PRE-ADMISSION REVIEW

The process of a Participant formally requesting that Blue Cross Blue Shield of Wyoming approve specified Healthcare Services for Participant. Pre-admission does not guarantee payment of Benefits. Participant's Inpatient hospitalization Benefits will be reduced by \$200.00 for In-Network Hospital services and \$500.00 for Out-of-Network Hospital services if Pre-admission Review is not obtained. The additional \$200.00/\$500.00 a Participant must pay for failing to obtain a Pre-admission Review cannot be applied toward satisfaction of the Participant's Deductible or Out-of-Pocket Maximum.

YY. PRE-CERTIFICATION

The process of a Participant formally providing information to Blue Cross Blue Shield of Wyoming substantiating the medical appropriateness of specified Healthcare Services in order to received Benefits for such Healthcare Services. Blue Cross Blue Shield of Wyoming reserves the right to reduce or deny Benefits if Pre-certification is not obtained.

ZZ. PREMIUM

The specified amount of payment periodically required in order to receive coverage under this Plan for a defined period of time.

AAA. PRIMARY CARE

Medical Services provided by a Physician, Physician's Assistant or Nurse Practitioner specializing in general medical practice, family practice, obstetrics, gynecology or pediatrics.

BBB. PRIVATE DUTY NURSING SERVICES

Services which require the training, judgment and technical skills of an actively practicing Registered Nurse (R.N.). Private Duty Nursing Services must be prescribed by the attending Healthcare Provider for the continuous treatment of Participant's Condition.

CCC. PRESCRIPTION DRUGS

Drugs and medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber. All drugs and medicines must be approved by the Food and Drug Administration for the Condition for which they are prescribed and not be identified as "investigational" or "experimental".

DDD. PROSTHESIS

Any device that replaces all or part of a missing body organ or body member.

EEE. PROTECTED HEALTH INFORMATION (PHI)

Information, including summary and statistical information, collected from or on behalf of a Participant that:

1. Is created by or received from a Healthcare Provider, healthcare employer, or healthcare clearinghouse;
2. Relates to a Participant's past, present or future physical or mental health or Condition;
3. Relates to the provision of Healthcare Services to a Participant;
4. Relates to the past, present, or future payment for Healthcare Services to or on behalf of a Participant; or
5. Identifies a Participant or could reasonably be used to identify a Participant.

Educational records and employment records are not considered PHI under federal law.

FFF. RADIATION THERAPY

The treatment for malignant diseases and other medical conditions by means of x-ray, radon, cobalt, betatron, telecobalt, and telecesium, as well as radioactive isotopes.

GGG. RESPIRATORY THERAPY

Treatment of respiratory illness and/or disease by the use of inhaled oxygen and/or medication. The equipment used is necessary to allow adequate oxygen to be delivered to the lungs in an effort to appropriately oxygenate the blood.

HHH. SPEECH THERAPY (also called speech pathology)

Services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

III. SURGERY

Surgery includes:

1. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examination and other invasive procedures.
2. The correction of fractures and dislocations.
3. Usual and related pre-operative and post-operative care.

JJJ. SURGICAL ASSISTANT

Either a licensed Physician who actively assists the operating surgeon in the performance of a covered Surgery or a specially trained individual (physician's assistant or registered nurse) who has met the necessary certification or licensure qualifications in the state where the Surgery is being performed.

KKK. WAITING PERIOD

A period of time that the Applicant must wait before the Applicant is eligible for coverage.

Appendix:

Important Notices

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Wyoming who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Wyoming Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Wyoming Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Wyoming. You should not rely on coverage by the Wyoming Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for the purpose of sales or to induce you to purchase any kind of insurance policy.*

The Wyoming Life and Health Insurance Guaranty Association
P.O. Box 36009
Denver, CO 80236-0009
(888) 959-4091
(303) 292-5022
Fax: (303) 292-4663

State of Wyoming
Department of Insurance
106 East 6th Avenue
Cheyenne, Wyoming 82002-0400
(800) 438-5768 (in Wyoming)
(307) 777-7401

Fax: (307) 777-2446

The state law that provides for this safety-net coverage is called the Wyoming Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are *not* protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of

nonprofit educational institutions and their employees;

- unallocated annuity contracts (which give rights to group contract holders, not individuals).
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

LIMITS ON AMOUNT OF COVERAGE – EFFECTIVE 07/01/2012

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender values for life insurance policies, \$300,000 for basic hospital, medical and surgical insurance or major medical insurance, \$300,000 for disability insurance, disability income insurance and long-term care insurance, \$100,000 for coverages not defined as disability insurance or disability income insurance or basic hospital medical and surgical insurance or major medical insurance or long term care insurance, including any net cash surrender and net cash withdrawal values, \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or \$300,000 in life insurance death benefits -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.