Wyoming Educators' Benefit Trust

Fremont County School District #6

Medical Benefit Document with Standard Dental Option

$1,500 Deductible

Effective July 1, 2017

Claims Supervisor:

BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross and Blue Shield Association

Fremont County School District #6

Effective July 1, 2017

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 DO NOT REQUIRE THE USE OF AN IN-NETWORK PROVIDER. FOR A FULL DESCRIPTION OF THESE BENEFITS, PLEASE REFER TO THE BENEFITS SECTION OF THIS BENEFIT DOCUMENT. THIS BENEFIT DOCUMENT DOES NOT MEET THE MINIMUM COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY THE WYOMING INSURANCE CODE.

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

Translation Services

If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-2376.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-442-2376 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.

Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.

Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.

ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Wyoming についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。

यदि तपाई आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ,Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Wyoming ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید.800-442-2376 تماس حاصل نمایید.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે,આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.

Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídílkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bą́ą́h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnil 800-442-2376.

Non-Discrimination Notices

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

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

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

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

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

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

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INTRODUCTION

This document describes the Medical and Dental Plan (The Plan) maintained for the exclusive benefit of the Employees of Fremont County School District #6. The Employer intends to maintain this Plan indefinitely, but reserves the right to terminate in accordance with the WEBT Participation Agreement. Changes in the Plan may be made in any or all parts of the Plan including, but not limited to, services covered, Deductibles, Copayments, maximums, exclusions or limitations, definitions, eligibility, etc.

Benefits under the Plan will only be paid for expenses incurred while the coverage is in force. Benefits will not be provided for services incurred before coverage under the Plan began or after coverage under the Plan is terminated. An expense is considered to be incurred on the date the service or supply was provided.

Blue Cross Blue Shield of Wyoming provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

GENERAL INFORMATION

NAME OF PLAN: Wyoming Educators' Benefit Trust Medical and Dental Benefit Plan

TYPE OF PLAN: The plan is a self-funded health and dental benefit plan

PLAN NUMBER: 501

TAX ID NUMBER: 74-2382896

PLAN YEAR: July 1 through June 30

PLAN SPONSOR: Wyoming Educators' Benefit Trust

SOURCE OF FUNDING: Funding for benefits is derived from the contributions of the Employer and the covered Employees. The Plan is not insured.

PLAN ADMINISTRATOR: Wyoming Educators' Benefit Trust

AGENT FOR SERVICE OF LEGAL PROCESS: Wyoming Educators' Benefit Trust

NAMED FIDUCIARY: Wyoming Educators' Benefit Trust

CLAIMS SUPERVISOR: Blue Cross Blue Shield of Wyoming (BCBSWY)
4000 House Avenue
PO Box 2266
Cheyenne, WY 82003
307-634-1393

SCHEDULE OF BENEFITS

EMPLOYER NAME: Fremont County School District #6
GROUP NUMBER: 312380
EFFECTIVE DATE: July 1, 2017

The below designated Schedule of Benefits is provided under the terms and provisions of the Plan.

A Participant's coverage may not include all the benefits shown in this Benefit Document and may instead be limited to medical benefits only or dental benefits only.

Hospital care benefits are based on Allowable Charges.

Physician benefits are based on Allowable Charges.

DEDUCTIBLES:

Deductible per Participant per calendar year: $1,500

Maximum Aggregate Deductible per calendar year: $3,000

NOTE: Pharmacy Copayments and Coinsurance do not apply to the Deductible requirements.

COINSURANCE:

After the Deductible has been satisfied:

Benefits will be paid at 80% of Allowable Charges and Participants pay 20% Coinsurance for most Covered Services.

NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.

MEDICAL COPAYMENTS:

Visits to a Physician's office will be subject to a $40 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)

COINSURANCE MAXIMUM AMOUNT:

$1,500 per Single Coverage or,

$3,000 per Family, Two Adult, or Adult & Dependent Coverage.

Once the Medical Cost-Share Maximum is met by any combination of medical Copayment and Coinsurance Amounts, Participants are no longer responsible for medical Copayment and Coinsurance Amounts.

NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.

MEDICAL OUT-OF-POCKET MAXIMUM AMOUNT:

$3,000 per Single Coverage or,

$6,000 per Family, Two Adult, or Adult & Dependent Coverage.

Once the Medical Out-of-Pocket Maximum Amount is met by satisfaction of the Deductible and Medical Cost Share Maximum Amounts, medical Covered Services will be paid at 100% of the Allowable Charges for the remainder of the calendar year.

NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.

Preferred Specialty Pharmacy Program and Mail Service Prescription Drug Program:

Preferred Specialty Pharmacy Retail Prescription Drug Program:

Tier 1 Drugs:	Covered generic drugs require a $15.00 Copayment.
Tier 2 Drugs:	Covered Formulary brand drugs require a $40.00 Copayment.
Tier 3 Drugs:	Covered non-Formulary brand drugs require a $60.00 Copayment.
Specialty Drugs:	Covered specialty drugs require 20% Coinsurance.

Mail Service Prescription Drug Program:

Tier 1 Drugs:	Covered generic drugs require a $30.00 Copayment.
Tier 2 Drugs:	Covered Formulary brand drugs require an $80.00 Copayment.
Tier 3 Drugs:	Covered non-Formulary brand drugs require a $120.00 Copayment.
Specialty Drugs:	Covered specialty drugs require 20% Coinsurance.

The total Copayment and Participant's Coinsurance expenses for the Preferred Specialty Pharmacy Program and the Mail Services Prescription Drug Program are limited to a Pharmacy Out-of-Pocket Maximum Amount of $1,500 per Participant per calendar year.

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit cannot be applied

toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for Prescription Drugs and Medicines will be applied toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out- of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 3.

TOTAL IN-NETWORK OUT-OF-POCKET MAXIMUM AMOUNT:

$7,150 per Single Coverage or,

$14,300 per Family, Two Adult, or Adult & Dependent Coverage.

Once the Total In-Network Out-of-Pocket Maximum Amount has been met by satisfaction of the Deductible and any combination of Medical Cost Share Maximum Amounts and Pharmacy Out- of-Pocket Maximum Amounts, benefits will be provided at 100% of Allowable Charges for the remainder of the calendar year.

Charges that exceed the Allowable Charges for non-participating providers and charges for services not covered by this Plan will NOT count toward satisfaction of Participants' Medical Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount. Participants may be responsible for amounts over the Allowable Charges.

MEDICAL BENEFITS:

A Participant's coverage may not include all the benefits shown in this Benefit Document and may instead be limited to medical benefits only or dental benefits only.

Accidents
Allergy
Services
Ambulance
Services
Anesthesia
Services Blood
Expenses
Consultations
Dental Services
Diabetic Services
Extended Care Facility
Hemodialysis and Peritoneal Dialysis
Home Health Care
Hospice Care
Human Organ Transplant
Inherited Enzymatic Disorders

Laboratory, Pathology, X-ray, and Radiology Services
Magnetic Resonance Services
Maternity and Newborn Care
Medical Care for General
Conditions
Mental Health or Substance Use Disorder Care
Phase II Outpatient Cardiac Rehabilitation
Prescription Drugs & Medicines
Preventive Care
Private Duty Nursing Services
Prophylactic Surgery
Rehabilitation
Room Expenses & Ancillary
Services Skilled Nursing Facility
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)
Surgical Assistants
Teladoc
Therapies (Chemotherapy, Radiation Therapy, Physical Therapy, & Respiratory Therapy)

Please see the sections on BENEFITS and GENERAL LIMITATIONS AND EXCLUSIONS for possible limitations and exclusions on these benefits.

Pre-admission review: Required before hospitalizations, except for emergencies or maternities. (See HOW BENEFITS WILL BE PAID section for details.) Call 1-800-251-1814 for Pre-admission review.

DEFINITIONS

This section defines many of the terms and words that are found later in this document. The terms and words defined here are capitalized wherever they are used elsewhere in the document. NOTE: Not every service and supply discussed in the DEFINITIONS section is a covered benefit of this Plan.

A. *ADULT AND DEPENDENT COVERAGE*
Coverage provided to the Employee and one or more eligible Children.

B. *AGGREGATE DEDUCTIBLE*
A specified amount of Allowable Charges for Covered Services that Participants under Family, Adult and Dependent, and Two Adult coverages are responsible for within a specified period of time before all the Participants under that coverage are considered to have met their Deductibles.

C. *ALLOWABLE CHARGES*
The maximum amount allowed for Covered Services under this Plan. Allowable Charges are determined by the Blue Cross Blue Shield of Wyoming payment system in effect at the time the services are provided.

D. *APPLICANT OR EMPLOYEE*
The person who applies for coverage.

E. *BENEFIT PERIOD*
Unless otherwise specified, a period of (12) twelve months commencing on (and including) 12:00 A.M. January 1 and ending at 11:59 P.M. on December 31 of that year. In the calendar year in which the Participant's coverage becomes effective, the "Benefit Period" will be the period between 12:00 A.M. on the effective date of the Participant's coverage and 11:59 P.M. on December 31 of that year. All expenses shall be considered to have been incurred on the date the service or supply for which the charge is made, is provided or received.

F. *BILLING SERVICE DATE*
The date used in assigning effective dates and issuing billings. This date will always be the first of the month.

G. *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 care in states other than Wyoming.

H. *CLAIMS SUPERVISOR*
Blue Cross Blue Shield of Wyoming.

I. COINSURANCE

The portion of a Participant's Allowable Charges for which they are responsible after the Deductible has been met.

J. COPAYMENT

A specified amount of Allowable Charges for Covered Services that the Participant must pay each time a specific occurrence takes place. (NOTE: Prescription Drug and Medicine benefits may be subject to separate Copayment requirements.)

K. COVERED SERVICE

A service or supply specified in this Plan for which benefits will be provided when rendered by a provider.

L. DEDUCTIBLE

A specified amount of Allowable Charges for Covered Services that the Participant is responsible for within a specified period of time before benefits are provided.

M. DEPENDENT

An Employee's Dependents are the following persons, who are eligible for coverage under this Plan, and for which the Employee has elected coverage under this Plan:

1. Spouse. A person (of the same or opposite sex of the Employee) to whom a person is legally married to under the laws of the state or nation that were in place at the time and in the location that the marriage was entered into, and who is currently a permanent resident in the home of the Employee.
2. Child/Children. The child or children, including newborn children, step children, adopted children, children which the court has decreed support to the Employee or the Employee's covered Spouse and legal wards of the Employee or the Employee's covered Spouse. The limiting age for covered Children is the end of the month in which age 26 is attained.
3. Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Employee, or the Employee's covered Spouse, for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the employer within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee, or the Employee's covered Spouse, must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.

N. DIAGNOSTIC SERVICE

A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A Diagnostic Service must be ordered by a Physician or Professional Other Provider.

O. ENROLLMENT DATE

The Enrollment Date means the first day of coverage.

P. 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.

NOTE: Certain services related to cancer clinical trials will be covered in accordance with federal and state law. Coverage shall be provided for individuals enrolled in a cancer clinical trial as follows:

1. Coverage will only be provided for Phase II, III, and IV cancer clinical trials;
2. The cancer clinical trial must be approved by an agency of the National Institutes of Health or, the United States Food and Drug Administration or, the Department of Veterans Affairs, or the Department of Defense;
3. Coverage is only available if medical care is rendered by a licensed health care provider operating within the scope of the provider's license;
4. Coverage for medical treatment shall be limited to routine patient care costs as follows:
    a. A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment;
    b. A drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal Food and Drug Administration for use in treating the patient's particular condition.

5. Coverage shall NOT be available for:
    a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
    b. Any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;
    c. Health care services customarily paid by the sponsor of the clinical trial or study;
    d. Extraneous expenses related to the clinical trial or study including but not limited to travel, housing or other such expenses for the Participant or the Participant's family or companions;
    e. Any item or service solely provided to satisfy a need for data collection or analysis or related to the clinical management of the patient;
    f. Any costs for management of research relating to the trial or study.

NOTE: For a complete description of coverage and limitations for cancer clinical trials, please refer to Wyoming State Statutes, W.S. 26-20-301 et seq.

Q. FACILITY OTHER PROVIDER

A medical facility other than a Hospital which is licensed, where required, to render Covered Services. Facility Other Providers include, but are not limited to:

1. Substance Use Disorder Treatment Center or Facility is a detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism, or a Facility Other Provider which is primarily engaged in providing detoxification and rehabilitation treatment for substance use disorders.
2. Ambulatory Surgical Facility is a Facility Other Provider, with an organized staff of Physicians, which:
    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 supervision of Physicians and nursing services whenever the patient is in the facility,
    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 Physician, or Professional Other Provider.
3. Freestanding Dialysis Facility is a Facility Other Provider other than a Hospital which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
4. Outpatient Psychiatric Facility is a Facility Other Provider which for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness on an outpatient basis.
5. Psychiatric Hospital is a Facility Other Provider which for compensation from its patients, is primarily engaged in providing rehabilitation care services on an inpatient basis. Psychiatric rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

6. Skilled Nursing Facility is a Facility Other Provider which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:
    a. minimal care, custodial care, ambulatory care, or part-time care services, or
    b. care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.
7. Hospice is a Facility Other Provider that offers a coordinated program of home care for a terminally ill patient and the patient's family.
8. Other medical facilities not specifically listed above.

R. FAMILY COVERAGE

Coverage that includes the Employee, the Employee's eligible Spouse, and one or more eligible Children.

S. 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.

T. GROUP

The Plan Sponsor that has signed an agreement with the Claims Supervisor to provide administrative services to its eligible Employees and eligible Dependents.

U. HOSPITAL

A provider that is a short-term, acute, general Hospital which:

1. Is a duly licensed institution.
2. For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians.
3. Has organized departments of medicine and Surgery.
4. Provides 24-hour nursing services by or under the supervision of registered graduate nurses, which are both physically present and on duty.
5. Is not other than incidentally a:
    a. skilled nursing facility,
    b. nursing home,
    c. custodial care home,
    d. health resort,
    e. spa or sanitarium,
    f. place for rest,
    g. place for the aged,
    h. place for the treatment of Mental Illness,
    i. place for the treatment of alcoholism or drug abuse,
    j. place for the provision of hospice care,

k. place for the provision of rehabilitative care,
l. place for the treatment of pulmonary tuberculosis.

V. INCURRED DATE

The date that a service or supply for which a charge is being made was provided or received. The Incurred Date may also be referred to as the date of service.

W. INPATIENT

A Participant who is treated as a registered bed patient in a Hospital or Facility Other 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.

X. LATE ENROLLEE

An eligible Employee or Dependent who requests coverage more than thirty (30) days after the initial date of eligibility and who is not eligible for a special enrollment period at the time of the request.

Y. MEDICAL CARE

Professional services rendered by a Physician or a Professional Other Provider for the treatment of an illness or injury.

Z. MEDICAL COST SHARE MAXIMUM AMOUNT

The total Coinsurance and medical Copayment Amounts for Covered Services that are a Participant's responsibility during a single calendar year.

Copayments and Coinsurance Amounts paid for Prescription Drugs and Medicines under the Preferred Specialty Pharmacy Program do not apply to the Medical Cost Share Maximum Amount.

The calculation of the total Coinsurance and medical Copayment Amounts toward the Medical Cost Share Maximum Amount begins anew on January 1 of each calendar year.

AA. MEDICAL EMERGENCY

A Medical Emergency condition is:

1. 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:
   a. 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
   b. Serious impairment to bodily functions, or
   c. Serious dysfunction of any bodily organ or part, or
2. 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.

BB. 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 health care 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.

CC. MEDICAL OUT-OF-POCKET MAXIMUM AMOUNT

The total Deductible and Medical Cost Share Maximum Amounts for Covered Services that are a Participant's responsibility during a single calendar year. When the Participant's Medical Out-of-Pocket Maximum Amount is met during a single calendar year, Covered Services will be provided at 100% of the Allowable Charges for the remainder of that calendar year.

Copayments and Coinsurance Amounts paid for Prescription Drugs and Medicines under the Preferred Specialty Pharmacy Program do not apply to the Medical Out-of-Pocket Maximum Amount.

The calculation of the total Deductible and Medical Cost Share Maximum Amounts toward the Medical Out-of-Pocket Maximum Amount begins anew on January 1 of each calendar year.

DD. MENTAL ILLNESS

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

EE. OPEN ENROLLMENT PERIOD

The period from November 1 through November 30 each year. A Late Enrollee whose application is received by Blue Cross Blue Shield of Wyoming prior to the following January 1 will have coverage under this Plan effective on January 1.

FF. OUTPATIENT

A Participant who receives services or supplies while not an Inpatient.

GG. PARTICIPANT

The Employee or the Employee's eligible Dependents who are covered under this Plan.

HH. PARTICIPATING

1. Participating Hospitals and Facility Other Providers have entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan to accept the Allowable Charge as the full allowance for Covered Services. Payment for services provided by Participating Hospitals and Facility Other Providers will be made directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Participating Physicians and Professional Other Providers have entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Participating Physicians and Professional Other Providers will be made directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

   NOTE: A Hospital, Facility Other Provider, Physician, or Professional Other Provider who has not entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan is called non-participating. When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by such Non-participating Providers, the amount(s) a 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. A non- participating Physician or Professional Other Provider may bill Participants directly and payments will be made directly to the Participant. If Participants choose a non- participating Hospital or Facility Other Provider, they may be billed directly and payments may be made directly to the Participant. Participants will be responsible to non-participating providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

II. PHARMACY

Any licensed establishment where prescription legend drugs are dispensed by a licensed pharmacist.

JJ. PHARMACY OUT-OF-POCKET MAXIMUM AMOUNT

The total Copayment and Coinsurance Amounts for Covered Services that are a Participant's responsibility under the Preferred Specialty Pharmacy Program Prescription Drug and Medicine benefit during a calendar year. When a Participant meets the Pharmacy Out-of- Pocket Maximum Amount, the Participant is no longer responsible for Prescription Drug and Medicine Copayments and Coinsurance, but still must pay the difference between a brand name drug and the generic equivalent, if a generic is available.

KK. PHYSICIAN

A licensed doctor of medicine or osteopathy licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

LL. PLAN ADMINISTRATOR

The administrator of the Plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

MM. PRESCRIPTION DRUGS

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.

NN. PROBATIONARY/WAITING PERIOD

A length of time established by the employer for which the Employees must fulfill before they are eligible for coverage. Waiting periods will not be considered in determining if a significant break in coverage has occurred.

OO. PROFESSIONAL OTHER PROVIDER

A person or practitioner who is licensed, where required, to render Covered Services. Professional Other Providers include, but are not limited to:

1. Chiropractor is a Board Qualified and licensed Doctor of Chiropractic who treats disease by manipulation of the joints of the body.
2. Clinical Psychologist is a licensed clinical psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.
3. Dentist includes, and only includes, a dentist duly licensed to practice by the state in which the services shall have been provided.
4. Optometrist is a person (O.D.) who measures the eye's refractive powers, performs medical eye examinations and fits glasses to correct ocular defects.
5. Physical Therapist is a licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.
6. Physician Assistant is an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a licensed Wyoming Physician and must be certified by the state to practice.
7. A Nurse Practitioner is 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.

PP. 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 health care provider, health care employer, or health care clearinghouse;
2. Relates to a Participant's past, present or future physical or mental health or condition;
3. Relates to the provision of health care to a Participant
4. Relates to the past, present, or future payment for health care 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.

QQ. REHABILITATIVE ADMISSIONS

Admissions primarily for the purpose of receiving therapeutic or rehabilitative treatment (such as physical, occupational or oxygen therapy, etc.).

RR. SINGLE COVERAGE

Coverage provided for the Employee only.

SS. THERAPY SERVICE

Services or supplies used for the treatment of an illness or injury to promote the recovery of the Participant.

1. Radiation Therapy is 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.
2. Chemotherapy is drug therapy administered as treatment for conditions of certain body systems.
3. Dialysis Treatments are the treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
4. Physical therapy involves the use of physical agents for the treatment of disability resulting from disease or injury. Physical therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries.
5. Respiratory Therapy is the treatment of respiratory illness and/or disease by the use of inhaled oxygen and/or medication.
6. Occupational Therapy is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
7. Speech Therapy includes those services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

TT. TOTAL IN-NETWORK 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. Once the Participant's Total In-Network Out-of-Pocket Maximum Amount is met medical Covered Services and Prescription Drug and Medicine benefits will be provided at 100% of the Allowable Charges for the remainder of the calendar year.

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

UU. TWO ADULT COVERAGE

Coverage provided to the Employee and the Employee's eligible Spouse.

VV. WYOMING EDUCATORS' BENEFIT TRUST (WEBT)

A fully-funded trust, WEBT was established to provide medical, dental, vision, life and disability benefits to active and retired school and other public entity Employees in the state of Wyoming. The WEBT's goal is to maximize the purchasing power and economic leverage of the participating employers and to include quality benefit levels, rate stabilization, and cost competitive programs.

FUNDING LEVELS AND CONTRIBUTIONS

The coverage of eligible Participants under this Plan is subject to the following provisions:

A. *HOW FUNDING LEVELS ARE ESTABLISHED AND CHANGED*

Funding levels for Single, Adult and Dependent, Two Adult, and Family coverages are established by WEBT. Funding levels are established to anticipate the required funding necessary for the operation of this Plan and may change from time to time at the sole discretion of WEBT.

B. *CONTRIBUTION REQUIREMENTS*

The Employer contributes to the required funding and reserves the right to change their contribution at any time. Employees may be required to contribute to the funding levels established under this Plan. The amount of contribution required by the Employees will be determined based on their classification under this Plan (Single, Adult and Dependent, Two Adult, or Family) and will be deducted directly from the Employees' paychecks. The Employer's contribution will end when the Employee is no longer eligible as stipulated in the section on ELIGIBILITY REGULATIONS, or when the Employer elects to terminate coverage under this Plan.

ELIGIBILITY REGULATIONS

Employees and their Dependents are eligible for coverage under this Plan according to the following paragraphs and the employer's final, conclusive, and binding authority to determine the Employees' and their Dependent's eligibility for benefits in accordance with this Plan.

A. ELIGIBILITY FOR EMPLOYEES AND OTHERS

1. Unless otherwise specified, all Employees who are employed thirty (30) or more hours a week are eligible.
2. The Employee must be employed by the employer that is making application for benefit coverage.
3. The Employee must have deductions made for Federal Income Taxes and Social Security by the employer.
4. Directors/Partners/Owners are eligible only if they are also bona fide Employees as provided above.
5. Retirees are eligible for coverage only if specifically permitted by the employer's policy. Record of this policy must be on file with both WEBT and Blue Cross Blue Shield of Wyoming.

NOTE: Any eligible Employee who enters the armed forces on full-time duty may elect continuation of coverage, provided that contributions continue to be paid timely and in full. Eligible Employees who enter the armed forces on full-time duty also have rights to continuation of coverage under the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT. (See the section on HOW TO ADD, CHANGE, OR END COVERAGE.)

NOTE: Except for retirees as described above, retired Employees are not eligible for coverage. However, qualified retirees may be eligible for coverage through the Wyoming Educators' Benefit Trust. See Retiree Continuous Coverage under HOW TO ADD, CHANGE, OR END COVERAGE.

NOTE: Eligible active Employees age 65 and over have a choice of either:

1. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
2. Choosing the federal Medicare program as their primary coverage, in which case coverage for both the Employee and all covered Dependents under this Plan will terminate.

B. DEPENDENT ELIGIBILITY

1. All Dependents of the covered Employee as defined by the Plan are eligible.
2. Dependents of an eligible Employee who enters the armed forces on full-time duty are eligible for continuation of coverage under this Plan, regardless of whether the eligible Employee elects to retain coverage for him/herself. See CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) under the section on HOW TO ADD, CHANGE, OR END COVERAGE.

NOTE: Covered Spouses who turn age 65 have a choice of either:

1. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
2. Choosing the federal Medicare program as their primary coverage, in which case coverage under this Plan will terminate.

C. REQUIRED PERCENTAGE

1. The employer must maintain an enrollment percentage of 75% of the total eligible Employees to continue coverage under this Plan.
2. Any Employee enrolled through other group coverage will not be considered when calculating the required percentage in paragraph one.

HOW TO ADD, CHANGE, OR END COVERAGE

A. HOW TO ADD EMPLOYEES

1. The eligible Employee should complete an application for coverage which should be forwarded to Blue Cross Blue Shield of Wyoming and which must be received within thirty (30) days of the date of hire.
2. Based upon the acceptability and timeliness of the application, the effective date of coverage will be the 1st of the month following the date of hire.
3. If an application is not submitted as described above, the Employee will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the group's annual Open Enrollment Period (November 1-30). Provided the application is received the employer prior to the following January 1, a Late Enrollee will have coverage effective under this Plan on January 1.
4. In addition to the methods of application described above, an Employee may also be eligible to apply for coverage during a special enrollment period. (See ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS below.)

B. HOW TO ADD DEPENDENTS

1. Eligible Dependents can be included at the time the Employee applies for coverage by listing their names and dates of birth on the application for coverage. If the Dependent is included on the Employee's application, the effective date of coverage for the Dependent will be the same as the Employee's effective date.
2. To add eligible Dependents who were not included on the original application, a new application is required. Eligible Dependents who are considered to be Late Enrollees because their application was not received by the employer within thirty (30) days of their initial date of eligibility are eligible to apply for coverage during the group's annual Open Enrollment Period (November 1-30). Provided the application is received by the employer prior to the following January 1, a Late Enrollee will have coverage effective under this Plan on January 1.
3. To add newly acquired eligible Dependents, the Employee should complete an application for coverage and forward it to the employer immediately. The application must be received by the employer within the prescribed period following the acquisition of the new Dependent as described below.
4. The effective date of coverage for newly acquired Dependents will be as follows:
    a. The new Spouse will be effective on the date of marriage provided the application, along with documentation verifying the marriage, is received by the employer within thirty (30) days after the date of marriage.
    b. Newborn children will be effective on the date of birth for a period of thirty-one (31) days. A completed application for the child will be required before claims will be processed. The Employee may continue coverage for the newborn child beyond the thirty-one (31)-day automatic coverage provided that the completed application for coverage of the newborn child is received by the employer within sixty-one (61) days of the child’s date of birth.
    c. An adopted child or legal ward will be effective on the earlier of the date the petition for adoption is 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

will be the date of entry of a final adoption decree by the court), for a period of thirty-one (31) days. A completed application for coverage for the child will be required before claims will be processed. The Employee may continue the coverage for the adopted child or legal ward beyond the thirty-one (31)-day automatic coverage provided that the completed application for the adopted child or legal ward is received by the employer 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). NOTE: (1) The adoption or legal guardianship papers must accompany the application; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

5. All applications for newly acquired Dependents must be accompanied by a Letter of Transmittal from the employer to Blue Cross Blue Shield of Wyoming. If a new application is not received by the employer within the prescribed periods as described above or during a special enrollment period, the Dependent will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the group's annual Open Enrollment Period (November 1-30). Provided the application is received by the employer prior to the following January 1, a Late Enrollee will have coverage effective under this Plan on January 1.

C. CHANGES

1. The Employee must notify the employer within thirty (30) days of all changes in an Employee's status, such as those resulting from marriage, divorce, birth, adoption, or change of residence and within ninety (90) days of death or entrance into, or return from, the armed services. All changes must be in accordance with the ELIGIBILITY REGULATIONS section of this Plan.
2. The employer will notify Blue Cross Blue Shield of Wyoming of any changes in Employee eligibility status within ten (10) days of the date of change.

D. WHEN COVERAGE FOR THE EMPLOYEE ENDS

1. When the Employee leaves employment (except if an eligible retiree or as described below under COBRA or RETIREE CONTINUOUS COVERAGE).
   NOTE: Accrued vacation time and sick leave will not extend coverage beyond the first Billing Service Date following the last day of employment.
2. Upon the death of the Employee.
3. Eligible active Employees age 65 and over have a choice of either:
   a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
   b. Choosing the federal Medicare program as their primary coverage, in which case coverage for both the Employee and all covered Dependents under this Plan will terminate.
4. When the Plan is terminated. No continuation of coverage will be offered by Blue Cross Blue Shield of Wyoming if the employer adopts another group health plan.
5. The end of the month following the Employee's written request.

6. When there is improper use of this Plan or the identification card, or when there is fraud or material misrepresentation associated with the application, or with the filing of a claim by the Participant. The Employee is liable for any benefits payments made through such improper actions.
7. When the employer notifies Blue Cross Blue Shield of Wyoming within thirty (30) days of a leave of absence of a covered Employee, the covered Employee may remain on the coverage by paying the full amount of the monthly contribution. The leave of absence coverage will be applied toward the eighteen (18) or thirty-six (36) month period of COBRA coverage. The COBRA benefit period will be measured from the date of leave.

   If, after the leave of absence, the covered Employee will not be returning to work or is not maintained on the payroll, the covered Employee must be removed from the coverage on the first service date following the leave of absence. Any COBRA coverage benefit period remaining will be extended to the covered Employee. If notification of this change is received within thirty (30) days of the loss of eligibility as stated above, Blue Cross Blue Shield of Wyoming will notify the Employee of any remaining COBRA benefits or conversion rights if the COBRA benefit period has been exhausted and convert the Employee's coverage to the appropriate Group Conversion program with continuous coverage.

E. RETIREE CONTINUOUS COVERAGE

Upon retirement, retirees and their eligible Dependents are eligible to continue coverage through the Wyoming Educators' Benefit Trust retiree program if the retiree meets the following criteria:

1. Eligible for and immediately receiving an early retirement benefit from the participating employer, and/or
2. Eligible for and immediately receiving a monthly retirement benefit from the Wyoming State Retirement System.

Prior to transferring into the Wyoming Educators' Benefit Trust retiree program, the eligible retiree and eligible Dependents shall have completed the following:

1. Any retiree eligibility for medical coverage with the participating employer, and/or
2. Their COBRA eligibility period (only if the retiree elected COBRA coverage).

If this Plan between the employer and the Wyoming Educators' Benefit Trust is terminated, coverage for all retirees under the age of 65 and their eligible Dependents shall not be continued. The under age 65 retirees will have their coverage terminated and it will be the responsibility of the employer and the under age 65 retiree to arrange for continued coverage. Over age 65 retirees and their eligible Dependents will be allowed to continue coverage through the Wyoming Educators' Benefit Trust retiree program.

F. WHEN COVERAGE FOR DEPENDENTS ENDS

1. When the Employee's coverage ends. However, the eligible Dependent may apply for a continuation of coverage as described below under COBRA.
2. Covered Spouses who turn age 65 have a choice of either:

a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
b. Choosing the federal Medicare program as their primary coverage, in which case coverage under this Plan will terminate.

3. On the next Billing Service Date following the date the Dependent no longer qualifies as a Dependent as defined in this Plan.
4. The first Billing Service Date following a final divorce decree or legal separation for a Spouse.
5. The end of the month following the Employee's written request to end coverage for the Dependent.
6. The end of the month in which a Dependent Child attains age twenty-six (26).

   Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Employee, or the Employee's covered Spouse, for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the employer within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee, or the Employee's covered Spouse, must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.
7. When an Employee is on a leave of absence, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.
8. 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 the employer no later than thirty (30) days after the end of that automatic coverage period.

G. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

1. Under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) Participants may qualify for continued coverage under this Plan for a specified period of time after coverage would normally terminate. Such continued benefits may last for up to 18, 29, or 36 months, depending on the "Qualifying Event".
2. The continued benefits provided under COBRA will be the same as that provided for similarly situated individuals who have not had a qualifying event. Continued coverage under COBRA is subject to the timely payment of monthly contributions by the Participant.
3. Qualified Beneficiaries are eligible for COBRA continuation coverage under this Plan. A Qualified Beneficiary is any individual who, on the day before a qualifying event (or newly born or adopted child, even if after the qualifying event), is covered under this Plan by being either:
   a. A covered Employee,

b. A covered Spouse, or
c. A covered Child.

4. Up to 18 months of COBRA continuation coverage is available (29 months if a covered Employee or eligible Dependent is disabled within 160 days of the date of termination) to covered Employees and their covered eligible Dependents in the event of loss of coverage due to:
   a. Voluntary termination of employment,
   b. Involuntary termination of employment (except for "gross misconduct"), or
   c. Reduction in work hours, resulting in the Employee's ineligibility for coverage.
5. Up to 24 months of COBRA continuation coverage is available to covered Employees and their eligible Dependents in the event of loss of coverage due to the Employee's entering the Armed Forces on a full time basis.
6. Up to 36 months of COBRA continuation coverage is available to covered Spouses and covered Children in the event of the loss of coverage due to:

a. Death of the Employee,
b. Divorce, legal separation, or dissolution
c. Ineligibility of a Dependent Child under the terms of this Plan, or
d. The Employee's entitlement to Medicare.

7. Multiple Qualifying Events occur when a Participant becomes a Qualified Beneficiary due to termination of employment (voluntary or involuntary) or a reduction in work hours, and subsequently experiences a secondary qualifying event (death of the Employee, divorce, a child's ineligibility, or the Employee's entitlement to Medicare) during the initial COBRA continuation period. If this occurs, Qualified Beneficiaries may be entitled to up to 36 months of continued coverage, calculated from the initial qualifying event date.
8. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected Qualified Beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to timely payment of monthly contributions. If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, an 11 month extension is available to all individuals who are Qualified Beneficiaries due to the termination or reduction in hours of employment. This disabled individual can be a covered Employee or any other Qualified Beneficiary. However, to be eligible for the

   11 month extension, affected individuals must still comply with the notice requirements in a timely fashion. Monthly contribution rates during this 11 month extension period may increase.
9. COBRA continuation of coverage may be terminated only upon:
   a. The abolition of all health plans by the employer,
   b. The Qualified Beneficiaries' failure to make timely payment of monthly contributions due,
   c. A Qualified Beneficiary's entitlement to Medicare.
10. The employer must notify Blue Cross Blue Shield of Wyoming within thirty (30) days of a Participant's termination or reduction in hours of work resulting in the loss of eligibility for health coverage. Blue Cross Blue Shield of Wyoming will provide the Participant with an election form for COBRA continuation coverage within 14

days of receiving notification from the employer. The Participant must sign and return the 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: Employees who do not exercise their right to elect COBRA continuation coverage within sixty (60) days as described are not later eligible to apply for COBRA coverage during the employer's Open Enrollment Period.

11. In the case of Death, Divorce, Legal Separation, Dissolution or Entitlement to Medicare, the Employee or Qualified Beneficiary must notify Blue Cross Blue Shield of Wyoming within sixty (60) days of the event. Blue Cross Blue Shield of Wyoming will then provide qualified beneficiaries with notification of alternatives as required by law. NOTE: If an Employee or other Qualified Beneficiary fails to report a qualifying event within the 60 days as described, the Qualified Beneficiary loses the right to continuation coverage.
12. Participants are required to pay for COBRA continuation coverage in a timely fashion. Up to the amounts permitted by law, Participants may be charged a monthly amount for coverage which is slightly higher than the total amount contributed for a similarly situated individual to whom a qualifying event has not occurred. Failure to make the initial or any subsequent payment in a timely fashion will result in termination of COBRA continuation coverage.

H. FAMILY MEDICAL LEAVE ACT

1. Under the Family and Medical Leave Act of 1993 (FMLA), Participants may be eligible for continued coverage under this Plan while on unpaid leave for the reasons described below.
2. If the Employee has to attend to any of the following family needs, the Employee may be eligible for unpaid FMLA leave for up to a maximum period of 12 work weeks during any 12-month period:
   a. The birth or adoption of a child,
   b. The placement of a child in the Employee's custody for foster care,
   c. The care of a spouse, child, or parent with a serious health condition, or
   d. The Employee's own serious health condition which makes it impossible to perform the functions of the job.
   e. A "qualifying exigency" (as defined by the Department of Labor) caused by the call up of an Employee’s immediate family member (spouse, child, or parent), including reservist or member of the National Guard, to active duty in the armed forces.

   This period will include any period of family or medical leave provided under any state or local law.
3. The Employee may be eligible for unpaid FMLA leave for up to a maximum period of 26 work weeks during any 12-month period when the Employee is providing care to a family member who was wounded in the line of duty while on active duty in the armed forces. The leave is to care for veterans undergoing medical treatment, recuperation, or therapy, are in Outpatient status, or are on the temporary disability retired list for a serious injury or illness. This FMLA leave is available to an Employee who is the spouse, son, daughter, parent, or next of kin of the wounded

service member.

4. Eligible Employees are those who:
   a. Have been employed for at least 12 months by the employer, and
   b. Have worked for at least 1,250 hours with the employer during the previous 12 months, and
   c. Have been employed at a worksite where 50 or more Employees are employed by the employer within 75 miles of that worksite, and
   d. Are covered for benefits under this Plan.
5. Blue Cross Blue Shield of Wyoming must be notified by the employer within thirty (30) days of the beginning of any FMLA leave for a covered Employee. Blue Cross Blue Shield of Wyoming must also be notified by the employer of the conclusion of the leave period(s).
6. As long as monthly contributions are paid, coverage for the benefits provided under this Plan will be continued for Participants while the Employee is on FMLA leave. Coverage for the Participants will be on the same basis as that provided for any other similarly situated Participants.
7. The employer may grant an FMLA leave request and continue contributions for the Employee's coverage under appropriate personnel rules.
8. If the Employee does not return to work after the FMLA leave, the employer may recover from the Employee that portion of the funding paid by the employer on the Employee's behalf in order to maintain the coverage, except if the Employee fails to return because of a serious health condition or circumstances beyond the Employee's control.

I. ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS

Employees and Dependents can be added for coverage under this Plan during special enrollment periods as described in applicable federal and state law. Employees and Dependents eligible for special enrollment will not be considered Late Enrollees.

1. If at the time of initial eligibility, Employees or Dependents decline coverage under this Plan because of other health coverage, they may be eligible for a special enrollment, provided they request enrollment within 30 days after the other health coverage ends.

   To qualify for this special enrollment, the Employees or Dependents must have lost their other coverage due to either:
   a. The termination of employer contributions,
   b. The Employee's or Dependent's loss of eligibility due to divorce, death, legal separation, termination of employment, or reduction in work hours, or
   c. The exhaustion of group continuation coverage if the Employee or Dependent had been on group continuation coverage at the time of initial eligibility.

   The Employee must complete an application for coverage which must be received by the employer within thirty (30) days after the Employee's or Dependent's other coverage ends. The effective date of coverage under this Plan will be the 1st of the month following the date that the previous health coverage ended.
2. If Employees gain a new Dependent as a result of marriage, birth, adoption, or

placement for adoption, they may be eligible for a special enrollment for themselves and their Dependents, provided they complete an application for coverage which is received by the employer within thirty (30) days after the marriage, birth, adoption, or placement for adoption. The effective date of coverage will be:

a. In the case of marriage, the date of marriage,
b. In the case of a Dependent's birth, the date of birth, and
c. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

3. If the Employee or any Dependents dropped coverage under this Plan due to the Employee's entrance into the armed forces on full-time duty, they may be eligible for a special enrollment. The Employee and any Dependents being added to the coverage must complete an application which must be received by the employer within thirty (30) days after the date of termination of the Employee's full-time duty status. The effective date of coverage under this Plan for all such applicants will be the first day of the month following receipt by the employer of a substantially complete application. Such coverage shall be without any exclusion of Pre-existing Conditions, except as otherwise set forth in this Plan, including the remainder of any waiting period that was unfulfilled at the time of the Employee's termination of coverage.
4. If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, they may be eligible for coverage if the Employee completes an application which is received by the employer within sixty (60) days after the termination. The effective date of coverage will be the first of the month following receipt of the application.
5. If the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP), they may be eligible for coverage if the Employee requests coverage within sixty (60) days after eligibility is determined. The effective date of coverage will be the first of the month following receipt of the application.
6. If there are changes to local, state or federal laws that influence eligibility under this Plan, an Employee or Dependent may become eligible for a special enrollment.

HOW BENEFITS WILL BE PAID

The Plan Sponsor's decision shall be the final, conclusive, binding and exclusive authority as to all issues of interpretation and fact-finding regarding the payment and denial of all claims.

This coverage pays benefits for Allowable Charges (subject to Deductible, Copayment, and Coinsurance provisions) as indicated on the Schedule of Benefits page, for service and supplies as shown in the section on BENEFITS.

A Participant's coverage may not include all the benefits shown in this Benefit Document and may instead be limited to medical benefits only or dental benefits only.

A. HOSPITALS AND FACILITY OTHER PROVIDERS

Payment for inpatient services will be based on the Allowable Charges. If a Participant has a private room in a Hospital, covered charges under the Plan will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

1. Blue Cross Blue Shield of Wyoming Participating Hospitals and Facility Other Providers have entered into an agreement with it to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Participating Hospitals and Facility Other Providers will be made directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Payment for Covered Services provided to Participants by non-participating Hospitals or Facility Other Providers may be made to the Participants. Participants are responsible to non-participating providers of services for all charges, regardless of the Allowable Charge or the amount of payment made under this Plan.

Any specific service or supply listed in Blue Cross Blue Shield of Wyoming's Allowable Charges schedules shall not be construed to extend coverage to any service not specified as a Covered Service.

PRE-ADMISSION REVIEW

If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program.

B. PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS

Payment for Covered Services will be based on the Allowable Charges.

1. Blue Cross Blue Shield of Wyoming Participating Physicians and Professional Other Providers have entered into an agreement with it to accept its Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Participating Physicians and Professional Other Providers will be made

directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

2. Payment for Covered Services provided to Participants by non-participating Physicians or Professional Other Providers will be made to the Participant and Participants are responsible for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

Any specific service or supply listed in Blue Cross Blue Shield of Wyoming's Allowable Charges schedules shall not be construed to extend coverage to any service not specified as a Covered Service.

If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming. See PRE-ADMISSION REVIEW under HOSPITAL AND FACILITY OTHER PROVIDERS above.

C. OUTPATIENT SURGERY

If a Participant undergoes a surgical procedure as an Outpatient, benefits will be provided according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

D. PRE-ADMISSION TESTING

Benefits will be provided for pre-admission testing ordered by a surgeon leading up to surgery, 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.

Covered Services will be provided at 100% of Allowable Charges after the Deductible. Pre-admission testing that is repeated in the Hospital will not be covered unless medically necessary.

E. COPAYMENT REQUIREMENTS

Visits to a Physician’s office will be subject to a $40 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan’s annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan’s Deductible and Coinsurance provisions.)

F. DEDUCTIBLE REQUIREMENTS

Under Single Coverage, the Deductible is shown on the Schedule of Benefits.

Under Two Adult, Adult and Dependent, or Family Coverage, the maximum Aggregate Deductible amount for each calendar year is also shown on the Schedule of Benefits. This maximum Aggregate Deductible may be satisfied in any of the following ways:

1. When one Participant meets one-half of the maximum Aggregate Deductible, 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 maximum Aggregate Deductible.
2. When two Participants each meet one-half of the maximum Aggregate Deductible, the remaining Participants will then be eligible for benefits without regard to that Deductible.
3. When no one Participant meets one-half of the maximum Aggregate Deductible, but all the Participants collectively meet the maximum Aggregate Deductible, 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 maximum Aggregate Deductible.

NOTE: The Deductible does not apply to PREVENTIVE CARE.

G. PAYMENT ALLOWANCES UNDER THIS COVERAGE

Except as indicated elsewhere in this Plan, all required Deductibles or Copayments must be satisfied before any benefits under this Plan will be provided.

Unless otherwise indicated, Participant's responsibility for Covered Services will be as follows:

1. Participants pay 20% Coinsurance and medical copayments until the Medical Cost Share Maximum Amount shown on the Schedule of Benefits is met, unless otherwise specified within this Plan.
2. Once the Medical Out-of-Pocket Maximum Amount is met, medical Covered Services will be provided at 100% of the Allowable Charges for the remainder of the calendar year.
3. Once the per Participant Pharmacy Out-of-Pocket Maximum Amount is met, Prescription Drugs and Medicines for that Participant will be provided at 100% of the Allowable Charges for the remainder of the calendar year.

H. CALCULATION OF OUT OF AREA PAYMENTS

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, the Participant will obtain the Covered Services from Physicians, Professional Other Providers, Hospitals and Facility Other 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, the Participant may obtain Covered Services from Physicians, Professional Other Providers, Hospitals and Facility Other 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 access' 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. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

   Whenever a Participant access' Covered Services outside Blue Cross Blue Shield of Wyoming's service area and the claim 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 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 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 its 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.

BENEFITS

The following pages describe the various services and supplies for which benefits are payable under this Plan and to what extent benefits are provided on an Inpatient or Outpatient basis by different types of providers.

Benefits are only provided for services and supplies related to and required for the treatment of a specific illness or injury. All benefits are subject to the GENERAL LIMITATIONS AND EXCLUSIONS section and the HOW BENEFITS WILL BE PAID section.

A Participant's coverage may not include all the benefits shown in this Benefit Document and may instead be limited to medical benefits only or dental benefits only.

A. ACCIDENTS

DEFINITIONS- An "accident" is 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. 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, or an intentionally self-inflicted injury (unless the injury is the result of a medical condition [either physical or mental] or domestic violence).

BENEFITS-
Inpatient: See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: Covered when services are provided by a Physician, Professional Other Provider, Hospital, or Facility Other Provider.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ALLERGY SERVICES

BENEFITS-
Benefits will be provided for allergy services. Covered Services will be subject to Deductible and Coinsurance. Covered Services include but are not limited to:

1. Allergy Testing
    a. Direct skin or,
    b. Patch testing.
2. Onsite administrations of allergy shots.

LIMITATIONS AND EXCLUSIONS-

1. Benefits are not available for clinical ecology, orthomolecular therapy, vitamins, dietary nutritional supplements, or related testing rendered on an Outpatient basis.
2. Benefits are not available for the following allergy testing modalities: nasal challenge testing, provocative/neutralization testing, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgE level testing for food allergies, general volatile organic screening test and mauve urine test.
3. Benefits are not available for the following methods of desensitization: provocation/neutralization therapy by sublingual (drops) intradermal and subcutaneous routes, urine autoinjections, repository emulsion therapy, candidiasis hypersensitivity syndrome treatment or IV vitamin C therapy.

See GENERAL LIMITATIONS AND EXCLUSIONS

C. AMBULANCE SERVICES

DEFINITIONS- An "ambulance" is a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must employ trained personnel.

BENEFITS-
The following professional ambulance services are covered when the Participant cannot be safely transported by any other means. Benefits will be determined based on the final diagnosis:

1. For Inpatient care to the nearest Hospital with appropriate facilities or, under similar restrictions, from one Hospital to another.
2. For Outpatient care to the nearest Hospital with appropriate facilities when such care is related to a Medical Emergency or an accident.
3. From the nearest Hospital to the Participant's home, nursing home, or skilled nursing facility in the same locale.

LIMITATIONS AND EXCLUSIONS-

1. Air Ambulance: In most cases, ground ambulance is the normally approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's condition warrants air ambulance services.
2. Other Transportation Services: Benefits will not be paid for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.
3. Patient Safety Requirement: If Participants could have been transported by automobile or public transportation without danger to their health or safety, an ambulance trip will not be covered. No benefits will be provided for such ambulance services even if other means of transportation were not available.

NOTE: No benefits will be provided for ambulance charges for the convenience of the family or Participant. (Example: Transportation of an infant to be closer to the family's home.)

See GENERAL LIMITATIONS AND EXCLUSIONS

D. ANESTHESIA SERVICES

DEFINITIONS- "Anesthesia" services are performed by a Physician or Certified Registered Nurse Anesthetist (C.R.N.A.) trained in this specialty. General anesthesia produces unconsciousness in varying degrees with muscular relaxation and reduced or absent pain sensation. Regional or local anesthesia produces similar muscular and pain effects in a limited area with no loss of consciousness.

BENEFITS-
Inpatient: Benefits will be provided for anesthesia services provided by a Physician or C.R.N.A. when necessary for covered surgery.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, benefits will be provided according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

The Allowable Charges will be based on the type of surgery and the amount of time necessary for anesthesia services.

LIMITATIONS AND EXCLUSIONS-

1. Hypnosis: Not covered for anesthesia purposes.
2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to anesthesia services.

See GENERAL LIMITATIONS AND EXCLUSIONS

E. BLOOD EXPENSES

DEFINITIONS- "Blood" expenses include the following:
1. Charges for processing, transportation, handling, and administration.
2. Cost of blood, blood plasma, and blood derivatives.

BENEFITS-
Benefits will be paid for blood transfusions including the cost of blood (except when donated or replaced), blood products, and blood processing.

LIMITATIONS AND EXCLUSIONS-
The "limitations and exclusions" that apply to SURGERY benefits also apply to blood expenses.

See GENERAL LIMITATIONS AND EXCLUSIONS

F. CONSULTATIONS

DEFINITIONS- When requested by the Physician in charge, a "consultation" is the service of another Physician to provide advice in the diagnosis or treatment of a condition which requires the consultant's special skill or knowledge.

BENEFITS-
Inpatient and Outpatient: Benefits will be provided for Physician consultations.

Second Surgical Opinion: Benefits will be provided for the Physician's services, as well as for any charges for tests necessary to receive a second surgical opinion before undergoing any surgery. If possible, Participants should provide any test results provided by their Physician when they obtain the second surgical opinion.

If the first and second opinions differ, benefits will also be provided for covered expenses incurred for a third opinion.

LIMITATIONS AND EXCLUSIONS-
Staff Consultations: Consultations that are required by rules and regulations of a Hospital or other facility are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. DENTAL SERVICES (Medical Plan)

DEFINITIONS- "Dental services" are those which are performed for treatment of conditions related to the teeth or structures supporting the teeth.

BENEFITS-
Hospital:
Inpatient: If a Participant is hospitalized for one of the following reasons, benefits will be provided as shown under ROOM EXPENSES AND ANCILLARY SERVICES, when Covered Services are provided by a Hospital:

1. 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).
2. 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).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis not originating in the teeth or gums.
5. Incision of accessory sinuses, salivary glands or ducts.
6. Accidental injury (see limitation #1).
7. Reduction of dislocations of the temporomandibular joints as a result of an accident.

Benefits will also be provided for the room allowance and ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICE) in a Hospital when a hazardous medical condition (such as heart condition) makes it necessary to have an otherwise non-covered dental procedure performed in the Hospital.

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 Participant's Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, benefits will be provided only if written authorization is obtained from Blue Cross Blue Shield of Wyoming in advance of the date services are performed.

Outpatient: Benefits will be provided for initial services provided by a Hospital or Facility Other Provider for any one of the seven procedures listed above under "INPATIENT" benefits.

Physician:
Inpatient and Outpatient: Benefits will be provided for the seven procedures listed above under INPATIENT benefits when provided by a Physician, dentist or oral surgeon. The Allowable Charge for surgery includes payment for pre-operative visits, local infiltration of anesthesia, and follow-up care.

LIMITATIONS AND EXCLUSIONS-

1. Accidental Injury Benefit: Benefits will not be provided for restoring the mouth, tooth, or jaw because of injuries from biting or chewing. Benefits will be provided for accident-related dental expenses only under the following conditions:
   a. Services, supplies, and appliances must be required due to an accidental injury.
   b. Treatment must be for injuries to sound natural teeth.
   c. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
   d. Related services must be performed within one year after the accident.
   e. All services must be performed while the Participants coverage is still in effect.
2. Hazardous Medical Conditions: If, due to a hazardous medical condition (e.g. a heart condition or severe diabetes), hospitalization occurs for a non-covered dental procedure, benefits may be provided for Inpatient or Outpatient Hospital charges. However, benefits for the services provided by the Participant's dentist or oral surgeon will be limited to those described under DENTAL EXPENSES (Dental Plan), if applicable.
3. Restorative Services: 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.
4. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
5. Physician services are not covered for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.
6. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under DENTAL EXPENSES (Dental Plan), if applicable.

See GENERAL LIMITATIONS AND EXCLUSIONS

DENTAL EXPENSES (Standard Dental Plan)

NOTE: Coverage under this section is available only to those Participants who have selected the dental benefits option.

Deductible Requirements: Dental expense benefits are subject to a separate Dental Deductible. The Deductible on Single Coverage is $50.00; on Two Adult, Adult and Dependent or Family Coverage, the Aggregate Deductible is $100.00. The Deductible does not apply to Preventive and Diagnostic Services.

BENEFITS-
PREVENTIVE AND DIAGNOSTIC: Payable at 100% of Allowable Charges.

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. Diagnostic X-rays:
    a. Full mouth x-rays (but not more than one set in 36 consecutive months).
    b. Bite wing x-rays (but not more than two sets per calendar year).
    c. X-rays required in connection with diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic procedures and treatment.
4. Emergency palliative treatment.
5. *Fluoride treatments.
6. *Space maintainers.
7. Sealants on posterior permanent teeth for dependent children up to the date of their sixteenth birthday, but not more than once in every three (3) calendar years.

(*Only a Covered Service for dependent children through their limiting age. See DEPENDENT in DEFINITIONS for additional information on limiting age.)

RESTORATIVE PROCEDURES: Payment for Restorative Procedures is limited to 80% of Allowable Charges, subject to the Dental Deductible. Participant is responsible to provide payment for the remaining 20% of the Allowable Charges.

1. Extractions (except extractions for orthodontics).
2. Oral surgery (excluding procedures covered under the medical portion of this Plan).
3. Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).
4. General anesthetics.
5. Periodontal treatment, diseases of gums.
6. Endodontic treatment (Pulp infection and root canal therapy).
7. Injection of antibiotic drugs.

PROSTHODONTIC TREATMENT: Payment for Prosthodontic Treatment is limited to 50% of Allowable Charges, subject to the Dental Deductible. Participant is responsible to provide payment for the remaining 50% of the Allowable Charges.

1. Initial installation of fixed bridgework.
2. Initial installation of partial or full removable dentures.
3. Inlays, onlays, crowns.

4. Gold fillings. (See LIMITATIONS AND EXCLUSIONS below for more information.)
5. Repair or replacement or addition to bridgework, dentures, crowns, inlays including recementing where necessary because of:
   a. One 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. Dental implants.

ORTHODONTIC TREATMENT: The following Orthodontic Treatment that is not Medically Necessary is limited to 50% of Allowable Charges, Participant is responsible to provide payment for the remaining 50% of the Allowable Charges. Orthodontic Treatment is limited to a lifetime maximum of one thousand five hundred dollars ($1,500) and is available only to covered, unmarried dependent children until the end of the month in which they turn age nineteen (19).

1. Orthodontic diagnostic procedures (including cephalometric X-rays).
2. Surgical therapy (surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion).
3. Appliance therapy (braces) including oral exams, surgery, extractions, and X-rays.

Orthodontia claims are handled as follows: Upon proper submission of written proof of claim, benefits for the initial visit will be payable as described above. Benefits for all subsequent services require continued submission of written proofs of claims and continued coverage of the patient under this Plan.

Medically Necessary Orthodontic Treatment is covered as described below under Pediatric Dental Services.

PEDIATRIC DENTAL SERVICES:

1. Preventive and Diagnostic, Restorative Procedures and Prosthodontic Treatment:
   Preventive and diagnostic, restorative procedures and prosthodontic treatment are available to Participants until the end of the month in which they turn 19 and are not subject to any lifetime or calendar year maximums. These services will still be subject to the dental deductible and the specified payment of Allowable Charges as stated above.
2. Medically Necessary Orthodontic Treatment:
   Orthodontic Treatment that is Medically Necessary is available only to covered, unmarried dependent children until the end of the month in which they turn 19. Medically Necessary Orthodontic Treatment is limited to 50% of the Allowable Charges and the Participant is responsible to provide payment for the remaining 50% of the Allowable Charges. Medically Necessary Orthodontic Treatment is not subject to any lifetime or calendar year maximums stated above.

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 dental coverage. Blue Cross Blue Shield of Wyoming will reimburse a pro-rated portion of the Allowable Charge for the Covered Services provided after the effective date of dental coverage.

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.

MAXIMUM BENEFITS: Except as provided above for orthodontic treatment, the maximum benefits for Covered Services under this Dental Expenses (Standard Dental Plan) for each Participant are $1,200.00 per calendar year. (Note: This maximum benefit provision does not apply to Participants under the age of 19)

Benefit Payments:

1. Payment for Covered Services will normally be made directly to the Participating dentist providing the service or supply. An explanation of benefits will be forwarded to the Participant.
2. If the estimated charges exceed five hundred dollars ($500.00), a Pre-certification estimate of charges is required and should be handled as follows:
    a. The dentist should complete the 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.
    b. After review by Blue Cross Blue Shield of Wyoming, the claim form will be returned to the dentist indicating the coverage available.
    c. When the work is completed the dentist should indicate on the claim form:
        1) The specific service performed;
        2) Identify the tooth, or teeth, involved in the procedure;
        3) The date the specific service was completed;
        4) The actual charges for the service or supply.
    d. The claim form should be forwarded to Blue Cross Blue Shield of Wyoming for processing.
3. Alternate Procedures: 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 Participant will be responsible for the excess amount over the benefits allowed for the less costly procedure.

LIMITATIONS AND EXCLUSIONS-

1. Pre-certification: 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.

2. Restorative Services: 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.
3. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
4. Dentures and Bridgework: Benefits will not be provided for replacement of existing dentures or bridgework, except in the following cases:
    a. When existing partial dentures, full removable dentures or fixed bridgework cannot be made serviceable and were installed five years before replacement, and/or
    b. When replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while the Participant is covered under this Agreement.
5. Gold or other precious metals used in restorative or prosthodontic procedures will be payable at the semi-precious allowance.
6. General Exclusions: Benefits will not be provided for the following:
    a. Replacement of stolen or lost prosthetic devices.
    b. Missed appointments.
    c. Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.
    d. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.
    e. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.
    f. Extra sets of dentures or other prosthetic devices or appliances.
    g. Temporary or treatment dentures.
7. Any limitations under this Dental Expenses (Standard Dental Plan) on annual or calendar year maximums do not apply to Participants under the age of 19.

See GENERAL LIMITATIONS AND EXCLUSIONS

H. DIABETES SERVICES

DEFINITIONS- The term "diabetes services" applies to outpatient self-management training, education, and equipment and supplies for the management of diabetes.

BENEFITS-
Inpatient: Not covered under DIABETES SERVICES. (See ROOM EXPENSES AND ANCILLARY SERVICES).

Outpatient: Covered Services will be subject to Deductible and Coinsurance, benefits will be provided for 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 a health care professional legally authorized to prescribe such items under law.

Covered diabetes Outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes. Required covered Outpatient self-management training and education shall be limited to:

1. A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis, and
2. 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.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

I. EXTENDED CARE FACILITY

DEFINITIONS- Extended care facility means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for Participants convalescing from injury or sickness, and:

1. Is approved by and is a participating extended care facility of Medicare, and
2. Has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or registered nurse, and
3. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement, and
4. Provides appropriate methods for dispensing and administering drugs and medicines, and
5. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

An Extended Care Facility is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or part-time care services.

Prior approval must be obtained through Blue Cross Blue Shield of Wyoming case management before benefits are provided.

BENEFITS-
Inpatient: Benefits will be provided to a lifetime maximum of forty-five (45) days per Participant for daily charges for room and board and general nursing services in a licensed, extended care facility.

Outpatient: Not covered.

Physician:
Inpatient and Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

J. HEMODIALYSIS AND PERITONEAL DIALYSIS

DEFINITIONS- "Hemodialysis" is the treatment of a kidney disorder by removal of blood impurities with dialysis equipment.

"Peritoneal dialysis" is a treatment where blood impurities are removed by using the lining of the peritoneal cavity as the filter.

BENEFITS-
Hemodialysis and peritoneal dialysis are covered when a Physician provides treatment to an Inpatient, in the Outpatient department of a Hospital or other facility, or in the Participant's home. Benefits will also be provided for the rental or purchase (whichever is less) of dialysis equipment when prescribed by a Physician and required for therapeutic use.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

K. HOME HEALTH CARE

DEFINITIONS- "Home health care" is Medical Care provided in the patient's home in lieu of Inpatient hospitalization.

"Home health agency" is a private or public organization which: 1) is certified by the U.S. Department of Health and Human Services and; 2) provides services to Participants in their homes.

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

1. Admittance to a Hospital or skilled nursing facility would be required if the Participant did not receive home health care.
2. A plan for home care must be submitted and approved, in writing, by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the condition for which hospitalization was required.
5. The program must begin within fourteen (14) days of discharge from the Hospital or skilled nursing facility.
6. Pre-certification must be obtained through Blue Cross Blue Shield of Wyoming before benefits are payable.

BENEFITS-
Inpatient: Not covered.

Outpatient: Benefits will be provided only for the following services:

1. Nursing Care: Part-time or periodic home nursing care. A registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed public nurse, or a licensed vocational nurse under the supervision of a registered nurse may provide the service.
2. Home Health Aide Care: Part-time or periodic care by home health aides.
3. Rehabilitative Care: Physical, occupational, or speech therapy, if provided by the home health care agency.
4. Medical Supplies: Medicines and medical supplies ordered by a Physician and provided by the home health care agency.

After satisfaction of the Deductible, benefits will be provided at 100% of the Allowable Charges. Benefits will NOT be provided for custodial care such as the provision of meals, housekeeping or other non-medical assistance or for services provided by a member of the patient's immediate family or a person ordinarily residing in the patient's home.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

L. HOSPICE BENEFITS

DEFINITIONS- A "hospice" offers a coordinated program for a terminally ill patient and the patient's family at an inpatient licensed hospice facility or at the patient's home. 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.

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

1. An illness must be diagnosed for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
3. 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.
4. Pre-certification must be obtained through Blue Cross Blue Shield of Wyoming before benefits are payable.

BENEFITS-
Benefits are provided for the following:
Home Hospice:

1. Periodic nursing care by registered or practical nurses.
2. Home health aides.
3. Homemaker services.
4. Physical, occupational and respiratory therapy.
5. Medical social workers.

Inpatient Hospice:

1. Room expense and ancillary service for inpatient care.
2. Skilled nursing care.
3. Medical social worker.

Bereavement counseling sessions for Participants. (Benefits for counseling sessions will be provided at $25 per session to a maximum of twelve [12] sessions during the twelve [12] months following the death of the Participant.)

After satisfaction of the Deductible, benefits will be provided at 100% of the Allowable Charge.

These hospice benefits are in place of all other benefits provided under any other part of the Plan for the same services.

LIMITATIONS AND EXCLUSIONS-

1. Inpatient hospice benefits are limited to a lifetime maximum of 180 days per Participant.

2. Inpatient hospice benefits will only be provided for terminally ill Participants with a life expectancy of no greater than 6 months.

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HUMAN ORGAN TRANSPLANTS

DEFINITIONS- "Human Organ Transplant" services are those required in connection with the replacement of a diseased human organ by transplantation of a healthy human organ from a donor. Those transplants covered under this benefit include, but are not limited to, the following:

1. Heart Transplants
2. Liver Transplants
3. Heart-Lung Transplants
4. Pancreas Transplants
5. Kidney Transplants
6. Corneal Transplants
7. Lung and Double-Lung Transplants
8. Bone Marrow Transplants

Except for corneal transplants, Pre-certification must be obtained through Blue Cross Blue Shield of Wyoming before benefits are payable.

BENEFITS-
Hospital:
Inpatient and Outpatient: Benefits will be provided for recipient expenses directly related to the transplant procedure, including pre-operative and post-operative care.

Physician:
Inpatient and Outpatient: Benefits will be provided for recipient 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.

LIMITATIONS AND EXCLUSIONS-

1. Benefits for transportation, meals, and lodging costs shall not exceed $10,000.
2. Coverage of these services is subject to all Blue Cross Blue Shield of Wyoming pre- certification requirements, including the use of designated facility providers.
3. Donor expenses are not Covered Services if the donor is a Participant but the recipient is not.
4. Donor expenses for which benefits are available from another source are not covered.
5. Services and supplies for which government funding of any kind is available are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

N. INHERITED ENZYMATIC DISORDERS

BENEFITS-
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.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

O. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, & MAGNETIC RESONANCE SERVICES

DEFINITIONS- "Laboratory" and "pathology" services are 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).

"X-ray", "radiology", and "magnetic resonance services" 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.

BENEFITS-
Benefits will be provided for Covered Services provided by a Hospital or other facility or by a Physician, independent pathology laboratory, or independent radiology laboratory.

Pre-admission Testing: Benefits will be provided for pre-admission testing ordered by the Participant's surgeon leading up to Surgery, 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.

Benefits for pre-admission testing will be provided at 100% of the Allowable Charges after the Deductible. If Participants receive these tests while hospitalized benefits will be subject to 20% Coinsurance after the Deductible. Pre-admission testing that is repeated in the Hospital will not be paid unless medically necessary.

LIMITATIONS AND EXCLUSIONS-
1. Unrelated services: Services which are not related to a specific illness or injury are not covered.
2. Routine Examinations: Services related to routine examinations (such as yearly physicals or screening examinations for school, camp, or other activities) are not covered except as described under PREVENTIVE CARE.
3. Weight Loss Programs: Benefits will not be paid for laboratory or X-ray services related to weight loss programs.
4. When more than one magnetic resonance service is performed on the same day, benefits for the technical component will be limited to 50% of the Allowable Charge for each magnetic resonance service after the first.
5. Venipuncture/Handling Fee: Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.

See GENERAL LIMITATIONS AND EXCLUSIONS

P. MATERNITY AND NEWBORN CARE

DEFINITIONS- "Maternity" services are those required by covered female Employees and covered female Spouses of Employees for the diagnosis and care of a pregnancy and for delivery services.

Delivery services include the following:
1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Therapeutic or elective termination of pregnancy prior to full term.
5. Ectopic pregnancies.

"Newborn" services include the following:
1. Routine nursery charges for a newborn well baby billed by a Hospital.
2. Routine care of a newborn well baby billed by a Physician.

NOTE: Under provisions of federal law, group health plans generally may not restrict benefits for any Hospital length of 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 caesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

BENEFITS-
Hospital:
Inpatient: Benefits include Covered Services for room expenses and ancillary services for the eligible female Participant. See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: The following services are covered for the eligible female Participant:
1. Delivery in the Outpatient department of a Hospital or other facility.
2. Pathology and X-ray services (see LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

Physician: The following services are covered when obtained by an eligible female Participant and billed by a Physician:
1. Delivery services (pre- and post-natal Medical Care is included in the allowance for delivery services).
2. Laboratory and X-ray services (See LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

NOTE: Visits to a Physician’s office will be subject to a $40 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan’s annual Deductible. Copayments will be applied to the Cost Share Maximum Amount and Total

In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)

Newborn Care:
1. Routine nursery charges billed by a Hospital.
2. Routine Inpatient care of the newborn child and standby care of a pediatrician at a caesarean section.

NOTE: Beginning on their effective date, newborn children become subject to their own individual Deductible for each calendar year.

LIMITATIONS AND EXCLUSIONS-
1. Artificial conception: Benefits will not be provided for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.
2. Genetic counseling: Benefits will not be provided for genetic counseling, such as discussions of family history and tests to determine the sex or physical characteristics of an unborn child. Amniocentesis will not be payable when performed to determine the sex of the child.
3. Dependent children are not eligible for maternity-related benefits.

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. MEDICAL CARE FOR GENERAL CONDITIONS

DEFINITIONS- Inpatient Medical Care" expenses are those billed by a Physician for services provided while a Participant is confined as an Inpatient in a Hospital for a condition which does not require surgery. For services provided by a Hospital, Inpatient Medical Care includes both medical and surgical services.

"Outpatient Medical Care" expenses are those billed by a Physician, a Hospital, or other facility for services provided in the Physician's office, the outpatient department of a Hospital or other facility, or the Participant's home, for a condition which does not require Surgery.

BENEFITS-
Hospital:
NOTE: If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.

Inpatient: Benefits will be provided for the room expenses and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

Outpatient: Benefits include Medical Care provided at a Hospital or other facility when medically necessary.

Physician:

Inpatient: Benefits will be provided for care by a Physician 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.
3. Only one medical visit per day when charged by the same Physician will be covered.

Inpatient Medical Care benefits will be payable for one Physician per covered hospitalization. (See CONSULTATIONS if more than one Physician is involved.)

Outpatient: Benefits will be provided for Medical Care by a Physician when required for the treatment of a specific illness or injury.

NOTE: Visits to a Physician's office will be subject to a $40 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost

of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)

LIMITATIONS AND EXCLUSIONS-

1. Private Room Expenses: If a Participant has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
2. Routine Examinations: Services related to routine examinations and immunizations (such as yearly physicals or screening examinations for school, camp or other activities) are not covered except as described under PREVENTIVE CARE.
3. Eye Care: Except as described under VISION CARE (if applicable), services will not be covered for the condition 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.

See GENERAL LIMITATIONS AND EXCLUSIONS

R. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

DEFINITIONS- "Mental health or substance use disorder" is a condition requiring specific treatment primarily because the Participant requires psychotherapeutic treatment, rehabilitation from a substance use disorder or both.

"Mental health benefits" means benefits with respect to services for mental health conditions as defined under the terms of this Plan and in accordance with any applicable Federal and State Law.

"Substance use disorder benefits" means benefits with respect to services for substance use disorders as defined under the terms of this Plan and in accordance with any applicable Federal and State Law.

"Inpatient care" expenses are those billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider while the Participant is confined as an Inpatient.

"Outpatient care" expenses are those services billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider, for services provided in either the Physician's or Professional Other Provider's office, the outpatient department of a Hospital, or Facility Other Provider, or the Participant's home.

BENEFITS-
Inpatient:
Hospital: Subject to any Deductible and Coinsurance provisions, benefits will be based on the Allowable Charges.

Physician or Professional Other Provider: Subject to any Deductible and Coinsurance provisions, benefits will be based on the Allowable Charges.

Intensive Outpatient:
Subject to any Deductible, Coinsurance, or Copayment provisions, benefits will be provided based on the Allowable Charges for intensive outpatient services provided by a Hospital, Facility Other Provider, Physician, or Professional Other Provider.

Other Outpatient or Office:
Subject to any Deductible, Coinsurance, or Copayment provisions, benefits will be based on the Allowable Charges.

NOTE: Participating Providers have agreed to accept Blue Cross Blue Shield of Wyoming's Allowable Charges as payment in full and will not bill Participants for amounts that exceed Blue Cross Blue Shield of Wyoming's Allowable Charges. Reimbursement for care rendered by a

provider not participating with Blue Cross Blue Shield of Wyoming will be made directly to Participants on the same basis as if the provider were Participating. Participants may be responsible for amounts that exceed Blue Cross Blue Shield of Wyoming's Allowable Charges. Charges in excess of the Allowable Charges will not apply toward the Deductible, Medical Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount.

LIMITATIONS AND EXCLUSIONS-

1. Diagnosis for Mental Health or Substance Use Disorder: Services must be for the diagnosis and/or treatment of manifest mental health or substance use disorders. These disorders are described in two publications:
   a. The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693).
   b. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
2. Professional Services: Professional services must be performed by a Physician, licensed clinical psychologist, or Professional Other Provider who is properly licensed or certified. A Professional Other Provider must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All providers, whether performing services or supervising the services of others, must be acting within the scope of their license.
3. Educational Credits: 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 regardless of the diagnosis or symptoms that may be present.
4. Marital Counseling: Benefits will not be paid for marital counseling or related services.
5. Tobacco Dependency: Benefits will not be paid for services, supplies or drugs related to tobacco dependency except as described under PREVENTIVE CARE.
6. Co-dependency Treatment: Services related to the treatment of the family of a person receiving treatment for tobacco, chemical or alcohol dependence are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

S. PHASE II OUTPATIENT CARDIAC REHABILITATION

DEFINITIONS- "Outpatient Cardiac Rehabilitation" combines education and exercise to help Participants recover from heart disease. The goal is to return the patient to "productive" levels of work and "enjoyable" levels of leisure time. Cardiac Rehabilitation is designed for the following patients: Those diagnosed with coronary artery disease, chronic stable angina, post M.I. (heart attack), post PTCA/DCA (balloon or "roto rooter" procedure)/Stents, post CABC (Coronary Artery Bypass Graft Surgery), valve repair or replacement, septal defect repair, or cardiovascular risk factor modification.

BENEFITS-
Phase II Outpatient Cardiac Rehabilitation is covered only when following acute cardiac diagnosis and treatment and within the first year after the cardiac event. Benefits include up to three (3) sessions per week for up to thirty-six (36) sessions.

The rehabilitation sessions include, but are not limited to Physician supervised and EKG, blood pressure, and heart rate monitored exercise, plus education on the anatomy and physiology of the heart, risk factors for heart disease, diagnostic tests and treatments, home activities and exercise, the heart healthy diet, community resources and readjustment, understanding medications and stress management.

LIMITATIONS AND EXCLUSIONS-
Limited Term: Benefits are limited to three (3) sessions per week with a maximum lifetime benefit of thirty-six (36) sessions.

See GENERAL LIMITATIONS AND EXCLUSIONS

T. PRESCRIPTION DRUGS AND MEDICINES

DEFINITIONS- "Prescription drugs and medicines" are those which by Federal law require a written prescription for purchase. They must be listed in the United States Pharmacopeia, the National Formulary, or the Homeopathic Pharmacopeia, and must be evaluated as "probably effective" in the current edition of the American Medical Association's Drug Evaluations. 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 "Experimental".

Insulin and diabetic supplies are also considered to be covered under the Preferred Specialty Pharmacy Program benefits.

Blue Cross Blue Shield of Wyoming may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain covered prescription drugs. Such discounts will not be considered in calculating any Participant's Coinsurance, Copayment, or benefit maximums. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the Wyoming Educators Benefit Trust.

A. BENEFITS AVAILABLE THROUGH THE PREFERRED SPECIALTY PHARMACY PROGRAM

Prescription Drugs and medicines are covered by the Preferred Specialty Pharmacy Program when purchased from a Participating Pharmacy. When a Participant needs a prescription filled, the Participant should go to a Participating Pharmacy and present his or her identification card. The Participating Pharmacy will only charge for the Copayment and Coinsurance as shown below. The Pharmacy will be reimbursed for the remaining balance.

Benefits for Prescription Drugs and medicines purchased through a Participating Pharmacy are based on Allowable Charges and payable as follows:

1. Tier 1 Drugs: Covered generic drugs require a $15.00 Copayment.
   Tier 2 Drugs: Covered Formulary brand drugs require a $40.00 Copayment.
   Tier 3 Drugs: Covered non-Formulary brand drugs require a $60.00 Copayment.
   Specialty Drugs: Covered specialty drugs require 20% Coinsurance.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and Medicines under this benefit cannot be applied toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for covered Prescription Drugs and Medicines under this benefit will apply toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out-of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 3.
2. If the Participant chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the Pharmacy Out-of-Pocket

Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount has been reached, the Participant still pays the difference in cost between the brand name and the generic drug, even though the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance.

3. The maximum amount or quantity of prescription drugs that will be considered as eligible charges may not exceed a 90 day supply when taken in accordance with the direction of the prescriber, applying a Copayment and Coinsurance for each 30 day supply. For example, a Tier 2 prescription drug is filled at the pharmacy for a 60 day supply. The Participant will be responsible for two $40 Copayments for each thirty (30) day supply.

B. BENEFITS AVAILABLE UNDER THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM:

Prescription Drugs and medicines taken on a long term basis ("maintenance drugs") may be purchased through the Mail Service Prescription Drug Program.

Benefits for Prescription Drugs and medicines purchased through the Mail Service Prescription Drug Program are as follows:

1. Tier 1 Drugs: Covered generic drugs require a $30.00 Copayment.
   Tier 2 Drugs: Covered Formulary brand drugs require an $80.00 Copayment.
   Tier 3 Drugs: Covered non-Formulary brand drugs require a $120.00 Copayment.
   Specialty Drugs: Covered specialty drugs require 20% Coinsurance.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and Medicines under this benefit cannot be applied toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for covered Prescription Drugs and Medicines under this benefit will apply toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out-of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 3.
2. If the Participant chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the Pharmacy Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount has been reached, the Participant still pays the difference in cost between the brand name and the generic drug, even though the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance.
3. The maximum amount or quantity of Prescription Drugs that will be considered as Allowable Charges may not exceed a 90 day supply when taken in accordance with the directions of the prescriber.

C. SPECIALTY DRUGS

"Specialty drugs" are generally prescribed for people with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis, and rheumatoid arthritis. (The list of those drugs deemed specialty drugs is available from Blue Cross Blue Shield of

Wyoming and is subject to change without notice.) Specialty drugs typically have one or more of the following characteristics:

1. High cost.
2. Injected or infused, but some may be taken by mouth.
3. Unique storage or shipment requirements.
4. Additional education and support required from a healthcare professional.
5. Usually not stocked at retail pharmacies.

All prescriptions for Specialty drugs must be authorized through Blue Cross Blue Shield of Wyoming prior to filling. Participants must contact Blue Cross Blue Shield of Wyoming for both medical review Pre-certification and referral to a preferred specialty drug provider.

If medical review Pre-certification and referral to a preferred specialty drug provider are received, benefits will be subject to 20% Coinsurance on the initial first-fill. Benefits for all subsequent fills at a preferred Specialty drug provider will be subject to 20% Coinsurance up to the Pharmacy Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount. If medical review pre-certification and/or referral to a preferred specialty drug provider are not received, NO benefits will be provided.

If, after medical review Pre-certification and after the initial first-fill of the Specialty drug prescription by a preferred Specialty drug provider, a Participant elects to fill the prescription through a non-preferred Specialty drug provider, Blue Cross Blue Shield of Wyoming will pay only 50% of the Allowable Charges and the Participant will be responsible for the remainder of the cost of the Specialty drug prescription. This remainder which the Participant must pay will not apply toward the Pharmacy Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount.

LIMITATIONS AND EXCLUSIONS-

1. Non-Prescription Items: Drugs and medicines that can be purchased without a written prescription are not covered, even if the Physician has prescribed such "over-the-counter" medications.
2. Take-Home Drugs: Drugs and medicines which are provided as "take-home supply" by the Hospital are not covered under the Preferred Specialty Pharmacy Program.
3. Weight loss: Prescription Drugs and medicines related to weight loss programs are not covered.
4. Hair Loss: Prescription Drugs and medications related to hair loss are not covered.
5. Cosmetic Drugs: Prescription Drugs and medicines used for cosmetic purposes are not covered.
6. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not covered.
7. Prescription Drugs purchased from an Out-of-Network Pharmacy are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

U. PREVENTIVE CARE

DEFINITIONS- "Preventive Care" includes the preventive health services recommended by the U.S. Preventive Services Task Force (USPSTF) (A and B rated only), the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA).

BENEFITS-

1. When Covered Services are provided by Participating providers, benefits will be provided at 100% of the Allowable Charges for Covered Services without regard to any Deductible or Coinsurance that might otherwise apply. (Benefits will also be provided at this level when services are provided by a licensed health fair. In addition, benefits will be provided at this level for testing procedures and for the examination of Employees and covered Spouses by Participating providers for breast cancer, prostate cancer, cervical cancer and diabetes.)

   When services are provided by Non-participating providers, benefits for Covered Services will be provided subject to the Deductible and Coinsurance provisions of this Plan.
2. In years when they are not recommended as covered by the agencies described in the DEFINITION section above, the following blood draw screenings will be covered for each covered Employee and covered Spouse at 100% of the Allowable Charges without regard to any Deductible or Coinsurance that might otherwise apply to a maximum of $50 per calendar year:
   a. Chemistry panel
   b. Hemogram or CBC
   c. Ferritin
   d. C-reactive protein (CRP)
   e. Vitamin D
   f. Blood type
   g. ColoKit
   h. Health assessment
   i. Thyroid panel

   Services must be provided by Participating Providers and no benefits will be provided for charges in excess of the $50 calendar year maximum. If services are provided by Non-participating providers, benefits for these services will be provided subject to the Deductible and Coinsurance provisions of this Plan.
3. If the Participant meets the criteria established by Blue Cross Blue Shield of Wyoming, injections for Immune Prophylaxis for Respiratory Synctial Virus (RSV) will be covered by both Participating and Non-participating providers subject to the Deductible and Coinsurance provisions of the Plan. Blue Cross Blue Shield of Wyoming must give authorization in advance of the date of services.

LIMITATIONS AND EXCLUSIONS-

Except for childhood screenings required due to recommendations by the HRSA, no benefits are provided under PREVENTIVE CARE for either eye care or dental services.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. PRIVATE DUTY NURSING SERVICES

DEFINITIONS- "Private duty nursing services" are those which require the training, judgment and technical skills of an actively practicing Registered Nurse (R.N.). They must be prescribed by the attending Physician for the continuous treatment of a condition.

BENEFITS-
Inpatient: Benefits will be provided for private duty nursing services only when:

1. 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
2. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Participant's condition.
3. The private duty nurse is not employed by the Hospital or Physician and is not a resident of the household or a relative of the Participant.

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS-

1. Alternative Care: Benefits will not be provided for nursing services which ordinarily would be provided by Hospital staff or its intensive care or coronary care units.
2. Claims Review: All claims will be carefully reviewed to be sure that private duty nursing services are absolutely required. The fact that private duty nursing services are covered under this Plan does not, in itself, guarantee that benefits will be paid for any or all services.
3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the Participant or the Participant's family. (Examples: bathing, feeding, exercising, homemaking, moving the Participant, giving medication, or acting as a companion or sitter.) In other words, services which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

W. PROPHYLACTIC SURGERY

DEFINITION - "Prophylactic Surgery" is an operating (cutting) procedure for preventing the development or spread of disease, including specialized instrumentations and usual and related pre-operative and post-operative care.

BENEFITS -
Pre-certification by Blue Cross Blue Shield of Wyoming is required for Prophylactic Surgery. The following prophylactic surgeries will be a Covered Service:

1. Mastectomy
2. Oophorectomy
3. Hysterectomy

Hospital:
Inpatient: Benefits will be provided for the room expenses and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject to 20% Coinsurance after the Deductible.

If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.
Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, the Plan will provide benefits according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

Physician:
Inpatient: The Allowable Charge for surgery performed by a Physician includes payment for pre- operative visits, local administration of anesthesia, follow-up care and recasting.

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject to 20% Coinsurance after the Deductible.

If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.

More than one Surgery performed by the same Physician during the course of only one operative period is called a "multiple surgery." Since the Allowable Charges 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.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, benefits will be provided according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

LIMITATIONS AND EXCLUSIONS –

1. Cosmetic Surgery: "Cosmetic surgery" is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery does not become reconstructive surgery because of 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. Benefits for reconstructive surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic surgery must have occurred after the Participant's original effective date and continuous coverage must be maintained from the date of birth, accident or disease treatment. Blue Cross Blue Shield of Wyoming must give written authorization for cosmetic surgery benefits in advance of the date of services.

   NOTE: Subject to Pre-certification, 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:
   a. Reconstruction of the breast on which the mastectomy has been performed,
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
   c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the primary Surgery. Additional benefits are not allowed for these procedures.
3. Private Room Expenses: If the Participant has a private room in a Hospital, Allowable Charges under the Plan are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

See GENERAL LIMITATIONS AND EXCLUSIONS

X. REHABILITATION

DEFINITIONS- Services primarily for the purpose of receiving therapeutic or rehabilitative treatment (such as physical, occupational, speech, or oxygen therapy, etc.).

“Physical therapy” involves the use of physical agents for the treatment of disability resulting from disease or injury. Physical therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries. Some examples of physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet, radiation, massage, and therapeutic exercise.

“Occupational therapy” is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

"Speech therapy" (also called speech pathology) includes those services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

BENEFITS-
Inpatient: Benefits are provided primarily for therapeutic or rehabilitative treatment when able to participate in a minimum of three (3) hours of individual therapy and an additional two (2) hours of group therapy per day. (Also see ROOM EXPENSES AND ANCILLARY SERVICES).

Outpatient: Benefits are provided primarily for therapeutic or rehabilitative treatment.

LIMITATIONS AND EXCLUSIONS-
Benefits are provided under this section only for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery, amputations, multiple fractures, severe burns, multiple sclerosis, amyotrophic lateral sclerosis, or acquired immune deficiency syndrome.

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. ROOM EXPENSES AND ANCILLARY SERVICES

DEFINITIONS- "Room expenses" include such items as the cost of a room, general nursing services, meal services for the Participant, and routine laundry service.

"Ancillary services" are those services and supplies (in addition to room services) that Hospitals, alcoholism treatment centers, and other facilities bill for and regularly make available to Participants when such services are provided for the treatment of the condition for which the Participant requires care. Such 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.

BENEFITS-
Inpatient:
Pre-admission Review: If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.

Outpatient: Ancillary services billed by a Hospital or other facility are covered. For additional Outpatient benefits under this coverage, see the following sections:

1. Laboratory, pathology, X-ray, and radiology services.
2. Therapies.

LIMITATIONS AND EXCLUSIONS-

1. Medical Care for General Conditions: All benefits for room expenses and ancillary services related to general conditions are paid according to MEDICAL CARE FOR GENERAL CONDITIONS.
2. Mental Health or Substance Use Disorders: All benefits for room expenses and ancillary services related to these conditions are paid according to the section of this Plan titled MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.
3. Personal or Convenience Items: Benefits will not be provided for services and supplies provided for 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.)
4. Private Room Expenses: If a Participant has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. SKILLED NURSING FACILITY

DEFINITIONS- A Facility Other Provider which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring convalescent and rehabilitation care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or part-time care services.

Prior approval must be obtained through Blue Cross Blue Shield of Wyoming case management before benefits are provided.

BENEFITS-
Inpatient: Benefits will be provided to a maximum of ninety (90) days per Participant per calendar year for daily charges for room and board and general nursing services in a licensed, skilled nursing facility.

Outpatient: Not covered.

Physician:
Inpatient and Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

AA. SUPPLIES, EQUIPMENT AND APPLIANCES

DEFINITIONS- "Medical supplies" are expendable items (except Prescription Drugs) which are required for the treatment of an illness or injury.

"Durable medical equipment" is any equipment that can withstand repeated use, is made to serve a medical purpose, and is useless to a person who is not ill or injured, and is appropriate for use in the home.

"Prosthesis" is any device that replaces all or part of a missing body organ or body member.

"Orthopedic appliance" is a rigid or semi-rigid support. It is used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

BENEFITS-

1. Durable medical equipment - Benefits will be paid for the rental or purchase of durable medical equipment, whichever is less expensive. When a purchase is covered, benefits will also be paid for repair, maintenance, replacement, and adjustment.
2. Medical supplies, including but not limited to:
   a. Colostomy bags and other supplies for their use.
   b. Catheters.
   c. Dressings for cancer, diabetic and decubitus ulcers and burns.
   d. Syringes and needles for administering covered drugs, medicines, or insulin.
   e. Hyperalimentation
3. The following prosthesis and orthopedic appliances are covered, as well as fitting, adjusting, repairing, and replacement due to wear, or a change in the Participant's condition which makes a new appliance necessary.
   a. Artificial arms or legs.
   b. Leg braces, including attached shoes.
   c. Arm and back braces.
   d. Cervical collars.
   e. Surgical implants.
   f. Artificial eyes.
   g. Pacemakers.
   h. Breast prosthesis and special bras.
4. 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.
5. Oxygen - Benefits will be provided for oxygen and the equipment needed to administer it.

LIMITATIONS AND EXCLUSIONS-

1. Deluxe or Luxury Items: If the supply, equipment, or appliance ordered includes more features than needed for the condition being treated, benefits will be paid only up to the Allowable Charge for the item that would have met medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars.")

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.

2. Durable Equipment: Items such as breast pumps, 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.
3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered.
4. Hospital Beds: Benefits will not be provided for Hospital beds (including waterbeds or other floatation mattresses).
5. Medical Supplies: 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.)
6. Special Braces: Benefits will not be provided for special braces or special equipment.

See GENERAL LIMITATIONS AND EXCLUSIONS

BB. SURGERY

DEFINITIONS- "Surgery" is an operating (cutting) procedure for treatment of diseases or injuries, including specialized instrumentations, endoscopic examinations and other invasive procedures, the correction of fractures and dislocations, usual and related pre and post-operative care.

BENEFITS-
Hospital:
Inpatient: Benefits will be provided for the room expenses and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject to 20% Coinsurance after the Deductible.

If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, the Plan will provide benefits according to where services are rendered as follows:
1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

Physician:
Inpatient: The Allowable Charge for surgery performed by a Physician includes payment for pre- operative visits, local administration of anesthesia, follow-up care and recasting.

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject to 20% Coinsurance after the Deductible.

If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program. See PRE-ADMISSION REVIEW under HOW BENEFITS WILL BE PAID.

More than one Surgery performed by the same Physician during the course of only one operative period is called a "multiple surgery." Since the Allowable Charges 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.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, benefits will be

provided according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

LIMITATIONS AND EXCLUSIONS-

1. Cosmetic Surgery: "Cosmetic surgery" is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery does not become reconstructive surgery because of psychiatric or psychological reasons.
2. 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. Benefits for reconstructive surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic surgery must have occurred after the Participant's original effective date and continuous coverage must be maintained from the date of birth, accident or disease treatment. Blue Cross Blue Shield of Wyoming must give written authorization for cosmetic surgery benefits in advance of the date of services.

   NOTE: Subject to Pre-certification, 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:
   a. Reconstruction of the breast on which the mastectomy has been performed,
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
   c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas
3. Dental Surgery: For a complete description of benefits allowed for dental services, see DENTAL SERVICES.
4. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the main surgery. Additional benefits will not be paid for these procedures.
5. Obesity and Weight Loss: Benefits will be paid for surgery required as the result of obesity only when pre-certified on the basis of the condition specified in section on GENERAL LIMITATIONS AND EXCLUSIONS.
6. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.
7. Private Room Expenses: If a Participant has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
8. Sex-Change Operations: Benefits will not be provided for sex change operations, or related expenses.
9. Sterilization Procedures: Such surgeries and related expenses will be covered. Reversals of sterilization procedures are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. SURGICAL ASSISTANTS

DEFINITIONS- "Surgical assistant" is either a licensed Physician who actively assists the operating surgeon in the performance of a covered surgical procedure or a specially trained individual (Physician's assistant, surgical technician or registered nurse) who has met the necessary certification or licensure qualifications in the state where the services are being performed.

BENEFITS-
Inpatient and Outpatient: Benefits will be provided when services are provided by a surgical assistant according to where services are rendered as follows:

1. Covered Services performed in the Outpatient department of a Hospital will be subject to 20% Coinsurance after the Deductible.
2. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be provided at 100% of the Allowable Charges after the Deductible.

NOTE: Benefits for surgical assistant services performed by another Physician will be based on 20% of the Allowable Charge. Benefits for services performed by a Professional Other Provider will be based on 10% of the Allowable Charge.

LIMITATIONS AND EXCLUSIONS-

1. Eligible Procedures: Surgical assistant benefits are available only for surgical procedures which are of such complexity that they require a surgical assistant.
2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to surgical assistant services.

See GENERAL LIMITATIONS AND EXCLUSIONS

DD. TELADOC

DEFINITION - "Teladoc" is a national network of state licensed primary care Physicians providing cross coverage consultations 24 hours per day, 7 days a week, and 365 days per year.

BENEFITS –
Benefits are provided and payable at 100% when Teladoc Physicians diagnose, recommend treatment and prescribe non-DEA controlled substances for routine, acute episodic medical conditions over the telephone.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

EE. THERAPIES
(CHEMOTHERAPY, RADIATION, RESPIRATORY, PHYSICAL, OCCUPATIONAL, SPEECH)

DEFINITIONS- "Chemotherapy" is the treatment of malignant disease by chemical or biological antineoplastic agents.

"Radiation therapy" is 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.

"Respiratory therapy" is the 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.

“Physical therapy” involves the use of physical agents for the treatment of disability resulting from disease or injury. Physical therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries. Some examples of physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet, radiation, massage, and therapeutic exercise.

“Occupational therapy” is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

"Speech therapy" (also called speech pathology) includes those services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

BENEFITS-
Hospital:
Inpatient: When provided by a Hospital and related to improvement of the condition for which the Participant is admitted, the following types of therapy are covered:

1. Chemotherapy (drug and administration charges) for malignant conditions
2. Radiation therapy.
3. Physical therapy provided by a registered physical therapist or Physician.
4. Respiratory therapy.
5. Occupational therapy.
6. Speech therapy.

Outpatient: When provided by a Hospital or Facility Other Provider, the following types of therapy are covered:

1. Chemotherapy (drug and administration charges) for malignant conditions
2. Radiation therapy.
3. Physical therapy provided by a registered physical therapist or Physician.
4. Respiratory therapy.

5. Occupational therapy.
6. Speech therapy.

Physician:
Inpatient: When provided by a Physician, the following types of therapy are covered in lieu of one medical day if charged by the same Physician:
1. Chemotherapy (drug and administration charges) for malignant conditions
2. Radiation therapy.
3. Respiratory therapy.
4. Occupational therapy.
5. Speech therapy.

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:
1. Chemotherapy (drug and administration charges) for malignant conditions
2. Radiation therapy.
3. Physical therapy provided by a registered physical therapist or Physician.
4. Respiratory therapy.
5. Occupational therapy.
6. Speech therapy.

NOTE: Benefits for Outpatient physical therapy (physiotherapy), occupational therapy and speech therapy are limited to a combined maximum of thirty (30) treatments per illness or injury per Participant.

NOTE: Benefits for spinal manipulations are limited to a maximum of 30 visits per calendar year per Participant.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS AND EXCLUSIONS

The general limitations and exclusions listed in this section apply to all benefits described in this Plan. In accordance with the provisions of this Plan, therefore, benefits will not be provided for any of the following services, supplies, situations, hospitalizations or related expenses.

A. *ACUPUNCTURE*
Services related to acupuncture, whether for medical or anesthesia purposes are not covered.

B. *ALTERNATIVE MEDICINE*
Treatments and services for alternative medicine are not covered benefits under this Plan. 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.

D. *AUTOPSIES*
Services related to autopsies are not covered.

E. *BIOFEEDBACK*
Services related to biofeedback are not covered.

F. *COMPLICATIONS OF NON-COVERED SERVICES*
Services or supplies that were received for complications resulting from services that are not covered (such as non-covered cosmetic surgery and Experimental procedures) are not covered.

G. *COSMETIC SURGERY*
Cosmetic Surgery: "Cosmetic surgery" is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery does not become reconstructive surgery because of 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. Benefits for reconstructive surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic surgery must have occurred after the Participant's original effective date and continuous coverage must be maintained from the date of birth, accident or disease treatment. Blue Cross Blue Shield of Wyoming must give written authorization for cosmetic surgery benefits in advance of the date of services.

NOTE: Subject to Pre-certification, 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:

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

H. 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 regardless of where they are furnished.

I. DIAGNOSTIC ADMISSIONS

If a Participant is admitted as an Inpatient to a Hospital for diagnostic procedures, 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.

J. 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 covered, even if therapy is included.

K. EAR WAX

Services for the removal of ear wax are not covered.

L. EDUCATIONAL PROGRAMS

Educational, vocational, or training services and supplies are not covered except as explicitly described in the Plan.

M. ENVIRONMENTAL MEDICINE

Treatment and services for environmental medicine and clinical ecology are not Covered Services under this Plan. 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.

N. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Procedures which are Experimental or Investigational in nature as defined in DEFINITIONS are not covered.

O. EYE CARE

Except as described under VISION CARE (if applicable), benefits will not be provided 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.

P. 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.

Q. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Genetic molecular testing is not covered 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.

R. 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 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.

S. HAIR LOSS

Wigs, artificial hairpieces, hair transplants, implants, prescription drugs, and medications are not covered, regardless of whether there is a medical reason for hair loss.

T. HOSPITALIZATIONS

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

U. HYPNOSIS

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

V. LATE ENROLLEES

Late Enrollees (who did not apply within 30 days of their initial date of eligibility) will be eligible to apply for coverage during the group's annual Open Enrollment Period (November 1-30). Provided the application is received by the employer prior to the following January 1, a Late Enrollee will have coverage effective under this Plan on January 1.

W. LEARNING DISABILITIES

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

X. 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 Plan are not covered except as required by the federal, state, or local government. This includes services provided by any person related to the Participant or ordinarily residing in the Participant's household.

Y. MANAGED CARE PROVISIONS

Coverage is subject to all Pre-certification and medical management policies. Failure by either the provider of services or the Participant to comply with such provisions may reduce or eliminate coverage in whole or in part.

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. MEDICALLY NECESSARY SERVICES OR SUPPLIES

No benefits will be provided for services or supplies that are not medically necessary. (See DEFINITIONS.)

BB. OBESITY AND WEIGHT LOSS

Obesity in itself is not considered an illness or disease, and benefits are not provided for the evaluation and treatment of obesity alone. The only situation under which benefits will be provided for obesity is when a surgical procedure is required due to morbid obesity. Benefits will only be paid when:

1. The Participant is twice or more the ideal weight, or 100 pounds or more above the ideal weight, whichever is greater. This is determined by accepted standard weight tables for frame, age, height, and sex.
2. The condition of morbid obesity must be of at least five years duration.
3. Non-surgical methods of weight reduction must have been unsuccessfully attempted for at least five years under a Physician's supervision.

CC. 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, or
2. Reconstructive procedures which correct deformities of the jaw, or
3. Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and recontouring of the facial bones).

Written authorization must be obtained through Blue Cross Blue Shield of Wyoming in advance of the date of surgery for orthognathic surgery benefits to be provided.

DD. PAYMENT IN ERROR

If Blue Cross Blue Shield of Wyoming on behalf of the employer makes a payment in error, it may require the provider of services, 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.

EE. PERSONAL COMFORT OR CONVENIENCE

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

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. (A sponsoring Physician is a licensed Physician approved to sponsor a physician assistant by the State Board of Medical Examiners.)

GG. PRE-ADMISSION REVIEW (PRIOR AUTHORIZATION)

If the Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition) services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's pre-admission review program.

Pre-Admission Review is sometimes referred to as Prior Authorization in Blue Cross Blue Shield of Wyoming documentation.

HH. PRE-CERTIFICATION (PROSPECTIVE REQUEST)

The following services must be certified for payment in advance before benefits will be paid:

1. Reconstructive surgery.
2. Dental-related services.
3. Obesity and weight loss services.
4. High cost prescription drugs and medicines.
5. Home Health Care.
6. Human Organ Transplants (excluding corneal transplants).
7. Breast reconstruction surgery.
8. Injections for Immune Prophylaxis for Respiratory Synctial Virus (RSV).
9. Cosmetic surgery.
10. Orthognathic surgery.
11. Hospice care.
12. Hospital grade breast pumps.
13. Inherited Enzymatic Disorders counseling.
14. Prophylactic surgery.

Pre-certification is sometimes referred to as a Prospective Request in Blue Cross Blue Shield of Wyoming documentation.

II. PROCEDURES RELATED TO STUDIES

Procedures related to studies are not covered except as expressly allowed by this Agreement. This includes any drugs and medicines, technologies, treatments, procedures, or services provided as a part of, or related to, any program, protocol, project, trial, or study in which the patient consent and/or protocol states that the program, protocol, project, trial, or study:

1. Is a "Phase I", "Phase II", or "Phase III" program, protocol, project, trial, or study, or
2. Is arranged so that the Participants selected to take part are randomized, with some Participants receiving the prescribed drugs, treatment, technologies, services, or procedures, and other Participants receiving a different drug, treatment, technology, service, or procedure, or
3. Is a "research" program, protocol, project, trial, or study, or
4. Is an "investigational" program, protocol, project, trial, or study, or
5. Is utilizing investigational or experimental drugs and medicines, technologies, treatments, or procedures, or
6. Has individuals administering the program, protocol, project, trial, or study who are identified as "investigators", or
7. Is a "controlled" program, protocol, project, trial, or study.

JJ. PROPHYLAXIS/PROPHYLACTIC MEDICINE

Except as explicitly described elsewhere in this Plan, medical benefits and treatment that are of a preventive or prophylactic nature are not Covered Services under this Plan. Preventive or prophylactic treatments and services are those which are rendered to a person for purposes other than treating a present and existing medical condition in that person including, but not limited to, immunizations or Surgery on otherwise healthy

body organs and/or parts.

KK. REHABILITATIVE ADMISSION
If Participants are admitted as Inpatients to a Hospital for rehabilitative procedures, but could have received these services as Outpatients without danger to their health, benefits will not be paid for Hospital room charges or other charges that would not be paid if the Participants had received Diagnostic Services as out-patients.

LL. REPORT PREPARATION
Charges for preparing medical reports or itemized bills or claim forms are not covered.

MM. 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 or for the services related to the prescription or fitting.

NN. ROUTINE PHYSICALS
Services connected with routine physical or screening exams and immunizations are not covered except as described in PREVENTIVE CARE.

OO. SERVICES AFTER COVERAGE ENDS
No benefits are provided for services incurred after the coverage is canceled. (EXAMPLE: If the Participant is hospitalized on July 30th and the coverage is canceled effective August 1st, no benefits are provided for any services received on or after August 1st.)

PP. SERVICES NOT IDENTIFIED
Any service or supply not specifically identified as a benefit in this Plan is not covered.

QQ. SERVICES PRIOR TO THE EFFECTIVE DATE
Charges incurred for supplies and services received prior to the effective date of coverage are not covered.

RR. SEX CHANGE OPERATIONS
Services related to sex change operations and reversals of such procedures are not covered.

SS. SUBLUXATION
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, is not covered.

TT. TAXES
Sales, service, mailing charges or other taxes imposed by law that apply to benefits covered under this Plan are not covered.

UU. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Benefits are not provided for the treatment of temporomandibular joint disorders and myofascial pain-dysfunction syndrome.

VV. THERAPIES

Benefits will not be provided for special therapies except as described under the Therapies section of this Plan. 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.

WW. TIMELY FILING OF CLAIMS

In no event will written notice of claim be accepted more than twelve (12) months after the Incurred Date.

XX. TRAVEL EXPENSES

Except where specifically indicated, travel expenses for Participants or their Physicians are not covered.

YY. UNRELATED SERVICES

Services which are not related to a specific illness or injury are not covered.

ZZ. WAR

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

AAA. WEIGHT LOSS PROGRAMS

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

GENERAL PROVISIONS

A. ASSIGNMENT OF BENEFITS

All benefits stated in this Plan are personal to the Participant. Neither those benefits nor the payments to the Participant may be assigned to any person, corporation, or entity. Any attempted assignment shall be void.

B. CHANGE TO THE PLAN

The Plan Sponsor reserves the right to amend, modify, suspend or terminate the Plan at any time for any reason. If the Plan is terminated, the rights of Plan Participants are limited to expenses incurred prior to termination.

C. CLAIM FORMS

Blue Cross Blue Shield of Wyoming shall furnish either to the person making a claim (claimant), or to the employer, for delivery to the person making a claim, the forms it usually furnishes for filing claims for benefits. If such forms are not furnished within fifteen (15) days of the filing of notice of claim, the claimant shall be deemed to have complied with the requirements of the Plan as to notice of claim upon submitting, within the time fixed in the Plan for filing notice of claim, written proof covering the date(s) medical services were rendered.

D. CLERICAL ERROR

Any clerical error by the Plan Sponsor or an agent of the Plan Sponsor in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. The Plan Sponsor reserves the right to correct payments made in error by deducting against subsequent claims or by taking legal action, if necessary.

E. COORDINATION OF BENEFITS

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Participants often have other coverage providing duplicate benefits. In the event of other coverage, the Plan 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 coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage, and the coverage secondarily liable shall then pay for Covered Services the unpaid balance, not exceeding its aggregate coverage or 100% of any Allowable Charges (whichever is greater), based upon the following priorities:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision will be primary payor.
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 an Employee will be primary over a plan that covers the patient as a Dependent.
4. Coverage of a plan which covers the patient as a Spouse will be primary over a plan that covers the patient as a Dependent child.
5. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payor.
6. 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 will be determined before the benefits of the plan which covers that child as a dependent of the parent without custody.
    c. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care 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.
7. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the Participant 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 Participant 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.

F. DISCLAIMER OF LIABILITY

The Plan Sponsor, the employer and Blue Cross Blue Shield of Wyoming have no control over any diagnosis, treatment, care, or other service provided to a Participant by any provider, and is not severally or jointly or severably liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

G. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION

All Protected Health Information (PHI) maintained by the Plan Sponsor, the employer and Blue Cross Blue Shield of Wyoming is confidential. Any PHI about a Participant that is obtained from that Participant or from a health care 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 Health Care 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 the Claims Supervisor 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 health care 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 health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims. This section does not apply to PHI disclosed by the Claims Supervisor to the insurance commissioner for access to records of the Claims Supervisor for purposes of enforcement or other activities related to compliance with state or federal laws.

H. EXECUTION OF PAPERS

On behalf of the Employee and the Employee's Dependents, the Employee 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 Plan.

I. GENERAL INFORMATION ABOUT FILING CLAIMS

Blue Cross Blue Shield of Wyoming identification cards indicate the type of coverage Participants have. Participants should:

1. Always carry their identification card and present it to the Hospital, Facility Other Provider, Physician or Professional Other Provider whenever the Participant receives treatment.
2. Be sure to carry the new identification card they will receive in the event that they change coverage. The old identification card should then be destroyed.
3. Contact Blue Cross Blue Shield of Wyoming at the address below for a replacement card if the original identification card is lost.

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

J. LIMITATION OF ACTIONS

No action at law or equity may be brought to recover benefits under the Plan prior to the expiration of sixty (60) days after written proof of a claim is furnished. No such action shall be brought later than three (3) years after the time written proof of claim for benefits is required to be furnished.

K. NOTICE OF DISCRETIONARY CLAUSE

This benefit Plan contains a discretionary clause. Determinations made by the Plan Administrator pursuant to the discretionary clause do not prohibit or prevent a Participant from seeking judicial review in court, of the Plan Administrator's decisions. By including this discretionary clause, the Plan Administrator agrees to allow a court to review its determinations anew (de novo) when a Participant seeks judicial review of the Plan Administrator's determinations of eligibility of benefits, the payment of benefits, or interpretations of the terms and conditions applicable to the benefit Plan.

L. PARTICIPANT'S LEGAL OBLIGATIONS

The Participant is liable for any actions which may prejudice the Plan Sponsor's rights under the Plan. If legal action must be taken to uphold those rights, then the Participant may be required to pay legal expenses, including attorney's fees and court costs, unless the court finds that the losing party's(ies') position was not frivolous, or that the losing party(ies) litigated his (their) position on a reasonable basis.

M. PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

N. PHYSICAL EXAMINATION AND AUTOPSY

The Plan, at its own expense, has the right to examine the person of any Participant, when and as often as it may reasonably require during the pendency or review of a claim under the Plan and to require or make an autopsy where it is not otherwise prohibited by law.

O. PRIVACY OF PROTECTED HEALTH INFORMATION

The Group is the plan sponsor of this group health plan (Plan) within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Group also administers the Plan for the benefit of the Plan and its Participants. In order for the Group to properly administer the Plan, the Plan, or Blue Cross Blue Shield of Wyoming at the Plan's request, may disclose summary health information to the Group if the Group requests the summary health information for purposes of: (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending or terminating the Plan. "Summary health information" is information that summarizes the claims history, claims expenses, or claims experience of Participants for whom the Group has provided benefits under the Plan, but which has been de-identified, pursuant to 45 C.F.R. §164.514(b)(2)(i). The Plan, or Blue Cross Blue Shield of Wyoming at the Plan's request, may also disclose to the Group information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

However, in some instances, it may be necessary for the Group to have access to a Participant's PHI in order to administer the plan. To avoid any conflict of interest that may be caused by the Group having access to a Participant's PHI for purposes of administering the Plan, the Plan hereby restricts the Group's use or disclosure of a

Participant's PHI (whether it is in an electronic or paper format) as follows:

1. The Group must ensure it takes the steps necessary to reasonably and appropriately safeguard all PHI it creates, receives, maintains or transmits on behalf of the Plan.
2. The Group must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
3. The Group will neither use nor further disclose a Participant's PHI except as permitted by this Benefit Document or as required by law.
4. The Group will ensure that its agents, including subcontractors, to whom it provides a Participant's PHI, agree to the same restrictions and conditions that apply to the Group with respect to a Participant's PHI.
5. The Group will not use or disclose a Participant's PHI for any actions or decisions related to a Participant's employment or in connection with any other Employee related benefits made available to a Participant.
6. The Group will promptly report to the Plan any use or disclosure of a Participant's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
7. The Group will make available to the Plan any PHI necessary to comply with the Participant's right to access his/her PHI.
8. The Group will make available to the Plan any PHI necessary to amend and/or incorporate any amendments to PHI as required by law.
9. The Group will document disclosures it makes of a Participant's PHI and make this disclosure information available to the Plan in order to allow the Plan to provide an accounting of disclosures as required by law.
10. The Group will make its internal practices, books, and records relating to its use and disclosure of a Participant's PHI available to the U. S. Department of Health and Human Services as necessary to determine compliance with federal law.
11. The Group will, where feasible, return or destroy a Participant's PHI and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Group must limit further uses or disclosures of a Participant's PHI to those purposes that make the return or destruction of the information infeasible.
12. The Group will ensure adequate separation between itself and the Plan in accordance with 45 C.F.R. §§164.504(f)(2)(iii) and 164.314(b)(2)(ii). Only the following Employees or classes of Employees will be given access to a Participant's PHI: The designated group contact and Employees in charge of benefit administration. These Employees' or classes of Employees' access to and use of a Participant's PHI is limited to the administrative functions that the Group performs for the Plan. Any issues relating to the Group's non-compliance of these requirements shall be handled pursuant to the requirements set out under HIPAA and other applicable federal and state law.

The Plan will not disclose, or permit another party to disclose, a Participant's PHI to the Group to carry out its administrative functions except as permitted by this section, and as described by the Group in its Notice of Privacy Practices. In no circumstance will the Plan disclose a Participant's PHI to the Group for the purpose of employment-related

actions or decisions or in connection with any other employment–related benefit of the Group.

P. PRUDENT MEDICAL CARE

The Plan Administrator may consider limited exceptions to the contractual provisions of this Plan, based upon Medical Necessity and prudent medical care standards. Such decisions will be made only after establishing the cost-effectiveness, relative to alternative covered services, of medically necessary services performed on behalf of a Participant, and with the agreement of the affected Participant.

Any such decisions will not, however, prevent the Plan Administrator from administering this Plan in strict accordance with its terms in other situations.

Q. SELECTION OF DOCTOR

Any Participant shall be free to select his or her doctor and Hospital. The Plan makes no guarantee as to the availability of a doctor or Hospital. The Plan's responsibility shall be solely to make payment for the benefits described in this Plan.

R. 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 Participant at the latest address appearing on Blue Cross Blue Shield of Wyoming's membership records.

S. STATEMENTS AND REPRESENTATIONS

All statements contained in a written application, evidence of insurability form, or other written document or instrument made by the Employer or Employee to obtain this Plan, shall be considered representations and not warranties. No such statement made by any person insured under this Plan shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the person's beneficiary or personal representative.

Misrepresentations, omissions, concealment of facts and incorrect or incomplete statements as provided in this section shall not prevent the Plan from remaining in effect or prevent the payment of covered benefits under this Plan unless the Plan Sponsor determines that either:

1. The statements and/or representations are fraudulent; or
2. The statements are material to the acceptance of the risk or coverage of the benefits provided under the Plan; or
3. The Plan Sponsor, in good faith, if it knew the true facts as required by any application or other document as provided in this section, would not have:
    a. Entered into the Plan or issued the coverage; or
    b. Provided coverage with respect to the condition which is the basis for a claim under this Plan.

T. SUBROGATION

If another person or entity, through an act or omission, has caused a Participant to suffer a Condition, and if WEBT has paid Benefits for that Condition under the terms of this Plan, the Participant agrees that WEBT 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 WEBT has paid Benefits for that injury under the terms of this Plan, the Participant agrees that WEBT shall be subrogated and succeed to any of Participant's rights of recovery for expenses incurred. WEBT'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 WEBT in full for Benefits WEBT has paid to or on behalf of the Participant. WEBT's share of any recovery extends only to the amount of Benefits WEBT 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 WEBT's right of recovery.
2. WEBT 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. WEBT's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3. WEBT 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 WEBT with its right of recovery. The Participant must not take any action that may prejudice WEBT's right of recovery.
5. If the Participant does not seek damages for his or her Condition, the Participant must permit WEBT 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 WEBT promptly that the Participant has made a claim against another party for a Condition that WEBT has paid or may pay Benefits. Participant must also seek recovery for WEBT's Benefit payments and liabilities, and the Participant must tell WEBT about any recoveries the Participant obtains, whether in or out of court. WEBT 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.

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

future Benefits.

NOTE: WEBT 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 WEBT 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.

U. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Plan not more than forty-five (45) days after receipt of written proof of the claim 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 Plan. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Plan, 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.

V. WRITTEN NOTICE OF CLAIM

1. Proof of claim must be furnished to Blue Cross Blue Shield of Wyoming at its office at 4000 House Avenue, Cheyenne, Wyoming 82003-2266.
2. Benefits will not be provided under the Plan unless proper notice (proof) is furnished to Blue Cross Blue Shield of Wyoming that Covered Services have been rendered to a Participant. Written notice must be given within twelve (12) months after completion of the Covered Service. An expense will be considered incurred on the date the service or supply was rendered. The notice must include the data necessary for Blue Cross Blue Shield of Wyoming to determine benefits.
3. Failure to give notice 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 give notice and that notice was given as soon as was reasonably possible, but in no event later than one (1) year from the incurred date.

W. INTERNAL CLAIMS REVIEW PROCEDURE FOR GROUPS NOT SUBJECT TO ERISA

If an Employer is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and a Participant is not satisfied with the results of the processing of his or her

claim, 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, include the Employer, agreement and claim numbers.

1. Emergency Services
   The Participant and/or the Participant's authorized representative have up to 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 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 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 Services
   The Participant and/or the Participant's authorized representative have up to one hundred and 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 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 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 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 representative at any stage of their appeal. Participants or their 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.

Additional inquiries can be addressed to the Plan Administrator at the following address:

The Wyoming Educators' Benefit Trust
(WEBT) 415 W 17th Street, Suite 140
Cheyenne, Wyoming 82001

X. EXTERNAL CLAIMS REVIEW PROCEDURE FOR GROUPS NOT SUBJECT TO ERISA

If Blue Cross Blue Shield of Wyoming denies the Participant's request for the provision of, or payment for, a health care 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 health care professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice. The Participant must submit a request for external review within one hundred and 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 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 health care service for which he or she received emergency services, but has not been discharged from a health care 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 health care 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 required, and in any event within 72 hours,

where:

a. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.
b. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care 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 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.

Y. WYOMING INSURANCE DEPARTMENT

Participants may also have rights under Wyoming Insurance law. For more information about those rights, Participants may write the following address or call the following phone number: Wyoming Insurance Department, 106 East 6th Ave., Cheyenne, WY 82002. (Phone: 1-800-438-5768)