

FREMONT COUNTY GOVERNMENT

Summary Plan Description

Original Effective Date July 1, 2014

Restated July 1, 2022

Claims Supervisor:



**BlueCross BlueShield
of Wyoming**

An independent licensee of the Blue Cross and Blue Shield Association

FREMONT COUNTY GOVERNMENT

July 1, 2022

THIS PLAN CONTAINS COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY THE WYOMING INSURANCE CODE. FOR A FURTHER DESCRIPTION OF THESE BENEFITS, PLEASE REFER TO THE “PREVENTIVE CARE” SUB-SECTION IN THE "BENEFITS" SECTION OF THIS BOOKLET.

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 사람이 Blue 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 위해서는 800-442-2376 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 तपाईं आफ्ना लागि आफैँ 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. تماس حاصل نمایید. 800-442-2376

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.

Dii kwe'e atah nilinigii Blue Cross Blue Shield of Wyoming haada yit'éego bina'idilkidgo éi doodago háida biká anilyeedigii t'áadoo le'e yina'idilkidgo beehaz'áanii hółq' dít t'áa hazaadk'ehii háká a'doowolgo bee haz'á doo báh ilinígóó. Ata' halne'igii koji' bich'i' hodiilnil 800-442-2376.



NOTICE OF NON-DISCRIMINATION PRACTICE

Blue Cross Blue Shield of Wyoming (BCBSWY) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. BCBSWY does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

BCBSWY provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-442-2376 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe BCBSWY has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Compliance Officer in our Legal Department

- by email at: Legal@bcbswy.com
- by mail at: BCBSWY Compliance Officer
Legal Department
PO Box 2266
Cheyenne, WY 82003-2266
- or by phone at: 1-800-442-2376

Grievance forms are available by contacting us at the contacts listed above or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://www.hhs.gov/ocr/complaints/index.html>
- by phone at:
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F HHH Bldg
Washington, DC 20201

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

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APPROVAL

BENEFIT BOOKLET

ACKNOWLEDGMENT OF RECEIPT AND APPROVAL

The Benefit Booklet for Fremont County Government

is hereby approved.

Effective date is July 1, 2022.

By: Travis Becker

Title: CHAIRMAN

Signature: [Signature]

Fremont County Government hereby allows the use of the Blue Cross Blue Shield of Wyoming benefit booklet portal so that Members may access this Benefit Booklet electronically.

By: Travis Becker

Title: CHAIRMAN

Date: 9-13-22

Signature: [Signature]

attest:
Juni Seese
Clerk 9/13/22



INTRODUCTION

This document describes the Medical and Dental Plan (The Plan) maintained for the exclusive benefit of the Employees of Fremont County Government. This Plan represents both the Plan Booklet and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974 and amends and replaces any prior statement of health coverage contained in the Plan or any predecessor to the Plan. The Employer intends to maintain this Plan indefinitely but reserves the right to terminate or change the Plan at any time and for any reason. 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: Fremont County 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: 83-6000107

PLAN YEAR: July 1 – June 30

PLAN SPONSOR: Fremont County
450 N 2nd St
Lander WY 82520

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: Fremont County
450 N 2nd St
Lander WY 82520

AGENT FOR SERVICE OF LEGAL PROCESS: Fremont County
450 N 2nd St
Lander WY 82520

NAMED FIDUCIARY: Fremont County
450 N 2nd St
Lander WY 82520

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

PPO NETWORK: Blue Cross Blue Shield of Wyoming (BCBSWY)
307-634-1393
www.yourwyoblue.com

COBRA ADMINISTRATOR: Lifetime Benefit Solutions, Inc (LBS)
PO Box 332
Liverpool, NY 13088
1-800-772-3830

SCHEDULE OF BENEFITS

EMPLOYER NAME: Fremont County

GROUP NUMBER: 10359745 et al

EFFECTIVE DATE: July 1, 2022

WAITING PERIOD: 60 days (See DEFINITIONS section for definition of WAITING PERIOD)

OPEN ENROLLMENT: The Open Enrollment Period for this group is set each year by the employer.

Members Calendar Year Schedule of Benefits				
Cost-Sharing:	Member's Responsibility for Covered Services			
	Plan A		Plan B	
	Network Providers	Non-Network Providers	Network Providers	Non-Network Providers
Deductible:				
Single Coverage	\$1,000	\$2,000	\$3,000	\$6,000
Two Adult, Adult & Dependent and Family Coverages	\$2,000	\$4,000	\$6,000	\$12,000
Out-of-Pocket Maximum Amount:				
Single Coverage	\$6,000	\$12,000	\$6,500	\$13,000
Two Adult, Adult & Dependent & Family Coverages	\$12,000	\$24,000	\$13,000	\$26,000

An individual's Out-of-Pocket expenses in the family plan will not exceed the ACA's self-only limitation.		
Any Deductible, Coinsurance and Copayments which Members pay for medical Covered Services will be applied toward both their Network and Non-network Deductibles and Out-of-Pocket Maximums.		
Covered Services		
Benefit Description:	Member's Responsibility for Covered Services:	
	Network Providers	Non-Network Providers
Supplemental Accident Benefit – within 90 days of accident:	Paid at 100% for the first \$300. After the first \$300 Covered Services subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum	Paid at 100% for the first \$300. After the first \$300 Covered Services subject to Deductible and Coinsurance Amount of 40% up to the Out-of-Pocket Maximum Amount.
Hospital Services:		
Room and Board:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Intensive Care Unit:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Emergency Room Services:	Subject to \$250 emergency room Copayment per Member per visit. After Copayment subject to Coinsurance Amount of 20% after the In Network Deductible. (The ER Copayment will be waived if the Member is admitted directly into the Hospital from the Emergency Room.)	

Outpatient and Ambulatory Surgical Facility:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Urgent Care Services:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Skilled Nursing Facility:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Physician Services:		
Inpatient Visits:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Office Visits (Primary Care Physician):	\$30 Copayment, not subject to Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Office Visits (Specialists):	\$50 Copayment, not subject to Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Surgery:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.

Second Surgical Opinion:	Paid at 100% Deductible waived.	Subject to Coinsurance Amount of 40% after the Deductible.
Ambulance Service (Air and Ground):	Subject to Coinsurance Amount of 20% after the Deductible.	
Cardiac Rehabilitation:	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 20 Outpatient visits per incident.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 20 Outpatient visits per incident.)
Chemotherapy and Radiation Treatment:	Subject Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Diabetes Services:	Subject to Coinsurance Amount of 20% after the Deductible. (Diabetes Education paid at 100% Deductible Waived. Limited to a maximum of 5 visits per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Diabetes Education limited to a maximum of 5 visits per Member per calendar year.) Diabetic supplies purchased through a non-participating Pharmacy are not covered Out of Network.
Diagnostic Lab and X-ray:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.

Durable Medical Equipment, Orthotics and Prosthetics:	Subject to Coinsurance Amount of 20% after the Deductible. Diabetic supplies purchased through a participating Pharmacy are subject to the Prescription Drug cost sharing amounts outlined above.	Subject to Coinsurance Amount of 40% after the Deductible. Diabetic supplies purchased through a non-participating Pharmacy are not covered Out of Network.
Fremont County Health Department:	Subject to Coinsurance Amount of 20% after the Deductible. (Includes any eligible expenses rendered and billed by the Fremont County Health Department including, but not limited to, immunizations and flu shots.)	
Home Health Care:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Home Infusion Therapy:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Hospice Care:	Subject to Deductible then paid at 100%	Subject to Coinsurance Amount of 40% after the Deductible.
Inherited Enzymatic Disorders:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.

Mental Health Treatment:		
Inpatient Services: (Maximum visits is combined maximum with Substance Use Disorder Care)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 10 days maximum per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 10 days maximum per Member per calendar year.)
Intensive Outpatient Services:	Subject to Coinsurance Amount of 20% after the Deductible. (Each day counts as ½ day toward the Inpatient maximum.)	Subject to Coinsurance Amount of 40% after the Deductible. (Each day counts as ½ day toward the Inpatient maximum.)
Outpatient Services:	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 25 visits maximum per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 25 visits maximum per calendar year.)
Additional Mental Health Disorder and Intellectual Disability Benefit: (This is a Covered Service only for Inpatient treatment in a tax supported institution in the State of Wyoming.)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to \$500 Lifetime maximum.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to \$500 Lifetime maximum.)

Occupational Therapy: (Outpatient)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 40 visits maximum per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 40 visits maximum per calendar year.)
Organ Transplants:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Physical Therapy: (Outpatient)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 40 visits maximum per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 40 visits maximum per calendar year.)
Pregnancy:	Subject to Coinsurance Amount of 20% after the Deductible.(Some services paid at 100% Deductible waived. See section) PREVENTIVE CARE.)	Subject to Coinsurance Amount of 40% after the Deductible.
Preventive Care: Routine Wellness Care:	Paid at 100% Deductible waived	Subject to Coinsurance Amount of 40% after the Deductible.

Registered Dietician:	Paid at 100% Deductible waived. (Limited to 5 visits Per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 5 visits Per Member per calendar year.)
Rehabilitation Therapy: (Inpatient)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 30 days per Member per calendar year; or 60 days Per Member per calendar year in the case of a spinal cord or head Injury or due to stroke.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 30 days per Member per calendar year; or 60 days Per Member per calendar year in the case of a spinal cord or head Injury or due to stroke.)
Routine Well Newborn Nursery Care: (while Hospital confined at birth)	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Skilled Nursing Facility:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Coinsurance Amount of 40% after the Deductible.
Speech Therapy: (Outpatient)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 25 visits per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 25 visits per Member per calendar year.)

Spinal Manipulation Chiropractic services:	Subject Coinsurance Amount of 20% after the Deductible. (Limited to 15 visits per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 15 visits per Member per calendar year.)
Substance Use Disorder Care:		
Inpatient Services: (Maximum visits is combined maximum with Mental Health Treatment.)	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 10 days per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 10 days per Member per calendar year.)
Outpatient Services:	Subject to Coinsurance Amount of 20% after the Deductible. (Limited to 25 visits per Member per calendar year.)	Subject to Coinsurance Amount of 40% after the Deductible. (Limited to 25 visits per Member per calendar year.)
Teladoc Consultation Benefit:	\$10 Copayment per consultations	
Travel Medical Benefits: (Only to selected medical facilities for eligible procedures. See section TRAVEL MEDICAL BENEFITS.)	Benefit maximum of \$200 per day & \$2,500 per calendar year paid at 100%	

Other Covered Services:	Subject to Coinsurance Amount of 20% after the Deductible.	Subject to Deductible and Coinsurance Amount of 40% up to the Out-of-Pocket Maximum.
NOTE: The maximums listed above are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar year maximum is 60 days total which may be split between Network and Non-Network providers.		

THIS COVERAGE PROVIDES BENEFITS FOR MANY COVERED SERVICES INCLUDING THOSE LISTED ABOVE. BENEFIT LEVELS MAY VARY. PLEASE SEE THE BENEFITS SECTIONS OF THIS PLAN FOR A MORE COMPLETE EXPLANATION OF THE BENEFITS.

CASE MANAGEMENT

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a Member's health care needs, using communication and available resources to promote quality, cost effective outcomes. Blue Cross Blue Shield of Wyoming will utilize case management techniques when appropriate to insure optimal results for all parties involved in particular healthcare cases.

QUALIFYING FOR THE DISEASE MANAGEMENT PRESCRIPTION INCENTIVE

New Members will be enrolled in the Prescription Incentive on a quarterly schedule after meeting eligibility requirements. Members in the Incentive Program will be removed from the program after each quarter if they do not actively participate or meet the program requirements. They will be notified two weeks before removal by mail, and if available, email. Members are eligible to reapply for participation for the next quarter after meeting with the Wellness Program Coordinator.

In order to qualify for 100% prescription coverage of maintenance medications, Members must meet the following guidelines for at least three (3) months:

1. Under the care of a Physician with a diagnosis of hypertension, hyperlipidemia, diabetes, or asthma;
2. Annual visit with the Physician to renew prescriptions covered by the program. Signed Physician statements are required annually by the Wellness Program;
3. Meeting with the Wellness Program Coordinator quarterly;

4. Completing quarterly activities assigned by the Wellness Program. Members will receive accommodation for activities that are not medically advisable.

Parents or guardians of Dependents who qualify for the program will be required to submit an annual Physician statement and meet with the Wellness Program Coordinator quarterly.

The Prescription Drug Benefit (30 Day Supply):

Tier 1 Drugs:	Covered Preferred generic drugs require a \$15.00 Copayment.
Tier 2 Drugs:	Covered non-Preferred generic drugs require a \$15.00 Copayment.
Tier 3 Drugs:	Covered Preferred brand drugs require a \$40.00 Copayment.
Tier 4 Drugs:	Covered non-Preferred brand drugs require a \$55.00 Copayment.

Mail Service Pharmacy Program (90 Day Supply):

Tier 1 Drugs:	Covered Preferred generic drugs require a \$37.50 Copayment.
Tier 2 Drugs:	Covered non-Preferred generic drugs require a \$37.50 Copayment.
Tier 3 Drugs:	Covered Preferred brand drugs require a \$100.00 Copayment.
Tier 4 Drugs:	Covered non-Preferred brand drugs require a \$137.50 Copayment.

Extended Supply Network (90 Day Supply; 1 Copay for 30 Days):

Tier 1 Drugs:	Covered Preferred generic drugs require a \$15.00 Copayment.
Tier 2 Drugs:	Covered non-Preferred generic drugs require a \$15.00 Copayment.
Tier 3 Drugs:	Covered Preferred brand drugs require a \$40.00 Copayment.
Tier 4 Drugs:	Covered non-Preferred brand drugs require a \$55.00 Copayment.

Specialty Drugs (30 Day Supply):

Tier 5 Drugs:	Covered Preferred Specialty drugs require a \$100.00 Copayment.
Tier 6 Drugs:	Covered non-Preferred Specialty drugs require a \$100.00 Copayment.

NOTE: Non-network Prescription Drugs are *not* a covered benefit.

This coverage provides Benefits for many Covered Services, including those listed below. Benefit levels may vary depending on where and how care is delivered. Please see the Section entitled HOW BENEFITS WILL BE PAID and the Section entitled BENEFITS for a more complete explanation of the Benefits.

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 dependent children.
- B. **AGGREGATE DEDUCTIBLE**
A specified amount of Allowable Charges for Covered Services that Members under Family, Adult and Dependent, and Two Adult Coverages are responsible for within a specified period of time before all the Members 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. **ANNIVERSARY DATE**
The date each year on which the Group may renew its coverage for the next twelve (12) months.
- E. **BLUECARD® PROGRAM**
A nationwide program coordinated by the Blue Cross Blue Shield Association that enables Members 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.
to providers periodically for Care Coordination under a Value-Based Program.
- F. **CLAIMS SUPERVISOR**
Blue Cross Blue Shield of Wyoming.
- G. **COINSURANCE**
A percentage of the cost of Covered Services, as described below, that is a Member's responsibility after the Deductible has been met. Blue Cross Blue Shield of Wyoming calculates a Member's Coinsurance Amount off of the Allowable Charges. In the case of services obtained out of Blue Cross Blue Shield of Wyoming's service area, a local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require a Coinsurance calculation that is not based on the discounted price the provider has agreed to accept from the Host Plan, but is, instead, based on the provider's full billed charges. This may result in a higher or, in some cases, lower Coinsurance payment for certain claims incurred when outside of Blue Cross Blue Shield of Wyoming's service area. Because of the many different arrangements between the host Plans and their providers, it is not possible

to give specific information for each out-of-area provider.

H. CONDITION

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

I. COPAYMENT

A specified dollar amount payable by the Member for certain Covered Services. Copayments do not accumulate toward the Member's satisfaction of the Deductible.

J. COVERED SERVICE

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

K. DEDUCTIBLE

A specified amount of expense for Covered Services that the Member must pay within a calendar year before benefits are provided. (**NOTE:** Dental Expense Rider and Routine Eye Exam benefits are subject to separate Deductible requirements.)

L. DEPENDENT

An Employee's Dependents are the following:

1. Legal spouse who is currently a permanent resident in the home of the Employee.
2. The children, including newborn children, stepchildren, adopted children, Dependents which the court has decreed support to the Employee and Legal wards of the Employee or the Employee's spouse. The limiting age for covered children is December 31 of the year in which age 26 is attained. Any child of a Plan Member who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan. A Member of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.
3. The covered spouse and child(ren) of deceased Retirees who were covered at the time of the Retiree's death may remain on the Plan as long as there is not a lapse in payments and they continue to make the payments. (In the event the spouse remarries, neither the child(ren) nor spouse may remain on the Plan. Child(ren) may not remain on the Plan after both the Retiree and spouse have died. In addition, coverage for the child(ren) will end when the spouse becomes Medicare eligible or on December 31 of the year when the child(ren) attains age 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 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 Blue Cross Blue Shield of Wyoming within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee 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.

M. DESIGNATED PROVIDER

A Hospital, Facility Provider, Physician, or Professional Provider that the Member is required to utilize for an authorized healthcare service.

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 Provider.

O. ENROLLMENT DATE

The Enrollment Date for timely entrants means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date for late entrants will be the effective date 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.
5. The Plan Administrator has the authority to determine what is experimental, investigational, or unproven.

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 or clinical trials for other life

threatening diseases or Conditions will be covered in accordance with Federal and State Law. Coverage shall be provided for individuals enrolled in a cancer clinical trial or a clinical trial for other life threatening diseases or Conditions as follows:

1. Coverage will only be provided for Phase I, II, III, and IV cancer and other life threatening disease or Condition clinical trial;
2. The cancer or other life threatening disease or Condition 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 or treatment for other life threatening diseases or Conditions;
 - b. A drug provided to a patient during a cancer or other life threatening disease or Condition 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 Member or the Member'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 PROVIDER

A medical facility other than a Hospital which is licensed, where required, to render Covered Services. Facility 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 Provider which is primarily engaged in providing detoxification and rehabilitation treatment for Substance Use Disorders.
2. Ambulatory Surgical Facility is a Facility 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 Provider.
- 3. Freestanding Dialysis Facility is a Facility 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 Provider which for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Health Disorder on an Outpatient basis.
- 5. Psychiatric Hospital is a Facility 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 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 Health Disorder, alcoholism, drug abuse or pulmonary tuberculosis.
- 7. Hospice is a Facility 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 Dependent 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 the pharmacy benefits manager.

T. GROUP

The Plan Sponsor who has signed an agreement with Blue Cross Blue Shield of Wyoming to provide administrative services to its eligible Employees and Dependents.

U. HOME HEALTH CARE AGENCY

A private or public organization certified by the U.S. Department of Health and Human Services. It provides skilled nursing services and other therapeutic services to patients in their homes.

V. *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 Health Disorder,
 - i. place for the treatment of alcoholism or drug abuse,
 - j. place for the provision of hospice care,
 - k. place for the provision or rehabilitative care,
 - l. place for the treatment of pulmonary tuberculosis.

W. *INITIAL MEASUREMENT PERIOD*

The eleven (11) month “look back period” during which an Employer measures the hours of service for its new Employees in order to determine their status as a Full-Time Employee or a Part-Time Employee which begins on the day the new Employee completes at least one hour of service with the Employer.

X. *INITIAL STABILITY PERIOD*

The twelve (12) month period following the Initial Measurement Period and following the Administrative Period which Employees worked the necessary amount of hours to be considered Full-Time during the Initial Measurement Period, who were offered coverage, and who enrolled in coverage, and are guaranteed access to coverage regardless of the number of hours worked during his or her Initial Stability Period.

Y. *INPATIENT*

A Member who is treated as a registered bed patient in a Hospital or Facility 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 Member is still a patient.

Z. *LATE ENROLLEE*

An eligible Employee or Dependent whose application has not been received by Blue Cross Blue Shield of Wyoming within the specified time period. An eligible Employee or Dependent will NOT be considered a Late Enrollee if:

1. The individual applied for coverage during one of the special enrollment periods described in the section on HOW TO ADD, CHANGE, OR END COVERAGE, or
2. The individual is employed by a Group which offers multiple health benefit plans and the individual elects a different plan during an Open Enrollment Period, or
3. A court has ordered coverage be provided for a spouse or minor child under a covered Employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

AA. *LEGAL EMPLOYEE*

An Employee who is legally authorized to work in the United States, verifiable by documents accepted by the Department of Homeland Security's USCIS Form I-9.

BB. *MEASUREMENT PERIOD*

A twelve (12) month period following a new Employee's date of hire.

CC. *MEDICAL CARE*

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

DD. *MEDICAL EMERGENCY*

A medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, in the case of a pregnant woman, her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any body organ or part.

EE. *MEDICAL NECESSITY*

Services or supplies provided by a Hospital, Physician or Other Provider that are:

1. Appropriate for the symptoms and diagnosis or treatment of the Member's Condition, illness, disease or injury; and
2. Provided for the diagnosis, or the direct care and treatment of the Member's Condition, illness, disease or injury; and
3. In accordance with standards of good medical practice; and
4. Not primarily for the convenience of the Member, or the Member's provider; and
5. The most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's Condition, and the Member cannot receive safe or adequate care as an Outpatient.

FF. *MEDICAL POLICY*

Policies that Blue Cross Blue Shield of Wyoming relies on to determine whether a medical service, procedure or supply meets the definition of Medical Necessity. In addition, the medical service, procedure or supply must meet all requirements in Blue Cross and Blue Shield of Wyoming Medical Policy.

NOTE: The Medical Policy requirements are available under the providers section of our website or by calling the Member Services at 1-(800)-442-2376.

GG. MEMBERS

The Employee and the Employee's covered Dependents.

HH. MENTAL HEALTH OR SUBSTANCE USE DISORDER

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

II. NETWORK

Network Hospitals and Facility 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 Network Hospitals and Facility Providers will be made directly to them. Employees are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

Network Physicians and Professional 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 Providers will be made directly to them. Employees are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

NOTE: A Hospital, Facility Provider, Physician, or Professional 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-Network. When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by such Non-network Providers, the amount(s) a Member pays for Covered Services will generally be based on either the Host Blue's Non-network Provider local payment or the pricing arrangements required by applicable State Law. A Non-network Physician or Professional Provider may bill Members directly and payments will be made directly to the Member. If Members choose a Non-network Hospital or Facility Provider, they may be billed directly and payments may be made directly to the Member. Members will be responsible to Non-network providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

JJ. OPEN ENROLLMENT PERIOD

The period of time as set forth in the Schedule of Benefits.

KK. OUT-OF-POCKET MAXIMUM

A specified amount of Deductible, Coinsurance and Copayments paid by the Member for Covered Services within a calendar year. The Out-of-Pocket Maximum does not include non-covered amounts or charges in excess of Blue Cross Blue Shield of Wyoming's

Allowable Charge Charges. When the Out-of-Pocket Maximum is reached, the level of benefits is increased as specified in the Schedule of Benefits.

LL. OUTPATIENT

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

MM. PHARMACY

Pharmacy means any licensed establishment where prescription legend drugs are dispensed by a licensed pharmacist.

NN. 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.

OO. PLAN ADMINISTRATOR/ PLAN SPONSOR

Fremont County.

PP. PRESCRIPTION DRUGS

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

QQ. PROFESSIONAL PROVIDER

A person or practitioner who is licensed, where required, to render Covered Services. Professional 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 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.

RR. PROTECTED HEALTH INFORMATION (PHI)

Information, including summary and statistical information, collected from or on behalf

of a Member that:

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

Educational records and employment records are not considered PHI under Federal Law.

SS. REHABILITATIVE ADMISSIONS

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

TT. RETIREE

Not eligible for Medicare and have been employed by Fremont County for ten (10) years and collecting benefits from the Wyoming Retirement System.

UU. SINGLE COVERAGE

Coverage provided for the Employee only.

VV. SUBSCRIBER OR EMPLOYEE

The person who applies for coverage.

WW. SURGERY

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

XX. TELEMEDICINE

Healthcare Services performed by physicians or other providers to diagnose, treat or prescribe drugs for medical Conditions over telephone or video.

YY. THERAPY SERVICE

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

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.

ZZ. TWO ADULT COVERAGE

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

AAA. WAITING PERIOD

A length of time (e.g. 30, 60, 90 days) established by the Group which the Employee must fulfill before the Employee is eligible for coverage. Waiting Periods will not be considered in determining if a significant break in coverage has occurred.

FUNDING LEVELS AND CONTRIBUTIONS

The coverage of eligible Members 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 the Employer. 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 the County.

B. *CONTRIBUTION REQUIREMENTS*

The County 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 County's contribution will end when the Employee is no longer eligible as stipulated in the section on ELIGIBILITY REGULATIONS, or when the County 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 Plan Sponsor's final, conclusive, and binding authority to determine eligibility for benefits in accordance with this Plan.

A. *ELIGIBILITY*

1. Unless otherwise specified, all Employees who are legally employed and regularly scheduled for twenty (20) or more hours a week are eligible.
2. Retirees who are not eligible for Medicare and have been employed by Fremont County for ten (10) years and are collecting benefits from the Wyoming Retirement System are eligible.
3. The Employee must have deductions made for Federal Income Taxes and Social Security by the employer.
4. Elected County officials are eligible.
5. Employees of off-line boards of other Fremont County government entities are eligible. These include the following:
 - a. Fremont County Library
 - b. Fremont County Museum
 - c. Fremont County Weed and Pest
 - d. Fremont County Fair Board

Employees of these off-line boards must be pre-approved by the Fremont County Commissioners

NOTE: Any eligible Employee or elected County official 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 as described under the section on HOW TO ADD, CHANGE, OR END COVERAGE and CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).

NOTE: The following are not eligible for coverage.

- a. Independent contractors
- b. Volunteers or non-compensated Employees
- c. Temporary and occasional Employees

NOTE: Active Employees age 65 and over must choose from the following:

- a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
- b. Benefits of the Federal Medicare program.

If the federal Medicare program is chosen, the Employee will NOT be allowed to remain on this Plan.

B. *DEPENDENT ELIGIBILITY*

1. All Dependents of the covered Employee, Retiree or elected County official as defined by the Plan are eligible.

NOTE: Covered Retirees may NOT add to their coverage a spouse or child who was not already covered under this Plan at the time of the Retiree's retirement.

2. Dependents of deceased Retirees are eligible. Dependents who were covered at the time of the Retiree's death may remain on the Plan as long as there is not a lapse in payments and they continue to make the payments. In the event the spouse remarries, neither the child(ren) nor spouse may remain on the Plan. Child(ren) may not remain on the Plan after both the Retiree and spouse have died. In addition, coverage for the child(ren) will end when the spouse becomes Medicare eligible or on December 31 of the year when the child(ren) reaches age 26.
3. Dependents of the covered Employee who enter the armed forces on full-time duty are eligible for continuation of coverage in this Plan, regardless of whether the eligible Employee elects to retain coverage for him/herself. See CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT under the section on HOW TO ADD, CHANGE, OR END COVERAGE.
4. Covered spouses age 65 and over must choose from the following,
 - a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
 - b. Benefits of the Federal Medicare program.

If the federal Medicare program is chosen, the spouse will NOT be allowed to remain on this Plan.

C. *MEASUREMENT AND STABILITY PERIODS*

If an Employee's total number of hours of service for a Measurement Period, divided by the number of months in the Measurement Period, equals at least 130, then the Employee was fulltime during the Measurement Period and must be considered full-time during the stability period that follows.

Under the Affordable Care Act Safe Harbors, an Employee can drop coverage due to a reduction in hours during a stability period that leads to an inability to pay the monthly Employee contribution. As an employer, if an Employee's payment is late, employer must provide the Employee with a 30-day grace period in order to make the payment. If the Employee does not make the payment within the grace period, the employer is not required to provide coverage for the period for which the contribution is not timely paid and may terminate coverage.

The Employee's revocation of the election of coverage under the Group health plan must correspond to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential

coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Plan may rely on the reasonable representation of an Employee who is reasonably expected to have an average of less than thirty (30) hours of service per week for future periods that the Employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes that date the original coverage is revoked.

D. LATE ENROLLMENT

If you did not enroll during your original 30 days, you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

E. SPECIAL ENROLLMENT EVENT

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

1. Loss of Other Coverage (other than under Medicaid or SCHIP):

If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

- a. The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
- b. Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
- c. Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the next day following the date the other health coverage was lost provided you submit the appropriate election and enrollment forms to the Plan Administrator.

2. Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy:

If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the next day following the date the other health coverage was lost or eligibility for a state premium assistance subsidy is appropriate election and enrollment forms to the Plan Administrator.

3. Acquisition of a New Dependent:

If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.

- a. Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the Child's birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.
- b. Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Eligible individuals must submit their enrollment forms prior to the effective dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.
- c. Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election

and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

HOW TO ADD, CHANGE, OR END COVERAGE

A. *HOW TO ADD EMPLOYEES*

1. The eligible Subscriber should complete an application for coverage which should be received by the Group within thirty (30) days of either:
 - a. The date of hire (for new Employees) or
 - b. The day they assume their official duties (for elected County officials).

The employer will then forward an electronic enrollment to BCBSWY.

NOTE: Former Employees who are being rehired are not subject to the Waiting Period and must submit their applications within thirty (30) days of their rehire date.

NOTE: Former Employees who were covered by the Plan when termination occurred and who are rehired and meet the eligibility criteria for coverage within 13 weeks of their termination date are not subject to the Waiting Period and are eligible for coverage the first of the month coinciding with or following the day the Employee completes one hour of service.

2. Based on the completeness and acceptability of the application, the effective date of coverage will be the first of the month following completion of the sixty (60) day Waiting Period for new Employees and elected officials.

NOTE: Employees who have been on COBRA coverage and who recover from their illness or injury and return to work are exempt from the Waiting Period.

3. If an electronic enrollment is not submitted as described above, the Subscriber will be considered a Late Enrollee. Late Enrollees are eligible to enroll during the Group's annual Open Enrollment Period. Provided the application is received by the Employer and an electronic enrollment is forwarded to BCBSWY during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.
4. A Subscriber may also be eligible to apply for coverage during a special enrollment period. (See **ADDING MEMBERS DURING SPECIAL ENROLLMENT PERIODS** below.)

B. *HOW TO ADD DEPENDENTS*

1. Eligible Dependents can be added at the time the Subscriber applies for coverage by including their names and dates of birth on the application and checking the appropriate box. If the Dependent is included on the application, the effective date of coverage will be the same as that of the Employee or official.
2. To add eligible Dependents who were not included on the original application, a new application is required. If the application for coverage is received by the Employer and an electronic enrollment is forwarded to BCBSWY within thirty-one (31) days of the Dependent's initial date of eligibility, the effective date will be the first of the month following receipt of the application. Eligible Dependents who are considered to be Late Enrollees because their application was

not received by the Employer within thirty-one days of their initial date of eligibility are eligible to apply for coverage during the Group's annual Open Enrollment Period. Provided the application is received by the Employer and an electronic enrollment is forwarded to BCBSWY during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.

3. To add newly acquired eligible Dependents, the Subscriber should complete an application for coverage, and the Employer should forward an electronic enrollment to BCBSWY. 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 providing an application is received either prior to the date of marriage, or within thirty-one days after the date of marriage.

NOTE: Eligible individuals must submit their enrollment forms prior to the effective date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

- b. If the Employee has Adult and Dependent, Two Adult or Family Coverage, coverage for a newborn child will be automatic beginning on the date of birth and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The eligible Employee may continue coverage for the newborn child beyond the 31-day automatic coverage provided that the completed application for coverage of the newborn child is received by the Employer and an electronic enrollment is forwarded to BCBSWY within sixty (60) days of the child's date of birth. If such application is received and accepted by the Employer, the eligible Employee's contribution will be adjusted and payable to account for the newborn's coverage after the automatic thirty-one (31) day coverage period. If the eligible Employee does not have Dependent coverage, coverage of the newborn child is not automatic.
 - c. To add an adopted child or legal ward, the adoption or legal guardianship papers must accompany the application for coverage if the Employee has Adult and Dependent, Two Adult or Family Coverage. Coverage for an adopted child will be automatic beginning on the date of birth and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The eligible Employee may continue coverage for the adopted child beyond the 31-day automatic coverage provided that the completed application for coverage of the adopted child is received by the Employer and an electronic enrollment is forwarded to BCBSWY within sixty (60) days of the date the petition for adoption is filed or the date of entry into the home, whichever is earlier. If such application is received and accepted by the Employer, the eligible Employee's contribution will be adjusted and payable to account for the newborn's coverage after the automatic thirty-one (31) day coverage period. If the eligible Employee does not have Adult and Dependent, Two Adult or

Family Coverage, coverage of the newborn child is not automatic and a completed application for coverage of the adopted child or legal ward must be received by the Employer within thirty-one (31) days of the earlier of the date of adoption or placement for adoption, (unless the child is in the custody of the State, in which case the application must be received by the Employer and an electronic enrollment must be forwarded to BCBSWY within thirty-one (31) days of the date of entry of a final adoption decree by the court), and coverage will be effective as of that date.

NOTE: 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 during the Group's annual Open Enrollment Period provided the application is submitted to the Employer and an electronic enrollment is forwarded to BCBSWY during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.

C. CHANGES

1. The Employee or elected County official shall notify the Employer within thirty-one (31) days of all changes in the Member'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. These changes will be made only upon approval by the Employer. All changes must be in accordance with the ELIGIBILITY REGULATIONS section of this Plan.
2. 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.
3. 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.

D. WHEN COVERAGE UNDER THIS PLAN ENDS

1. When the Employee or elected County official leaves employment or otherwise becomes ineligible, coverage will terminate on the last day of the month following thirty-one (31) days from the date on which the Member terminated (Except as described below under COBRA.)

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

2. When an Employee or elected County official is on a leave of absence and once all earned accrued leave has been exhausted, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.

3. Upon the death of the Employee or elected County official.

NOTE: Dependents of deceased covered Retirees may continue to be covered as described under the section on ELIGIBILITY REGULATIONS.

4. When the Plan is terminated. No continuation of coverage will be offered by Blue Cross Blue Shield of Wyoming.
5. By the Employee's or elected County official's request. Coverage ends on the first of the month following receipt of the 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 Member. The Employee or elected County official is liable for any benefits payments made through such improper actions.
7. When the covered Retiree becomes eligible for Medicare.
8. Active Employees or elected County officials age 65 and over must choose from the following:
 - a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
 - b. Benefits of the Federal Medicare program.

If the federal Medicare program is chosen, the Employee or elected County official will NOT be allowed to remain on this Plan.

NOTE: Except in cases where an Employee or other covered person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any covered person unless the covered person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Member or Dependent who would be affected before coverage will be retroactively terminated.

9. If an Employee becomes ineligible for coverage under the Plan due to a reduction in work hours below the minimum number of hours an Employee is required to work per week to be eligible to enroll in coverage, the Employee's coverage will terminate upon the start of the next Stability Period.

E. WHEN COVERAGE FOR DEPENDENTS ENDS

Coverage for a Dependent ends on the earliest of the following dates:

1. When the Employee's, elected County officials', or Retiree's coverage ends. However, the eligible Dependent may apply for a continuation of coverage as described below under COBRA.

NOTE: Dependents who were covered at the time of a Retiree's death may remain on the Plan as long as there is not a lapse in payments and they continue to make the payments. In the event the surviving spouse remarries, neither the

child(ren) nor the spouse may remain on the Plan. Child(ren) may not remain on the Plan after both the Retiree and spouse have died. In addition, coverage for the child(ren) will end either when the spouse becomes Medicare eligible or on December 31st of the year when the child(ren) reaches age 26.

2. December 31st of the year in which a Dependent child attains age 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 elected County official 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 Blue Cross Blue Shield of Wyoming 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 elected County official 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.

3. When no longer qualifying as a Dependent as defined in this Plan.
4. The first of the month following a final divorce decree or separation for a Dependent spouse.
5. When the Employee, elected County official, or Retiree notifies the Employer in writing to end coverage for a Dependent. Coverage ends on the first of the month following receipt of the written request.
6. 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.
7. When an Employee or elected County official is on a leave of absence and once all earned accrued leave has been exhausted, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.

F. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Blue Cross Blue Shield utilizes Lifetime Benefit Solutions (LBS) as a Third Party Administrator. The right to COBRA Continuation Coverage was created by a Federal Law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event". Under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) Members 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, 24, 29 or 36 months, depending on the "Qualifying Event".

1. Members who lose their coverage under this Plan may be eligible for a continuation of coverage as follows:

- a. When the Employee's employment is terminated (except for termination due to gross misconduct) or suffers a reduction in work hours (resulting in loss of coverage), the Employee is still eligible for continuation of coverage under the Plan.
- b. The Employee has the right to remain in the Plan at his or her own expense.
- c. The employer must notify Blue Cross Blue Shield of Wyoming within thirty-one (31) days after an Employee terminates or has a reduction in work hours resulting in the loss of eligibility for health coverage. LBS will notify the Employees of their continuation of coverage rights within 14 days of receiving notification. The Employee then must sign and return the COBRA election form to LBS 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. For more information, Employees can contact LBS at 1-800-772-3830.

NOTE: Employees who do not apply for coverage within 60 days as described are not later eligible to apply during the annual Open Enrollment period.

- d. The period of continuation of coverage for the Employee under the original Group plan is 18 months (24 months for an Employee who leaves the job and enters the Armed Forces on a full-time basis, or up to a maximum of 29 months if an Employee is disabled at the time of termination), or to the time of either coverage under another Group health plan or entitlement to Medicare, whichever occurs first.
- e. Continuation of coverage can be canceled only upon 1) abolition of all health plans by the employer, 2) the Employee's failure to make timely payment of monthly contributions, 3) the Employee's entitlement to Medicare, 4) the Employee's coverage under another Group health plan, and 5) a qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation of coverage (such as fraud).

2. Dependents who lose their coverage under the Plan may be eligible for a continuation of coverage as follows:

- a. Individuals covered as Dependents are entitled to elect to remain in the Plan after coverage otherwise would end. The period of continuation of coverage is 36 months (18 months in the case of the Employee's termination or reduction in work hours resulting in loss of coverage), for (1) surviving spouses and children of deceased Employees, (2) separated, divorced or Medicare ineligible spouses and children of current Employees, and (3) children of current Employees who lose their Dependent status under the terms of this Plan as specified above.

NOTE: The period of continuation of coverage is 24 months if the Employee left the job and entered the Armed Forces on a full-time basis.

- b. Dependents have the right to remain in the Plan at their own expense.
- c. The Employer must notify Blue Cross Blue Shield of Wyoming within 60 days of the date of the loss of eligibility of the covered Dependent. LBS will then notify Dependents of their rights to continuation of coverage within 14 days of notification. These Dependents will then have 60 days to elect continuation of coverage under the Plan. For more information, Dependents can contact LBS at 1-800-772-3830.

NOTE: If the Employee or covered Dependent fails to report the Dependent's loss of eligibility within 60 days as described, the Dependent loses the right to continuation of coverage.

- d. The period of continuation of coverage is 18, 24, 29 or 36 months as stated above, or to the time of either coverage under another Group health plan or entitlement to Medicare, whichever occurs first.
3. A lifetime continuation shall be available to a Retiree or the Dependent of a Retiree in the event of the following Qualifying Event: (1) the employer's filing of a bankruptcy proceeding under Title 11 of United States Code. Continued coverage must be offered when coverage is substantially reduced within one year before or after the filing for bankruptcy. Retirees and widows or widowers of Retirees who die before the bankruptcy filing are also covered by lifetime continuation coverage. Surviving spouses and Dependent children of Retirees who die after the bankruptcy filing may elect an additional thirty-six (36) months of continuation coverage.
 4. Other coverage options besides COBRA Continuation Coverage:
 - a. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other Group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. Qualified Beneficiary

- a. In general, you, your spouse, and any Dependent child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary". In addition, any Dependent child who is born or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary". Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

6. Qualifying Event

- a. If you are a covered Employee, you, your spouse, and/or Dependent child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:
 - (1) Your hours of employment are reduced; or
 - (2) Your employment ends for any reason other than gross misconduct.
7. You, your spouse, and/or Dependent child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA continuation coverage. You, your spouse, and Dependent Child have an independent right to elect COBRA continuation coverage. You and/or your spouse may elect coverage on behalf of either one of you and parents may elect on behalf of their Dependent child.
8. If you are the Spouse and/or Dependent child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:
 - a. Your spouse/parent – Employee dies;
 - b. Your spouse/parent – Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
 - c. You/your parents become divorced or legally separated.
9. Your spouse and/or Dependent child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such spouse and/or Dependent child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA continuation coverage and their obligation to provide such notice.
10. Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.
11. If you have questions, you may contact the COBRA Administrator or the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers are available at www.dol.gov/ebsa.
12. Are there other coverage options besides COBRA Continuation Coverage?

- a. Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

13. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

- a. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period^[1] to sign up for Medicare Part A or B, beginning on the earlier of
 - (1) The month after your employment ends; or
 - (2) The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

14. If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time

before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice.

G. *QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)*

Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan.

Procedures for determining a QMCSO may be obtained, free of charge by contacting the Plan Administrator.

H. *FAMILY AND MEDICAL LEAVE ACT*

Employees who have worked for at least one year and for at least 1250 hours over the previous 12 months are entitled to 12 weeks of leave under the Family and Medical Leave Act. The leave may be used for any of the following reasons:

1. For the care of the Employee's child (birth or placement for adoption or foster care);
2. For the care of an Employee's spouse, son or daughter, or parent who has a

- serious health Condition; or
3. For a serious health Condition that makes the Employee unable to perform his/her job.

If the need for leave under the Family and Medical Leave Act is foreseeable, the Employee must try to schedule treatment so as not to unduly disrupt the operations of the County, and the Employee must provide 30 days' notice to the Department Head. If the need for leave is unforeseeable, the Employee must notify the Department Head as soon as possible. After the Employee has been absent for three (3) days, the employer is encouraged to discuss options with the Employee, including this act. If the Employee is requesting leave under the FMLA for a serious health Condition (the Employee's or a family member's), the Employee must provide the Elected Official or Department Head with a medical certification attesting to the need for the leave.

The medical certification shall include: 1) the date the Condition began; 2) its expected duration; 3) diagnosis; and 4) brief statement of treatment. If the Employee is taking leave for his/her own medical Condition, the certification must also include a statement that the Employee is unable to perform the essential functions of his/her job. If the Employee is taking leave to care for a seriously ill family member, the medical certification must include a statement that the patient requires assistance and that the Employee's presence is necessary for treatment of the family member's serious health Condition or will assist with the recovery. A serious health Condition is one that requires Inpatient care at a Hospital, hospice or a residential Medical Care facility or a Condition which requires continuing care by a licensed health care provider.

Intermittent or reduced leave must be approved by the **elected official** or Department Head unless it is a Medical Necessity, in which case the Employee must provide medical certification attesting to 1) the need for a reduced work schedule; 2) the expected duration of the leave; 3) the dates on which leave for periodic treatment is needed; and 4) the expected duration of the treatment.

If the leave is being used for the Employee's serious health Condition, the County retains the right to hire a physician to examine the Employee concerning any certified information provided by the Employee's physician.

FMLA leave shall be taken concurrently with all accrued leave. Leave shall be deemed FMLA leave for eligible Employees by the employer, pursuant to Federal Laws and regulations. This determination shall be made by the employer, rather than at the Employee's discretion. The FMLA leave shall be calculated using the onset date of the Employee's leave and spanning twelve months from that date.

The County will continue to pay health benefits while the Employee is on leave unless refused by the Employee. If the Employee chooses to continue coverage, he/she must pay his/her share of the premiums if on unpaid leave. Should the Employee choose not to return to work, he/she shall be responsible for reimbursing the County

for the share of the premiums which the County paid on the Employee's behalf.

An Employee who takes leave under this policy will be able to return to the same job or a job with equivalent status, pay, benefits and other employment terms. The highest compensated 10 percent of County Employees are excluded from this provision.

If the Employee takes leave under the FMLA for his/her own serious health Condition, prior to returning to work the Employee must provide a written certification from the health care provider attesting to the fact that the Employee is able to resume work. If you have any questions concerning the Family and Medical Leave Act, contact your Elected Official or the Fremont County Government Deputy Clerk.

I. ADDING MEMBERS DURING SPECIAL ENROLLMENT PERIODS

1. 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. If at the time of initial eligibility, Employees or Dependents submitted a written statement to the Plan Administrator declining coverage under the Plan because of other Group health insurance coverage, they may be eligible for a special enrollment, provided they request enrollment within thirty-one (31) days after the other health insurance 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 submitted to the Employer and an electronic enrollment is forwarded to BCBSWY within thirty-one (31) days after the Employee's or Dependent's other coverage ends. The effective date under this Plan will be the 1st of the month following receipt by the Employer of a substantially complete application.

2. If Employees gain a new Dependent as a result of marriage, birth, adoption or legal ward, 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 submitted to the Employer and an electronic enrollment is forwarded to BCBSWY within thirty-one (31) days after the marriage, birth, adoption or legal ward, or placement for adoption. The effective date of coverage will be:
 - a. In the case of marriage, the date of marriage.

NOTE: Eligible individuals must submit their enrollment forms prior to the effective date of coverage in order for salary reductions to have preferred tax

- treatment from the date coverage begins.
- b. In the case of a Dependent's birth, the date of birth, and
 - c. In the case of a Dependent's adoption or legal ward 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. The Employee and any Dependents being added to the coverage must complete an application for coverage which must be submitted to the Employer and an electronic enrollment is forwarded to BCBSWY within thirty-one (31) 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 Subscribers will be the date of application, assuming receipt by the Employer of a substantially complete application.
 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 forwarded to 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 for coverage.
 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 will be the first of the month following receipt of the application for coverage.
 6. Special enrollment periods required under Federal or State Law:
If there is a conflict between this Agreement and applicable Federal or State Law, Federal or State Law controls.

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.

A Member's 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. *HOSPITALS AND FACILITY PROVIDERS*

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

1. Network Hospitals and Facility 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 Network Hospitals and Facility Providers will be made directly to them. Employees are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Payment for Covered Services provided to Members by Non-network Hospitals or Facility Providers may be made to the Employee. Employees are responsible to Non-network providers of services for all charges, regardless of the Allowable Charge or the amount of payment made under this Plan.

AUTHORIZATION REVIEW

If a Physician recommends that a Member be hospitalized (for any non-maternity or non-emergency Condition), services **MUST** be submitted in advance to Blue Cross Blue Shield of Wyoming's authorization review program. (In the event of an emergency Hospital admission, Blue Cross Blue Shield of Wyoming must be contacted within two (2) days after the admission.)

Certain Covered Services require authorization by Blue Cross Blue Shield of Wyoming. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization *before* receiving these healthcare services. Authorization may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service. Following is a list of Covered Services that require authorization:

1. Breast reconstructive Surgery
 2. Cosmetic Surgery
 3. Chemotherapy (including Physician's office)
 4. Dialysis (including Physician's office)
 5. Extended care facility/transitional or swing bed care (Inpatient admission)
 6. Hospital grade breast pumps
 7. High dose chemotherapy and/or radiation therapy with allogeneic or autologous bone marrow transplant or peripheral stem cell support
 8. Inherited enzymatic disorders counseling
 9. Non-accidental dental related medical services
 10. Obesity and weight loss services
 11. Orthognathic Surgery
 12. Outpatient surgical services
 13. Rehabilitation facility
 14. Radiation
 15. Skilled nursing facility
-

B. *PHYSICIANS AND PROFESSIONAL PROVIDERS*

Payment by Blue Cross Blue Shield of Wyoming for Covered Services will be based on the Allowable Charges.

1. Network Physicians and Professional 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 Network Physicians and Professional Providers will be made directly to them. Employees are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Payment for Covered Services provided to Members by Non-network Physicians or Professional Providers will be made to the Employee and Employees are responsible for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

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

C. *COPAYMENTS FOR EMERGENCY ROOM VISITS*

Visits to an emergency room, whether Network or Non-network, are subject to a \$250 Copayment per visit after which benefits will be provided subject to the Plan's appropriate Deductible and Coinsurance provisions. However, the emergency room

Copayment will be *waived* if the Member is admitted directly into the Hospital from the Emergency Room.

D. DEDUCTIBLE REQUIREMENTS

Under Single Coverage, the Deductible amount for each calendar year is shown on the Schedule of Benefits. (The Deductible does not apply to PREVENTIVE CARE)

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

1. When one family member meets one-half of the maximum Aggregate Deductible, that Member will be eligible for benefits. The remaining family members will be eligible for benefits when they have collectively satisfied the remaining balance of the maximum Aggregate Deductible.
2. When two family members each meet one-half of the maximum Aggregate Deductible, the remaining Members will then be eligible for benefits without regard to that Deductible.
3. When no one family member meets one-half of the maximum Aggregate Deductible, but all the Members collectively meet the maximum Aggregate Deductible, then all family members will be eligible for benefits.

Any Deductible amounts which Members pay for Covered Services will be applied toward both their Network and Non-network Deductibles.

NOTE: The Deductible does not apply to PREVENTIVE CARE when Covered Services are provided by a Network provider.

NOTE: A Member may not apply more than the individual Deductible expenses per Member to satisfy the maximum Aggregate Deductible.

NOTE: Only dollar amounts of the Maximum Allowable Amount will contribute toward satisfaction of the Deductible Amount.

COMMON ACCIDENT DEDUCTIBLE

When two or more family members covered under an Adult and Dependent or Family Coverage are injured in the same accident after the Member's effective date of coverage, the following provisions apply:

1. If one family member meets the individual Deductible, then the other family members will become eligible for Covered Services related to the accident during the same Member's calendar year. The other family members will not have to meet any additional Deductible requirements for charges related to the accident.
2. The common accident Deductible cannot be collectively met by all family members.

E. PAYMENT ALLOWANCES UNDER THIS COVERAGE

After the required Deductible is met, benefits will be provided for Covered Services as shown below unless otherwise specified:

Network Providers

1. Covered Services will be subject to 20% Coinsurance and any applicable Copayments until Members have paid the Out-of-Pocket Maximum for Network providers shown on the Schedule of Benefits, then
2. Covered Services will be reimbursed at 100% of the Allowable Charge over the Out-of-Pocket Maximum per calendar year for Network providers until reaching the end of the calendar year.

Coinsurance amounts which Members pay for Covered Services provided by Network providers will apply toward satisfying both their Network and Non-network Out-of-Pocket Maximums.

Non-network Providers

1. Covered Services will be subject to 40% Coinsurance and any applicable Copayments until Members have reached the Out-of-Pocket Maximum for Non-network providers shown on the Schedule of Benefits, then
2. Covered Services will be reimbursed at 100% of the Allowable Charge over the Out-of-Pocket Maximum per calendar year for Non-network providers until the end of the calendar year.

Coinsurance amounts which Members pay for Covered Services provided by Non-network providers will apply toward satisfying both their Network and Non-network Out-of-Pocket Maximums.

NOTE: No part of the Member's Coinsurance liability can be applied toward future Deductible requirements.

NOTE: Member's Coinsurance liability does not apply to PREVENTIVE CARE when Covered Services are provided by a Network provider.

F. 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 Member 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 Member will obtain the Covered Services from Physicians, Professional Providers, Hospitals and Facility 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 Member may obtain Covered Services from Physicians, Professional Providers, Hospitals and Facility 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 Member accesses Covered Services within the geographic area served by a Host Blue, Blue Cross Blue Shield of Wyoming will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever a Member 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 Member pays for Covered Services is calculated based on the lower of:

- a. The billed charges for the Member’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 Member’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 Member’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 Member’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. Member'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 Member 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 Member 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 Member 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.

G. *NO-SURPRISES BILLING*

In accordance with the requirements of Federal Law: 1) applicable Covered Services that are received from certain Non-Participating healthcare providers during an emergency, or 2) applicable Covered Services that are received from certain Non-Participating healthcare providers delivering emergency or non-emergency services at certain Participating facilities, that would otherwise be Covered Services if received from a Participating healthcare provider, will be covered at the same cost-sharing amounts as would be applied if the services were provided by a Participating healthcare provider (and such cost-share amounts shall be determined based upon an amount up to, but not to exceed, the Qualified Payment Amount—as defined by Federal Law) and the cost-sharing amounts applied to such services shall be counted towards the In-Network Deductible amount and Out-of-Pocket Maximum amount.

BENEFITS

The following pages describe the various services and supplies that the Plan covers and to what extent these items are covered 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.

If a claim is submitted for a service not listed on the following pages as a benefit, Blue Cross Blue Shield of Wyoming will deny that claim as not a benefit of this Plan. Before doing so, Blue Cross Blue Shield of Wyoming will review the claim to determine whether the service or supply qualifies to be paid in whole, or in part, as a benefit, or is an exclusion. In making this decision, it may request the advice of medical or other professionals.

Any decision rendered by Blue Cross Blue Shield of Wyoming is subject to the right of appeal in accordance with the appeal procedures found in this Plan.

A. ACCIDENTS

DEFINITION – 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 Provider, Hospital, or Facility Provider.

See SUPPLEMENTAL ACCIDENT BENEFIT for additional information relating to accidents.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are provided when a Member incurs accidental bodily injury (as defined under ACCIDENTS), providing such care is related to and received within ninety (90) days from the date of injury. The following benefits are provided to the maximum shown on the Schedule of Benefits, but not exceeding the Allowable Charges for such care:

1. Medical or surgical treatment by a Physician; or by a Doctor-of-Dental Surgery in connection with treatment for injury to sound, natural teeth;
2. Confinement and covered care in a licensed general Hospital;
3. Services of a registered nurse (R.N.) not related to nor a resident in the home of the patient;
4. Laboratory and X-ray examinations;
5. Ambulance service;
6. Any necessary supply or service.

When two or more family members covered under an Adult and Dependent or Family Coverage are injured in the same accident after the Member's effective date of coverage, the following provisions apply:

1. If one family member meets the individual Deductible, then the other family members will become eligible for Covered Services related to the accident during the same Member's calendar year. The other family members will not have to meet any additional Deductible requirements for charges related to the accident.
2. The common accident Deductible cannot be collectively met by all family members.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ACUTE REHABILITATIVE SERVICES

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Rehabilitative Services. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

BENEFITS –

1. Services rendered at an Acute Rehabilitation Unit.
2. Room Expenses
Room expenses, including such items as the cost of a room, general nursing services, meal services for the Member, and routine laundry service are Covered Services.
3. Rehabilitative Services
Healthcare services primarily for the purpose of therapeutic or rehabilitative treatment of the Member (such as physical, occupational, speech, or oxygen therapy, etc.) are Covered Services.

LIMITATIONS AND EXCLUSIONS –

1. Inpatient benefits will be provided to a maximum of thirty (30) days per Member per benefit period. In the case of a spinal cord or head injury, or a cerebral vascular accident (CVA or stroke), benefits are increased to a maximum of sixty (60) days per Member per benefit period. Authorization is required.
2. Rehabilitative benefits are only provided for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

See GENERAL LIMITATIONS AND EXCLUSIONS

C. 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

D. AMBULANCE SERVICES

DEFINITION - 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 Member 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 Member's home, nursing home, or skilled nursing facility in the same locale.
4. Transportation to the closest facility with the appropriate level of care will be required, unless otherwise approved by Blue Cross Blue Shield of Wyoming.

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 Member's Condition warrants air ambulance services. If the Member could have been safely transported by Ground Ambulance, Air Ambulance is not a Covered Service.
2. **Other Transportation Services:** The Plan will not pay for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.
3. **Patient Safety Requirement:** If Members 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 Member. (Example: Transportation of an infant to be closer to the family's home.)

See GENERAL LIMITATIONS AND EXCLUSIONS

E. ANESTHESIA SERVICES

DEFINITION - "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 and Outpatient: Anesthesia services provided by a Physician or C.R.N.A. are covered when necessary for covered Surgery. Allowances are determined by 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 service.

See GENERAL LIMITATIONS AND EXCLUSIONS

F. BLOOD EXPENSES

DEFINITION – “Blood” expenses include the following:

1. Charges for processing, transportation, handling, and administration.
2. Cost of blood, blood plasma, and blood derivatives.

BENEFITS – Blood transfusions, including the cost of blood, blood products and blood processing except when donated or replaced.

LIMITATIONS AND EXCLUSIONS –

General: The “limitations and exclusions” that apply to SURGERY benefits also apply to blood expense.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. CARDIAC REHABILITATION

DEFINITION – Cardiac rehabilitation is a program designed to assist Members recovering from recent heart problems by teaching them about their disease, symptoms, and management, and helping them to improve their coronary risk factors.

BENEFITS –

Inpatient: Not covered.

Outpatient: Benefits will be provided for cardiac rehabilitation and supplies for Members under the recommendation of a Physician. Expenses must be incurred while covered under this Plan.

LIMITATIONS AND EXCLUSIONS –

Phase III cardiac rehabilitation services (i.e. the maintenance phase of cardiac rehabilitation which emphasizes long-term lifestyle changes including, but not limited to, regular exercise programs) are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

H. CHEMOTHERAPY AND RADIATION THERAPY

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Chemotherapy and Radiation Therapy. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization *before* receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for Chemotherapy and Radiation Therapy.

BENEFITS –

1. Inpatient chemotherapy is a Covered Service.
2. Outpatient chemotherapy is a Covered Service.
3. Inpatient radiation is a Covered Service.
4. Outpatient radiation is a Covered Service.
5. Prescription chemotherapy is a Covered Service.

LIMITATIONS AND EXCLUSIONS –

Certain medications require use of specified facilities or Provider locations to be a covered benefit. You may seek an exception by calling us at 1-800-442-2376 or by writing to Blue Cross and Blue Shield of Wyoming, P.O. Box 2266, Cheyenne, WY 82003-2266. You can review a complete listing of these medications by visiting our website, www.bcbswy.com.

See GENERAL LIMITATIONS AND EXCLUSIONS

I. CONSULTATIONS

DEFINITION - 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 only for the office visit and consultation in connection with a voluntary second 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

J. DENTAL SERVICES

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Dental Services. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these Dental Services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the Dental Service.

DEFINITION - "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 Member 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. Reduction of dislocations of the temporomandibular joints.
7. Accidental injury (see limitation #1).
8. Removal of impacted teeth.

Benefits will also be provided for the room allowance and ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICE) in a Hospital if a Member has a hazardous medical Condition (such as heart Condition) which makes it necessary for him or her to have an otherwise non-covered dental procedure performed in the Hospital. (See "limitations".)

Outpatient: Benefits will be provided for initial services provided by a Hospital or other facility for any one of the eight 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 benefit allowance 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.
2. Hazardous Medical Conditions: If, due to a hazardous medical Condition (e.g. a heart Condition), a Member must be hospitalized for a non-covered dental procedure, he or she may receive benefits for Inpatient Hospital charges. However, benefits for the services provided by the dentist or oral surgeon will still be limited to those described under the Dental Expenses, if applicable.
3. Authorization: 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 Member 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.
4. 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.
5. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
6. 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.
7. Routine dental services such as cleaning, restoration, panoramic X-Rays are not Covered Services.
8. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under the Dental Expenses, if applicable.

See GENERAL LIMITATIONS AND EXCLUSIONS

DENTAL EXPENSE RIDER

Deductible Requirements: Dental expense benefits are subject to a separate Dental Deductible. The Deductible is \$50.00 per Member with a maximum Aggregate Deductible of \$150.00 for Adult and Dependent Coverage and Family Coverage. The Deductible does not apply to Preventive and Diagnostic Services. Blue Cross Blue Shield utilizes LBS as a Third Party Administrator to provide COBRA benefits to eligible Members.

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. Bite wing x-rays (but not more than two sets per calendar year).
4. Emergency palliative treatment.
5. Fluoride treatments.
6. Sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent further decay). Only for Dependent children under the age of 16 and limited to two (2) treatments per tooth.
7. X-rays as follows:
 - a. Full mouth x-rays (but not more than one set in 36 consecutive months).
 - b. X-rays required in connection with diagnosis of a specific Condition requiring treatment, except x-rays provided in connection with orthodontic procedures and treatment.
8. General anesthetics.

RESTORATIVE PROCEDURES: Payment for restorative procedures is limited to 80% of Allowable Charges, subject to the Dental Deductible. Member 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 contract).
3. Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).
4. Periodontal treatment, diseases of gums. (Periodontal benefits limited to a lifetime maximum of \$1,000 per Member. This lifetime maximum does not apply to Members age 19 and under. This maximum does not apply toward the \$2,000 Dental Expense Rider calendar year maximum.)
5. Endodontic treatment (Pulp infection and root canal therapy).
6. Injection of antibiotic drugs.
7. Space maintainers.

PROSTHODONTIC TREATMENT: Payment for Prosthodontic Treatment is limited to 80% of Allowable Charges, subject to the Dental Deductible. Member is responsible to provide payment for the remaining 20% 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.
5. Repair or replacement or addition to crowns and 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. Replacement or alteration of full or partial denture or fixed bridgework, if required due to change due to an accidental injury requiring oral Surgery, or oral Surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue. The Surgery must take place while covered under this Plan and must be finished within twelve (12) months after the Surgery. Replacement of a full denture, if needed due to a change in the structure of the mouth, if made more than five (5) years after the initial installation of such dentures or bridgework, and more than two (2) years after the effective date of the Member's benefits.

ORTHODONTIC TREATMENT: The following Orthodontic Treatment that is not Medically Necessary is payable at 50% of the Allowable Charges to a maximum of two thousand (\$2,000) per course of treatment. (This is in addition to the \$2,000 Dental Expense Rider calendar year maximum for non-orthodontic services), and to a lifetime maximum of four thousand dollars (\$4,000). Orthodontic treatment is available only to covered, unmarried Dependent children age 19 or under:

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.

Orthodontic Treatment that is Medically Necessary is available for Members under the age of 19 and is not subject to any maximums stated above. To be eligible for any Medically Necessary Orthodontic Treatment covered under this provision, the Member receiving the treatment must be enrolled as a Dependent under this Agreement.

TREATMENT IN PROGRESS: Benefits are not provided for treatment received prior to the Member'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 Member 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 Expense Rider for each Member are \$2,000.00 per calendar year. (**NOTE:** This Maximum Benefit provision does not apply to Members 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 on the basis of Allowable Charges. An explanation of benefits will be forwarded to the Employee.
2. 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 Employee will be responsible for the excess amount over the benefits allowed for the less costly procedure.

LIMITATIONS AND EXCLUSIONS –

1. Authorization: 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 Member 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 individual is covered.
 - c. When replacement is required due to change due to an accidental injury requiring oral Surgery, or oral Surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue.
- 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. Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth)
 - e. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.
 - f. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.
 - g. Extra sets of dentures or other prosthetic devices or appliances.
 - h. Temporary or treatment dentures.
- 7. Any limitations under this Dental Expense Rider on annual or calendar year maximums do not apply to Members under the age of 19.
- 8. To be eligible for any Medically Necessary Orthodontic Treatment covered under this Agreement, the Member must be under the age of 19 and have been enrolled as a Dependent under this Agreement for an entire and continuous 24 month period prior to receiving the Medically Necessary Orthodontic Treatment.

See GENERAL LIMITATIONS AND EXCLUSIONS

K. DIABETES SERVICES

DEFINITION - The term "diabetes services" applies to 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 diabetes Outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

LIMITATIONS AND EXCLUSIONS –

See Section SUPPLIES, EQUIPMENT AND APPLIANCES for diabetic equipment and supplies.

See GENERAL LIMITATIONS AND EXCLUSIONS

L. GENDER REASSIGNMENT

BENEFITS –

Benefits will be provided for the following services. Covered Services will be subject to Deductible and Coinsurance. Covered Services include:

1. Psychotherapy.
2. Hormone therapy.
3. Puberty-suppressing medication.
4. Laboratory testing to monitor the safety of continuous hormone therapy.
5. Surgery, including:
 - a. Male to Female:
 - (1) Clitoroplasty (creation of clitoris)
 - (2) Labiaplasty (creation of labia)
 - (3) Orchiectomy (removal of testicles)
 - (4) Penectomy (removal of penis)
 - (5) Urethroplasty (reconstruction of female urethra)
 - (6) Vaginoplasty (creation of vagina)
 - (7) Breast enlargement, including augmentation mammoplasty and breast implants
 - (8) Mastopexy (breast lift)
 - b. Female to Male:
 - (1) Bilateral mastectomy or breast reduction
 - (2) Hysterectomy (removal of uterus)
 - (3) Metoidioplasty (creation of penis, using clitoris)
 - (4) Penile prosthesis
 - (5) Phalloplasty (creation of penis)
 - (6) Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
 - (7) Scrotoplasty (creation of scrotum)
 - (8) Testicular prosthesis
 - (9) Urethroplasty (reconstruction of male urethra)
 - (10) Vaginectomy (removal of vagina)
 - (11) Vulvectomy (removal of vulva)

Note: Authorization by Blue Cross Blue Shield of Wyoming is required before benefits are payable. The medical policy requirements are available under the Providers section of our website or by calling Member Services at 1-(800)-442-2376.

LIMITATIONS AND EXCLUSIONS –

1. Coverage of this benefit is subject to all authorization review and requirements.

2. Covered surgeries are limited to one (1) per lifetime for each specified Surgery except when Medically Necessary due to complications.
3. Cosmetic procedures, including the following, are not Covered Services:
 - a. Abdominoplasty
 - b. Blepharoplasty
 - c. Body contouring, such as lipoplasty
 - d. Brow lift
 - e. Calf implants
 - f. Cheek, chin, and nose implants
 - g. Injection of fillers or neurotoxins
 - h. Face lift, forehead lift, or neck tightening
 - i. Facial bone remodeling for facial feminizations
 - j. Hair removal
 - k. Hair transplantation
 - l. Lip augmentation
 - m. Lip reduction
 - n. Liposuction
 - o. Pectoral implants for chest masculinization
 - p. Rhinoplasty
 - q. Skin resurfacing
 - r. Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's Apple).
 - s. Voice modification Surgery
 - t. Voice lessons and voice therapy

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HEMODIALYSIS AND PERITONEAL DIALYSIS

DEFINITION - "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 treats a Member as an Inpatient, in the Outpatient department of a Hospital or other facility, or in the Member's home. The Plan will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Physician and required for therapeutic use.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

*N. HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY
WITH BONE MARROW TRANSPLANT AND/OR PERIPHERAL STEM CELL SUPPORT*

THIS SECTION IS APPLICABLE ONLY TO BENEFITS FOR HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY WITH ALLOGENEIC OR AUTOLOGOUS BONE MARROW TRANSPLANT AND/OR PERIPHERAL STEM CELL TRANSPLANT ("HDC/ABMT"), AND ONLY TO THOSE DIAGNOSES FOR WHICH HDC/ABMT IS NOT EXCLUDED FROM COVERAGE ENTIRELY UNDER THE GENERAL LIMITATIONS AND EXCLUSIONS SECTION OF THIS PLAN, INCLUDING WITHOUT LIMITATION THE EXCLUSION INVOLVING EXPERIMENTAL AND INVESTIGATIVE PROCEDURES, AND THE EXCLUSION FOR STUDIES. ONLY HDC/ABMT IN THOSE CIRCUMSTANCES NOT OTHERWISE EXCLUDED BY THIS PLAN IS ELIGIBLE FOR COVERAGE, AND THEN ONLY IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF THIS SECTION.

DEFINITIONS - "High Dose Chemotherapy or Radiation Therapy" is the administration of chemotherapeutic drugs and/or radiation therapy when the dose or manner of administration is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt by the patient of autologous or allogeneic stem cells, whether derived from the bone marrow or the peripheral blood.

"Donor" is, in the case of an allogeneic transplant, the individual supplying the bone marrow and/or stem cells.

"Recipient" is the individual receiving the bone marrow and/or stem cells.

BENEFITS –

Authorization is required before benefits are payable.

Benefits are provided for high dose chemotherapy and/or radiation therapy with allogeneic or autologous bone marrow transplant or peripheral stem cell support in those circumstances not otherwise excluded from coverage under other provisions of this Plan. Covered Services include:

1. A clinical evaluation at the transplant facility.
2. Room expenses and ancillary services. See ROOM EXPENSES AND ANCILLARY SERVICES.
3. Administration of high dose chemotherapy and or radiation therapy.
4. Laboratory, pathology and X-ray services. See LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES.
5. Physician services, including those related to the procurement of bone marrow and/or stem cells.
6. Donor expenses in the case of allogeneic transplant.
7. Prescription medications, including immunosuppressive drugs.

LIMITATIONS AND EXCLUSIONS –

1. Coverage of this benefit is subject to all authorization review requirements, including the use of Designated Facility Providers.
2. Donor expenses are not Covered Services if the donor is a Member but the recipient is not.
3. Donor expenses for which benefits are available from another source are not covered.
4. Services and supplies for which government funding of any kind is available are not covered.
5. Transportation, meals, lodging: The cost of transportation, meals, and lodging related to a human organ transplant are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS.

O. HOME HEALTH CARE

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

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

1. The Member would have to be admitted to a Hospital or skilled nursing facility if he or she did not receive home health care.
2. The Member's home health care must be ordered 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.

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.

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

P. HOSPICE BENEFITS

DEFINITION - A "hospice" offers a coordinated program of home care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social, and economic stresses which are often experienced during the final stages of terminal illness and during dying.

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

1. The Member must experience an illness 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) that cannot be obtained at a lower level of care, rather than curative care, is considered most appropriate.
3. The attending Physician must refer the Member to the program and must be in agreement with the plan for treatment of the Member's Condition.

BENEFITS –

Inpatient benefits are provided for the following:

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

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

Outpatient benefits are provided for the following:

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

Benefits for a private Inpatient room will be provided to a maximum of \$50 per day.

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 –

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. HUMAN ORGAN TRANSPLANTS

DEFINITION - "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. Lung Transplants
4. Pancreas Transplants
5. Kidney Transplants
6. Bone Marrow/ Stem Cell Transplants
7. Intestine Transplants

BENEFITS –

Blue Cross Blue Shield of Wyoming (the Claims Supervisor) does not administer the benefits or process claims for transplant related services.

Instead, the Plan provides benefits for human organ and tissue transplantation through OptumHealth's Managed Transplant Program. Human organ or tissue transplant services for eligible Members are covered under a separate health benefit policy, according to its terms and conditions. Transplant claims will be paid by OptumHealth as described in their coverage document.

Please contact OptumHealth or your employer with any questions related to this benefit. OptumHealth's Managed Transplant Program Case Management department can be contacted at 800-367-4436.

Human organ or tissue transplant services not covered in whole or in part under the OptumHealth Managed Transplant Program may be a Covered Service under this Plan, subject to its Deductible and Coinsurance provisions.

Please refer to OptumHealth for details regarding benefits and eligibility.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

R. 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.
 - c. Coverage will only be provided for prescribed medical nutrition formula and supplies that are medically appropriate. Coverage will not be provided for medical grade food except in circumstances where formula nutrition is insufficient and not for the convenience or preference of the Member.

See GENERAL LIMITATIONS AND EXCLUSIONS

S. 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" 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 Facility Provider, or by a Physician, independent pathology laboratory, or independent radiology laboratory. Routine pap smears will be paid as indicated under PREVENTIVE CARE.

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: The Plan will not pay for laboratory or X-ray services related to weight loss programs.
4. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

T. MATERNITY AND NEWBORN CARE

DEFINITIONS - "Maternity" services are those required by covered female Employees, covered female Dependent children, 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 termination of pregnancy prior to full term. Elective termination is covered only in the case of rape or incest or where the mother is endangered, or medical complications arise from an abortion.
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.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under Federal Law, health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under Federal Law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under Federal Law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain authorization. For information on authorization, contact Blue Cross Blue Shield of Wyoming.

NOTE: Coverage of newborn services is available only to qualified Dependent children as defined by this Plan.

BENEFITS –

Hospital:

Inpatient: Benefits include covered charges for services for room expenses and ancillary services for the eligible female Member. See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: The following charges are covered:

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 Member and billed by a Physician:

1. Delivery services (pre- and post-natal Medical Care is included in the allowance for delivery services. Certain pre-natal services as required by law will be covered at 100% of Allowable Charges without reference to the Deductible.)
2. Laboratory and X-ray services (See LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

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 his/her effective date, a newborn child becomes subject to his/her own individual Deductible for each calendar year.

LIMITATIONS AND EXCLUSIONS –

1. Artificial conception: The Plan will not pay for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.
2. Genetic and chromosomal testing or 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.

3. Benefits will not be provided for home births and related services; however, any services rendered in a professional setting by a Professional Provider or in an institutional setting by an Institutional Healthcare Provider in connection with complications arising from an in-home birth will be covered under this section.

See GENERAL LIMITATIONS AND EXCLUSIONS

U. MEDICAL CARE FOR GENERAL CONDITIONS

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

DEFINITIONS-"Inpatient Medical Care" expenses are those billed by a Physician for services provided while a Member 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, Hospital, or Other Facility Provider for Covered Services rendered in the provider's office, the Outpatient department of a Hospital or Other Facility Provider, or in the Member's home, for a Condition which does not require Surgery.

BENEFITS –

Hospital:

Inpatient: Benefits include charges for the room allowance and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

Outpatient: Benefits will be provided for Medical Care rendered at a Hospital or Other Facility Provider 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.

LIMITATIONS AND EXCLUSIONS –

1. Private Room Expenses: If the Member 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.
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.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. *MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE*

DEFINITIONS – “Mental Health or Substance Use Disorder” is a Condition requiring specific treatment primarily because the Member 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 Provider, Hospital, or Facility Provider while the Member is confined as an Inpatient.

“Outpatient care” expenses are those services billed by a Physician, Professional Provider, Hospital, or Facility Provider, for services provided in either the Physician’s or Professional Provider’s office, the Outpatient department of a Hospital, or Facility Provider, or the Member’s home.

BENEFITS –

Mental Health Care

Inpatient:

Hospital: Benefits will be based on the Allowable Charges.

Physician or Professional Provider: Benefits will be based on the Allowable Charges. Intensive

Outpatient:

Benefits will be provided based on the Allowable Charges for intensive Outpatient services provided by a Hospital or Facility Provider.

Other Outpatient or Office:

Benefits will be based on the Allowable Charges.

Substance Use Disorder Care

NOTE: Detoxification is covered only if followed by either an Inpatient stay in a Hospital or residential chemical dependency treatment facility, or by an Outpatient treatment program.

Inpatient:

Hospital: Benefits will be based on the Allowable Charges.

Physician or Professional Provider: Benefits will be based on the Allowable Charges. Outpatient:

Benefits will be based on the Allowable Charges.

NOTE: Network Providers have agreed to accept Blue Cross Blue Shield of Wyoming's Allowable Charges as payment in full and will not bill Members 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 Members on the same basis as if the provider were Network. Members 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 or Coinsurance Maximum.

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 the following publication:
 - a. 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 Provider who is properly licensed or certified. A Professional 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 Member'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

W. OUTPATIENT MEDICATIONS

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for some Outpatient Medications. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these Outpatient Medications. Authorization may include the required use of Designated Providers. The failure to obtain authorization may result in a denial or reduction in coverage for the Outpatient Medication.

BENEFITS –

Certain medications may be administered in an Outpatient setting, such as those which are infused, injected, or delivered subcutaneously. The following service locations are covered:

1. Outpatient Facility
2. Provider's Office
3. Infusion Clinic
4. Home Health Administration
5. Other Appropriate Outpatient Locations

LIMITATIONS AND EXCLUSIONS –

1. Certain medications require use of specified facilities or Provider locations to be a covered benefit. You may seek an exception by calling us at 1-800-442-2376 or by writing to Blue Cross and Blue Shield of Wyoming, P.O. Box 2266, Cheyenne, WY 82003-2266. You can review a complete listing of these medications by visiting our website, www.bcbswy.com.
2. Prescription Drugs related to weight loss programs are not Covered Services.
3. Prescription Drugs considered “lifestyle” drugs are not Covered Services. Examples include but are not limited to: hair loss, facial hair, wrinkles, etc.
4. Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not a Covered Service.
5. For Chemotherapy medications, please see section CHEMOTHERAPY AND RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

X. PRESCRIPTION DRUGS AND MEDICINES

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Specialty Medications and those Prescription Drugs listed as requiring authorization at yourwyoblue.com. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

DEFINITIONS- "Prescription Drugs and medicines" are medications that have been approved or regulated by the Food and Drug Administration that can, under Federal and State Law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber. All drugs and medicines must be approved by the Food and Drug Administration for the Condition for which they are prescribed and not be identified as "Investigational" or "Experimental".

A. BENEFITS AVAILABLE THROUGH THE PRESCRIPTION DRUG BENEFIT

Prescription Drugs and medicines are covered by the Prescription Drug Benefit when purchased from a Participating Pharmacy. When a Member needs a prescription filled, the Member should go to a Participating Pharmacy and present his or her identification card. The Participating Pharmacy will only charge for the Member cost-share 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. 30 Day Supply:

- | | |
|---------------|--|
| Tier 1 Drugs: | Consists of the lowest cost prescription medications; primarily generic drugs but includes some preferred brand medications. |
| Tier 2 Drugs: | Consists of the lowest cost prescription medications; primarily generic drugs but includes some non-preferred brand medications. |
| Tier 3 Drugs: | Consists of higher-cost prescription medications; most are preferred brand drugs but may have generic-appearing drugs. |
| Tier 4 Drugs: | Consists of higher-cost prescription medications; most are non-preferred brand drugs but may have generic-appearing drugs. |

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming.

2. If the Member chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Member must pay the appropriate Member cost-share for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the Out-of-Pocket Maximum has been reached, the Member still pays the difference in cost between the brand name and the generic drug, even though the Member is no longer responsible for the Member cost-share.

3. The maximum amount or quantity of Prescription Drugs that will be considered as eligible charges may not exceed a ninety (90) day supply when taken in accordance with the direction of the prescriber. A Copayment will be collected for each thirty (30) day supply.

If a Member must purchase drugs from a non-participating Pharmacy, Blue Cross Blue Shield of Wyoming can provide the Member with special claim forms to obtain benefits under this section of the Plan. The claim forms must be sent to the address indicated on the form. When using a non-participating Pharmacy, the Member will be responsible for the difference between the Prescription Drug Benefit's Allowable Charge and the actual charge made by the Pharmacy. When the Out-of-Pocket Maximum has been reached, the Member still pays the difference between the Prescription Drug Benefit's Allowable Charge and the actual charge made by the Pharmacy, even though the Member is no longer responsible for the Member cost-share.

B. BENEFITS AVAILABLE THROUGH THE MAIL SERVICE PHARMACY PROGRAM:

Prescription Drugs and medicines taken on a long-term basis ("maintenance drugs") may be purchased through Blue Cross Blue Shield of Wyoming's preferred Mail Service delivery program.

Benefits for Prescription Drugs and medicines purchased through the Mail Service Prescription Drug Program are based on Allowable Charges and payable as follows:

1. Tier 1 Drugs: Consists of the lowest cost prescription medications; primarily generic drugs but includes some preferred brand medications.
- Tier 2 Drugs: Consists of the lowest cost prescription medications; primarily generic drugs but includes some non-preferred brand medications.
- Tier 3 Drugs: Consists of higher-cost prescription medications; most are preferred brand drugs but may have generic-appearing drugs.
- Tier 4 Drugs: Consists of higher-cost prescription medications; most are non-preferred brand drugs but may have generic-appearing drugs.

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming.

2. If the Member chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Member must pay the appropriate Member cost-share for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the Out-of-Pocket Maximum has been reached, the Member still pays the difference in cost between the brand name and the generic drug, even though the Member is no longer responsible for the Member cost-share.
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 directions of the prescriber.

C. BENEFITS AVAILABLE UNDER THE EXTENDED SUPPLY NETWORK (ESN):

Benefits for Prescription Drugs and medicines purchased through the ESN are as follows:

1. Tier 1 Drugs: Consists of the lowest cost prescription medications; primarily generic drugs but includes some preferred brand medications.
- Tier 2 Drugs: Consists of the lowest cost prescription medications; primarily generic drugs but includes some non-preferred brand medications.
- Tier 3 Drugs: Consists of higher-cost prescription medications; most are preferred brand drugs but may have generic-appearing drugs.
- Tier 4 Drugs: Consists of higher-cost prescription medications; most are non-preferred brand drugs but may have generic-appearing drugs.

D. 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.
6. Tier 5 Drugs: Consists of preferred Specialty drugs; most are highest-cost brand Specialty medications.
- Tier 6 Drugs: Consists of non-preferred Specialty drugs; most are highest-cost brand Specialty medications.

NOTE: Non-network Prescription Drugs are *not* a covered benefit.

NOTE: The Plan reserves the right not to apply manufacturer or provider cost-share assistance program payments (e.g. manufacturer cost-share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket Maximums.

LIMITATIONS AND EXCLUSIONS -

1. Birth Control Devices and Injections: Benefits will not be provided for services related to the insertion or removal of a birth control device, except as described under PREVENTIVE CARE. Removal will be paid if the device becomes dislodged. Benefits will also not be provided for services related to the administration of injectable forms of contraceptive products, except as described under PREVENTIVE CARE.
2. Non-Prescription Items: The Plan will not cover drugs and medicines that can be purchased without a written prescription, even if the Physician has prescribed such "over-the-counter" medications except as described under PREVENTIVE CARE.

3. Take-Home Drugs: Drugs and medicines which are provided as "take-home supply" by the Hospital are not covered.
4. Weight loss: Prescription Drugs and medicines related to weight loss programs are not covered.
5. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.
6. Hair Loss: Prescription Drugs and medications related to hair loss are not covered.
7. Tobacco Dependency: Prescription Drugs and medications related to tobacco dependency are not covered except as described under PREVENTIVE CARE.
8. Cosmetic Drugs: Prescription Drugs and medicines used for cosmetic purposes are not covered.
9. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not covered.
10. Prescription drugs that are not on the Formulary are not covered.
11. Certain Prescription Drugs are not covered. A list of excluded drugs is available at myprime.com. Navigate to the Forms page and either sign into your account or click "Continue without sign in" and select "BCBSWY Wyoming" as your health plan. For additional assistance, please call BCBSWY Member Services at 1-800-442-2376 or message us from your online account at yourwyoblue.com.

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. PREVENTIVE CARE

DEFINITION - "Preventive Care" includes the preventive health services recommended by:

1.
 - (a) United States Preventive Services Task Force (USPSTF) recommendations Grade A and B only;
 - (b) Center for Disease Control and Prevention's (CDC) and Prevention's Advisory Committee on Immunization Practices' (ACIP) recommendations for immunizations;
 - (c) Health Resources and Services Administrations' (HRSA) recommendations for children and women preventive care and screenings;
2.
 - (a) Testing procedures and examinations for cervical cancer and diabetes;
 - (b) Testing procedures and examinations for Subscribers and covered spouses for breast cancer and prostate cancer.

BENEFITS –

Covered Services include, but are not limited to, the following:

A. Well child care to the Member's 6th birthday:

1. Newborn blood screening
2. through 12 months – 7 visits
3. 13 months through 35 months – 4 visits
4. 36 months through 72 months – 1 visit per calendar year
5. Immunizations as recommended by the CDC
6. Congenital hypothyroidism screening under age 1
7. Hearing loss screening up to 1 month of age
8. Phenylketonuria (PKU) screening – once per lifetime ages 0 – 1 years old
9. Sickle cell disease screening – up to age 1
10. Iron deficiency anemia prevention for covered Dependent children at risk ages 6 to 12 months
11. Hematocrit or hemoglobin through age 1
12. Lead Screening through age 6
13. Developmental and autism screening through age 2
14. Fluoride varnish for the prevention of dental caries applied by primary care clinicians

B. Birth through age 21:

1. Sensory screening vision – 1 per calendar year
2. Sensory screening hearing – 1 per calendar year (in addition to screening listed above) through age 21
3. Tuberculin test

C. Members age 6 and older:

1. Routine physical examination (office visit) – males 1 per calendar year
2. Well-woman preventive care visits as medically appropriate
3. Adult aortic aneurysm screening for male Members ages 65-75– lifetime maximum of 1 screening
4. Alcohol misuse screening and behavioral counseling intervention – 1 visit per calendar year for Members age 6-17; unlimited for Members age 18 and older
5. Asymptomatic bacteriuria screening – pregnant women only
6. Hepatitis B virus infection screening – pregnant women only
7. Rh (D) incompatibility screening – pregnant women only
8. Osteoporosis screening once every 2 calendar years – females age 65 and older unless at risk, then age 60 and older
9. Iron deficiency anemia screening – pregnant women only
10. Sexually transmitted disease (STD) screening:
 - a. Chlamydial infection screening – males age 16-18 and females age 6 and older
 - b. Gonorrhea infection screening – males age 16-18 and females age 6 and older
 - c. Syphilis infection screening – pregnant women and men and women at risk
11. Counseling for sexually transmitted infections
12. Screening for diabetes in pregnant women 24-28 weeks gestation
13. HPV Testing – 30 yrs of age every 3 years
14. Screening & counseling for interpersonal & domestic violence
15. Lactation support & counseling services – 2 visits per pregnancy
16. Breast Pump – 1 pump per pregnancy (manual or electric pump from a Participating home medical equipment provider only). Prior approval is required for Hospital grade pumps.
17. Counseling and screening for HIV
18. Contraceptive methods & management (medical) – female sterilizations; IUD inserted or removed & inserted on the same day; injections used to prevent conception
19. Diagnostic screening procedure for HIV testing for at risk Members and pregnant women
20. Type 2 diabetes mellitus screening
21. Immunizations as recommended by the CDC
22. Colorectal cancer screening for Members aged 45 through 75 with a screening diagnosis:
 - a. Fecal occult blood test – 1 per calendar year
 - b. Colonoscopy (including related services) – 1 every 10 years OR
 - c. Sigmoidoscopy (including related services) – 1 every 5 years
 - d. CT colonography - 1 every 5 calendar years

- e. A follow-up colonoscopy performed within one year after a non-invasive stool-based screening test or direct visualization test.
 - f. FIT-DNA - one per three calendar years for ages 45-75
23. Colonoscopy services to include preliminary office visit and polyp removal & pathology
 24. Bowel prep medications required for the preparation of a Preventive colonoscopy – cover generic bowel prep medications at 100%, brand will continue to take cost-share
 25. Cervical cancer screening and related office visit – 1 per calendar year
 26. PSA test – 1 per calendar year for Employee and covered spouse only
 27. Mammogram screenings –for Employee and covered spouse only
 28. Tobacco cessation counseling – 8 visits per calendar year
 29. Lipid disorders screening (1) every calendar year
 30. BRCA testing and genetic counseling if appropriate for females whose family history is associated with an increased risk for breast and ovarian cancer and for those with a family history of tubal and peritoneal cancer
 31. Screening for lung cancer (screening with low-dose computed tomography [LDCT]) – 1 per calendar year for Members aged 50-80 with a diagnosis of tobacco dependency
 32. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease and diabetes prevention in Adults with cardiovascular risk factors Includes BMI's 30-70+ and group sessions for preventive medicine counseling – Limited to 26 visits per year from age 6-18 years and 12 visits per year from age 19
 33. Screening for high blood pressure in Adults – cover Ambulatory Blood Pressure Monitoring (ABPM) for diagnostic confirmation before starting treatment at 100%
 34. Routine prenatal services are covered at 100%
 35. Benefit Screening for latent tuberculosis infection in Adults covered at 100%
 36. Coverage for lactation support and counseling – 2 visits per pregnancy covered at 100%
 37. Coverage for Statin use for the prevention of cardiovascular disease in Adults covered at 100% 40-75 years of age (coverage limited to Lovastatin and Pravastatin)
 38. FIT-DNA for Members 50 years of age and older – 1 every 5 years covered at 100%
 39. Counseling intervention for pregnant and postpartum persons who are at risk of perinatal depression. Requires a pregnancy or post-partum diagnosis and cannot have a current depression diagnosis – 12 visits per calendar year (additional visits will apply normal cost-share)
 40. Routine HPV vaccinations for those aged 27-45 subject to Deductible and Coinsurance
 41. 1 Hemogram CBC per year
 42. 1 C-Reactive Protein per year
 43. 1 Vitamin D per year
 44. 1 Thyroid Panel per year

- 45. Chem Panel
 - 46. Hepatitis C screening – with a high risk or routine diagnosis
 - 47. Outpatient diet and behavioral counseling services for pregnant women
- D. Prescription Drugs – Must be filled as a prescription and submitted the Prescription Drug Benefit:
- 1. Medications for risk reduction of primary breast cancer in women 35 years of age and older:
 - a. Generic drugs require no Copayment and no preventive diagnosis is required.
 - b. Brand drugs are subject to any applicable Copayment and Coinsurance provisions unless the brand drug is both prescribed for preventive use and there is a demonstrated need for use of the brand rather than a generic drug. In that case, any applicable Copayment and Coinsurance would be waived.
 - 2. Aspirin – limited to 81 mg only
 - a. Ages 45 – 79 for Adults
 - b. For the prevention of morbidity and mortality from preeclampsia – pregnant women
 - 3. Oral fluoride – over the counter or prescription strength (for children age 6 months - to sixteen (16) years old when sufficient fluoride is lacking in available drinking water)
 - 4. PrEP with effective antiretroviral therapy to persons at high risk of HIV acquisition

LIMITATIONS AND EXCLUSIONS –

- 1. 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.
- 2. You may still be responsible for any amounts above the Maximum Allowable Amount if you choose to receive care from a non-participating provider, up to the amount of the provider's billed charges.

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. PRIVATE DUTY NURSING SERVICES

DEFINITION-"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 Member's Condition would ordinarily require that the Member 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 Member'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 Member.

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: Blue Cross Blue Shield of Wyoming will review all claims for appropriateness and Medical Necessity.
3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the Member or the Member's family. (Examples: bathing, feeding, exercising, homemaking, moving the Member, 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

AA. *ROOM EXPENSES AND ANCILLARY SERVICES*

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

"Ancillary services" are those services and supplies (in addition to room services) that Hospitals and Other Facility Providers bill for and regularly make available to Members when such services are provided for the treatment of the Condition for which the Member 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:

Authorization review: If a Member's Physician recommends that the Member be hospitalized (for any non-maternity or non-accidental Condition), services **MUST** be submitted in advance to Blue Cross Blue Shield of Wyoming's authorization review program. See **AUTHORIZATION REVIEW** under **HOW BENEFITS WILL BE PAID**.

Outpatient: Ancillary services billed by a Hospital or Facility Provider are covered. For additional Outpatient benefits, 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 Member's Condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

4. Private Room Expenses: If the Member 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

BB. SKILLED NURSING FACILITY

DEFINITION - A Facility Provider which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to Members 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:

1. Minimal care, custodial care, ambulatory care, or part-time care services, or
2. Care or treatment of Mental Health Disorder, alcoholism, drug abuse, or pulmonary tuberculosis.

BENEFITS –

Authorization is required before benefits are payable.

This coverage is to become available if such confinement complies with the following:

1. Care is provided under the recommendation and general supervision of a Physician;
2. Care is for the purpose of receiving Medical Care necessary for convalescence from the Conditions causing or contributing to the precedent Hospital confinement; and
3. The care provided is not custodial care.

Inpatient and Outpatient: Payment is to be made for daily charges for room and board and general nursing services in a licensed, skilled nursing facility.

Physician:

Inpatient and Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. SUPPLIES, EQUIPMENT AND APPLIANCES

DEFINITION-"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 provided for either the rental or the purchase of Medically Necessary durable medical equipment, whichever is less expensive. When a purchase is authorized, benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment. Durable medical equipment includes, but is not limited to, portable humidifiers and whirlpool attachments.
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.
3. The following Prosthesis and Orthopedic Appliances, if they satisfy Blue Cross Blue Shield of Wyoming's Medical Policy and are otherwise Medically Necessary, are Covered Services, as well as fitting, adjusting, repairing, and replacement of an appliance due to wear, or a change in the Member's condition which makes a new appliance necessary. Services and/or device costs covered by a manufacturer's warranty will not be Covered Services.
 - 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.

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for certain Prosthesis and/or Orthopedic Appliances. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider

who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the Prosthesis and/or Orthopedic Appliances.

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 Member's Physician recommends a change in prescription.
5. Oxygen – The Plan will pay for oxygen and the equipment needed to administer it.
6. Breast pumps as indicated under PREVENTIVE CARE. Authorization is required for any Hospital grade breast pumps.
7. Wigs – when hair loss is the result of radiation or chemotherapy.
8. Hospital beds when deemed medically appropriate by Blue Cross Blue Shield of Wyoming's case management team.
9. Diabetic Supplies:
Equipment and supplies for the treatment of diabetes including, but not limited to the following, are Covered Services:
 - a. Syringes
 - b. Blood glucose monitors, lancets and test strips
 - c. Continuous glucose monitors and sensors
 - d. Insulin Pumps

When purchased at a participating Pharmacy:

Tier 1: Consists of the lowest cost equipment and supplies

Tier 2: Consists of medium-cost, preferred brand equipment and supplies

Tier 3: Consists of higher-cost, brand name equipment and supplies

Determination of tier assignment (in collaboration with input from Pharmacy Benefit Management (PBM)) is made exclusively by BCBSWY. Copayment tier exceptions are not available. BCBSWY may update tier assignment or tier descriptions at any time.

Products available through the Pharmacy are limited to those on the NetResults Prescription Drug Formulary.

Member prescription cost-shares are dependent on both tier level and each respective benefit policy.

LIMITATIONS AND EXCLUSIONS –

1. Deluxe or Luxury Items: If the supply, equipment, or appliance which the Member orders includes more features than are warranted for the Member's Condition, the Plan will allow only up to Allowable Charges for the item that would have met the Member's 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 Member to operate the equipment without assistance.

2. Durable Medical Equipment: Items such as air conditioners, purifiers, dehumidifiers, exercise equipment, 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. Medical Supplies: Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid or available over the counter are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics, non-rigid braces.)
5. Special Braces: Benefits will not be provided for special braces or special equipment.
6. Diabetic supplies purchased from a Pharmacy that is not in the Wyoming Total Choice PPO Network are not Covered Services under this Agreement. Payment for diabetic supplies from a Pharmacy not participating in the Wyoming Total Choice PPO Network will be the sole responsibility of the Subscriber/Member.
7. Exception request for supplies and equipment purchased through the pharmacy:
 - a. Unless excluded, the Member may request access to clinically appropriate prescription supplies and equipment not otherwise covered by Blue Cross Blue Shield of Wyoming through a request for exception. For information about sending this request, please go to bcbswy.com/providers/rxtools. In these cases, Blue Cross Blue Shield of Wyoming will notify the Member, the prescribing physician and/or the facility of its coverage determination.

NOTE: If there are no supplies and equipment within a specific drug class included within the formulary list, the entire class is considered excluded for the purpose of the Prescription Drug coverage exception request.

See GENERAL LIMITATIONS AND EXCLUSIONS

DD. SURGERY

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

DEFINITION - "Surgery" is an operating (cutting) procedure for the Medically Necessary 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 include charges for the room allowance and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

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.

More than one Surgery performed by the same Physician during the course of only one operative period is called a "multiple Surgery." Since allowances for Surgery include benefits for pre- and post-surgical care, total benefits for multiple Surgeries are reduced as pre and post-Surgery allowances do not duplicate those of the primary Surgery. The reduced benefit varies, depending upon the circumstances of the multiple Surgeries.

Prophylactic Surgery:

The following prophylactic surgeries will be a Covered Service:

1. Mastectomy
2. Oophorectomy
3. Hysterectomy

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Prophylactic Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442- 2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

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.

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Cosmetic Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving Cosmetic Surgery. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

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

NOTE: Subject to authorization, any Member 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 The Women's Health and Cancer Rights Act of 1998 (WHCRA):

- 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.

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Reconstructive Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442- 2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

2. Dental Surgery: For a complete description of benefits allowed for dental services, see DENTAL SERVICES.
3. 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.
4. Obesity and Weight Loss: Benefits will be provided for Surgery required as the result of obesity only as specified in GENERAL LIMITATIONS AND EXCLUSIONS.
5. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.
6. Private Room Expenses: If the Member 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.
7. Sterilization Procedures: Sterilization procedures and related expenses will be covered. See PREVENTIVE CARE for certain Sterilization Procedures covered at 100% of the Allowable

Charges without regard to Deductible, Copayment or Coinsurance that might otherwise apply.
Reversals of sterilization procedures are not covered.

8. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

EE. 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 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: Covered when services are provided by a Physician, physician's assistant, or registered nurse.

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 as specified in the Medicare Correct Coding Initiative.
2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to surgical assistant services.

See GENERAL LIMITATIONS AND EXCLUSIONS

FF. TELADOC

DEFINITION – TelaDoc is a national Network of state licensed primary care Physicians providing cross coverage consultations 24 hours per day, 7 days per week, and 365 days per year. TelaDoc Physicians diagnose, recommend treatment and prescribe non-DEA controlled substances for routine, acute, episodic medical Conditions over the telephone.

BENEFITS –

TelaDoc phone consultations are provided as a covered benefit.

GENERAL LIMITATIONS AND EXCLUSIONS –

Teladoc exclusions: Please refer to the most updated exclusions found at www.teladoc.com.

See GENERAL LIMITATIONS AND EXCLUSIONS

GG. THERAPIES (OCCUPATIONAL, PHYSICAL, RESPIRATORY, SPEECH)

DEFINITIONS- “Occupational therapy” uses educational, vocational, and rehabilitative techniques in order to improve a patient's functional ability to achieve independence in daily living.

“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.

“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.

“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 Member is admitted, the following types of therapy are covered:

1. Respiratory therapy.

Outpatient: When provided by a Hospital or other facility, the following types of therapy are covered:

1. Occupational therapy.
2. Physical therapy provided by a registered physical therapist or Physician.
3. Respiratory therapy.
4. Speech therapy.

Physician:

Inpatient: When provided by a Physician, the following types of therapy are covered:

1. Respiratory therapy.

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Occupational therapy.
2. Physical therapy provided by a registered physical therapist or Physician.

3. Respiratory therapy.
4. Speech therapy.

LIMITATIONS AND EXCLUSIONS –

1. Outpatient benefits will be provided for physical therapy (maximum of forty [40] visits per Member per calendar year), occupational therapy (maximum of forty [40] visits per Member per calendar year) and speech therapy (maximum of twenty-five [25] visits per Member per calendar year).).
2. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

HH. TRAVEL MEDICAL BENEFIT

A “travel medical benefit” is available when Members travel for cardiac care, cancer care, knee and hip replacement, spine Surgery, and transplants covered under this Plan when provided by a Blue Distinction Center in Colorado, Utah, or Montana. The travel medical benefit is also available for cancer treatment at the University of Texas MD Anderson Center, the Johns Hopkins Kimmel Cancer Center in Maryland, Huntsman Cancer Institute in Utah or the Taussig Cancer Institute at the Cleveland Clinic in Ohio, as long as these cancer centers are In-network with Blue Cross Blue Shield of Wyoming. The patient is responsible for ensuring that the facility is Non-network with Blue Cross Blue Shield of Wyoming.

BENEFITS –

1. Reimbursement of the Deductible in the amount of \$800.

To receive this benefit the following steps must be completed:

- a. Confirm your procedure is eligible by calling Blue Cross Blue Shield of Wyoming at 1-800-442-2376.
- b. Find a Blue Cross Blue Shield of Wyoming Distinction Center:
<https://www.bcbs.com/blue-distinction-center/facility>
- c. Fill out a refund form and submit to the County Clerk. (Do not submit for FSA [flex spending account] reimbursement of the \$800 Deductible, as this is not allowed by the Internal Revenue Service. However, any amounts over \$800 do qualify for FSA reimbursement.)

2. Travel expenses for the Member and one companion. Travel expenses are limited to \$200 per day for food, lodging and travel (limited to a maximum of \$2,500 per Member per calendar year paid at 100%).

To receive this benefit the following steps must be completed:

- a. Confirm your procedure is eligible by calling Blue Cross Blue Shield of Wyoming at 1-800-442-2376.
- b. Find a Blue Distinction Center: **<https://www.bcbs.com/blue-distinction-center/facility>**
- c. Retain travel receipts and mail to:

Blue Cross Blue Shield of Wyoming
Attention: Case Management
4000 House Avenue, Cheyenne, WY 82001

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

II. VISION SERVICES

DEFINITIONS- "Vision Care" expenses are those billed by a Physician or Other Professional Provider for the routine care of the eye and the prescribing of corrective lenses. Blue Cross Blue Shield of Wyoming utilizes Davis Vision as a Third Party Administrator to provide Vision benefits to eligible Members.

BENEFITS –

1. Vision Examinations: Benefits will be provided for one vision exam for each Member up to the amount listed in the Schedule of Benefits below during any twelve (12) month period.
2. Frames: Benefits will be provided for one frame for each Member up to the amount listed in the Schedule of Benefits below during any twenty-four (24) month period.
3. Collection Frames: Refers to Eyeglass Frames offered to Members by certain private practice Participating Providers at zero to little out-of-pocket cost. There are three tiers of Collection Frames: Fashion, Designer and Premier, any of which may be selected in place of using the retail frame allowance. Other Network Providers that do not have an agreement with Davis Vision to offer the Collection must offer a similar selection of frames with a comparable retail value.
4. Lenses: Benefits will be provided for one pair of lenses for each Member during any twelve (12) month period as listed in the Schedule of Benefits below.

Contact lenses are covered as a substitute for conventional lenses and frames. Benefits will

be provided for contact lenses for each Member up to the amount listed in the Schedule of Benefits below during any twelve (12) period, providing there were no benefits paid for frames or (non-contact) lenses during the same period.

5. Evaluation and Fitting: Means the professional individualized fitting of Contact Lenses and the professional evaluation to check that the prescription is correct and that there is no irritation of the eyes.
6. Vision screening as indicated under PREVENTIVE CARE.
7. Provider: An ophthalmologist, optometrist, optician, Physician, or legally authorized eyeglass and contact lens retail store, licensed where required, performing within the scope of license, and approved by the Company. If a Provider is not subject to state or federal licensure, we have the right to define all criteria under which a Provider's services may be offered to our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.
8. Participating Provider: A Provider that has a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member. This Provider may also be referred to as a "Network Provider."
9. Non-Participating Provider: A Provider of optometric services that does not have a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member. This Provider may also be referred to as a "Non-Network" or "Out-of-Network" Provider.

SCHEDULE OF BENEFITS

In-Network:

Copayments:

Eye Examination	\$10
Spectacle Lenses	\$10

Eyeglass Benefit – Frame:

Frame Allowance (Retail)	Up to \$130, Plus a 20% discount on any overage
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(Additional discounts not available at Costco, Walmart & Sam's Club)

Davis Vision Exclusive Collection (in lieu of allowance):

Fashion	Covered
Designer	\$15
Premier	\$40

Eyeglass Benefit – Spectacle Lenses:

Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Covered
Digital Single Vision (intermediate) Lenses	\$30
Tinting of Plastic Lenses	Covered
Scratch-Resistant Coating	Covered
Polycarbonate Lenses (for Dependent children, monocular patients, and patients with prescriptions -/+ 6.00 diopters or greater)	\$0 – Children \$30 – Adults
Ultraviolet Coating	\$12
Blue Light Filtering	\$15
Anti-Reflective (AR) Coating	\$35 - Standard \$48 - Premium \$60 - Ultra \$85 - Ultimate

Progressive Lenses

\$50 - Standard
\$90 - Premium
\$140 - Ultra
\$175 - Ultimate

High-Index Lenses

1.67 - \$55
1.74 - \$120

Polarized Lenses

\$75

Plastic Photochromic Lenses

\$65

Scratch Protection Plan:

Single Vision

\$20

Multifocal Lenses

\$40

Contact Lens Benefit (in lieu of eyeglasses):

Contact Lens: Materials Allowance:

Up to \$130,
Plus a 15%
discount on
any overage

(Additional discounts not available at Costco, Walmart & Sam's Club)

Evaluation, Fitting & Follow-Up Care for Standard Lens Types

15% Discount

Evaluation, Fitting & Follow-Up Care for Specialty Lens Types

15% Discount

Visually Required Contact Lenses (with prior approval):

Materials, Evaluation, Fitting & Follow-Up Care

Covered

Additional Savings:

Retinal Imaging – Member charge

\$39

Additional Pairs of Eyeglasses

20% discount

(Additional discounts not available at Costco, Walmart & Sam's Club)

Laser Benefit:

Up to 25% on U & C
or 5% off any
participating
providers advertised
specials

Out-of-Network Reimbursement Schedule:

Eye Examination	Up to \$200 (less \$25)
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Up to \$65/ \$100/ \$110/ \$110
Digital Single Vision (intermediate) Lenses	Included in Lens Allowance
Tinting of Plastic Lenses	Included in Lens Allowance
Scratch-Resistant Coating	Included in Lens Allowance
Polycarbonate Lenses (for Dependent children, monocular patients, and patients with prescriptions -/+ 6.00 diopters or greater)	Included in Lens Allowance
Ultraviolet Coating	Included in Lens Allowance
Blue Light Filtering	Included in Lens Allowance
Anti-Reflective (AR) Coating	Included in Lens Allowance
Progressive Lenses	Up to \$110 (in lieu of bifocal reimbursement)
High-Index Lenses	Included in Lens Allowance
Polarized Lenses	Included in Lens Allowance
Plastic Photochromic Lenses	Included in Lens Allowance

Scratch Protection Plan:

Single Vision/ Multifocal Lenses	Included in Lens Allowance
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Contact Lens Benefit (in lieu of eyeglasses):**Contact Lens: Materials Allowance:**

Up to \$115

(Additional discounts not available at Costco, Walmart & Sam's Club)

Evaluation, Fitting & Follow-Up Care for Standard Lens Types	Included in Lens Allowance
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Evaluation, Fitting & Follow-Up Care for Specialty Lens Types

Included in Lens Allowance

Visually Required Contact Lenses (with prior approval):

Materials, Evaluation, Fitting & Follow-Up Care

Up to \$225

LIMITATIONS AND EXCLUSIONS –

1. EYE CARE - Services for the Conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia, and presbyopia will be covered only as described under BENEFITS above. In addition, benefits for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, the servicing of corrective lenses, and consultations related to such services will also be limited only to those benefits, if any, described above.
2. Prescription Sunglasses, Oversized, Photosensitive or Anti-Reflective Lenses: Will not be covered if the charge exceeds the Schedule of Benefits for lenses as defined.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

QUALIFYING FOR THE DISEASE MANAGEMENT PRESCRIPTION INCENTIVE

New Members will be enrolled in the Prescription Incentive Program on a quarterly schedule after they have met the eligibility requirements. Members in the Incentive Program will be removed from the program after each quarter if they do not actively participate or meet the program requirements. They will be notified two weeks before the removal by mail, and if available, email. Members are eligible to reapply for participation for the next quarter after meeting with the Wellness Program Coordinator.

In order to qualify for 100% prescription coverage of maintenance medications, Members must meet the following guidelines for at least three (3) months:

1. Under the care of a Physician with a diagnosis of hypertension, hyperlipidemia, diabetes, and/or asthma;
2. Annual visit with the Physician to renew prescriptions covered by the program. Signed Physician statements are required by the Wellness Program;
3. Meeting with the Wellness Program Coordinator quarterly;
4. Completing quarterly activities assigned by the Wellness Program. Members will receive accommodation for activities that are not medically advisable.

Parents or guardians of Dependents who qualify for the program will be required to submit an annual Physician statement and meet with the Wellness Program Coordinator quarterly.

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. AUTHORIZATION REVIEW

If the Member's Physician recommends that the Member be hospitalized services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's authorization review program (PH. 1-800-251-1814).

Certain Covered Services require authorization by Blue Cross Blue Shield of Wyoming. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of designated healthcare providers who have demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service. Following is a list of Covered Services that require authorization:

1. Breast reconstructive Surgery
2. Cosmetic Surgery
3. Chemotherapy (including Physician's office)
4. Dialysis (including Physician's office)
5. Extended care facility/transitional or swing bed care (Inpatient admission)
6. Hospital grade breast pumps
7. Human organ transplants
8. High dose chemotherapy and/or radiation therapy with allogeneic or autologous bone marrow transplant or peripheral stem cell support
9. Inherited enzymatic disorders counseling
10. Non-accidental dental related medical services
11. Obesity and weight loss services
12. Orthognathic Surgery

- 13. Outpatient surgical services
- 14. Rehabilitation facility
- 15. Radiation
- 16. Skilled nursing facility

E. AUTOPSIES

Services related to autopsies are not covered.

F. BIOFEEDBACK

Services related to biofeedback are not covered.

G. CLINICAL TRIALS

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

H. COMPLICATIONS OF NON-BENEFIT SERVICES

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

I. CONVALESCENT CARE

Convalescent care is that care provided during the period of recovery from illness or the effects of injury and Surgery. Benefits for convalescent care are limited to those normally received for a specific Condition, as determined by Blue Cross Blue Shield of Wyoming's medical consultants.

J. 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.

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Cosmetic Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving Cosmetic Surgery. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

Benefits for a cosmetic Surgery procedure and related expenses are allowed only when reconstructive Surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive Surgery will only be provided for the diseased body part except as noted below. **NOTE:** Any Member 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 The Women's Health and Cancer Rights Act of 1998 (WHCRA):

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

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Reconstructive Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442- 2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

K. CUSTODIAL CARE

Services furnished to help a Member 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.

L. DIAGNOSTIC ADMISSIONS

If a Member 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 Member had received Diagnostic Services as an Outpatient.

M. DOMICILIARY CARE

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

N. EAR WAX

Services for the removal of ear wax are not covered.

O. EDUCATIONAL PROGRAMS

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

P. 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.

Q. EXPENSES INCURRED IN CERTAIN TAX SUPPORTED INSTITUTIONS

Expenses for additional mental/nervous or intellectual disability treatment in a tax-supported institution of the state of Wyoming which has not set up and does not actively make use of professional standard review programs, or which is not subject to review in accord with Federal and State Law, are not covered. Expenses which would be payable under any other part of this Plan, except as specified, or those expenses which would be payable in the absence of limits on the number of days for confinement will not be considered eligible.

R. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

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

S. FELONIES OR ILLEGAL ACTS

Any injury or illness sustained during, or resulting from, the commission of, or attempt to, commit a felony, or to which a contributing cause was the Member's being engaged in an illegal occupation or any illegal act as indicated, will not be covered even if the cause of the Illness or Injury is not related to the commission of the crime. This exclusion will not apply if the Injury in question occurred as the result of being the victim of an act of domestic violence, or if it occurred as the direct result of the participant's mental or physical medical condition.

T. 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, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered.

U. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Except as described under PREVENTIVE CARE 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.

V. 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.

W. HAIR LOSS

Except as described under SUPPLIES, wigs or artificial hairpieces, or hair transplants or implants, regardless of whether there is a medical reason for hair loss, are not covered.

X. 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.

Y. HYPNOSIS

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

Z. LEARNING DISABILITIES

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

AA. LEGAL PAYMENT OBLIGATIONS

Services for which legally a Member 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 Member or residing in the Member's household.

BB. MANAGED CARE PROVISIONS

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

CC. 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 Member 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 Member 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 Member 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 Member's agreement to seek or receive such medical services or supplies.

DD. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

EE. OBESITY AND WEIGHT LOSS

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

1. The Member has a body mass index (BMI) of 40 or greater, or
2. The member has a BMI of 35 to 39.99 with co-morbidity.

NOTE: The number of gastric bypass procedures covered under this Agreement is limited to a lifetime maximum of one (1) per Member.

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Surgery for obesity. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

FF. 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)

IMPORTANT NOTE: Authorization by Blue Cross Blue Shield of Wyoming is required for Orthognathic Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442- 2376 to obtain authorization before receiving these healthcare services. Authorization may include the required use of a Designated Provider who has demonstrated high quality, cost efficient care. The failure to obtain authorization may result in a denial or reduction in coverage for the healthcare service.

GG. OVER THE COUNTER MEDICATIONS

Except when required by law, the Plan will not cover drugs and medicines that can be purchased without a written prescription, even if the Physician has prescribed such "over-the-counter" medications.

HH. PAYMENT IN ERROR

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

II. PERSONAL COMFORT OR CONVENIENCE

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

JJ. 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.)

KK. 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 Members selected to take part are randomized, with some Members receiving the prescribed drugs, treatment, technologies, services, or procedures, and other Members 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.

LL. REPORT PREPARATION

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

MM. RIOT/ REVOLT

Expenses resulting from a Covered Person's active participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition {physical or mental} or domestic violence.

NN. 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.

OO. ROUTINE PHYSICALS

Services connected with routine physical or screening exams and immunizations are not covered except as described in PREVENTIVE CARE. (Examples of services not covered: yearly physicals, screening examinations for school, camp or other activities.)

PP. SELF-INFLICTED INJURIES

Expenses for injury or illness arising out of attempted suicide or an intentional self-inflicted Injury, whether sane or insane, are not covered. This exclusion will not apply if self-inflicted injuries results from a medical Condition or domestic violence.

QQ. SERVICES AFTER COVERAGE ENDS

No benefits are provided after the coverage is cancelled. (EXAMPLE: If the Member is hospitalized on July 30th and the Group cancelled their Group coverage effective August 1st, no benefits are provided for any services received on or after August 1st.)

RR. SERVICES NOT IDENTIFIED

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

SS. SERVICES OUTSIDE THE UNITED STATES

Services obtained outside the United States are not covered unless the Member is travelling abroad and then requires medical attention. Services that are planned in advance to be obtained outside the United States are not covered.

TT. SERVICES PRIOR TO THE EFFECTIVE DATE

Charges incurred for supplies and services received prior to the effective date of coverage are not covered.

UU. 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.

VV. SUBSCRIPTION SERVICES

Subscription and membership fees for services including but not limited to health clubs, fitness trainers and coaches, health spas, diet and weight loss programs, and online health and wellness programs are not covered.

WW. TAXES

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

XX. TELEMEDICINE

Treatments and services which are not a benefit in an office, Outpatient, or Inpatient setting are not Covered Services. This includes provider to provider consultations.

Telemedicine Physical, Occupational, and Speech Therapies are not Covered Services.

Treatments and services provided without an audio and/or video component such as instant messaging are not Covered Services.

Equipment, other technology, technicians or personnel utilized to perform the Telemedicine service are not Covered Services. Telemedicine technologies must be of appropriate quality to allow for the accuracy of the assessment, diagnosis and evaluation of symptoms and potential medical side effects. Telemedicine technologies must comply with applicable Federal and State legal requirements of health/medical information privacy.

YY. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

ZZ. THERAPIES

Special therapies not specifically covered in this Plan. Such non-Covered Services include (but are not limited to): recreational and sex therapies, Z therapy, wilderness programs, self-help programs, transactional analysis, sensitivity training, assertiveness training, encounter groups, transcendental meditation (TM), religious counseling, rolfing, primal scream therapy, and stress management programs.

AAA. TOBACCO DEPENDENCY

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

BBB. TRAVEL EXPENSES

Except as specifically described under the TRAVEL MEDICAL BENEFIT, travel expenses are not covered.

CCC. UNRELATED SERVICES

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

DDD. WAR

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

EEE. WEIGHT LOSS PROGRAMS

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

FFF. WORKERS COMPENSATION

No benefits will be provided for services, supplies, or charges for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not the Member claims the benefit or compensation and whether or not the Member recovers losses from a third party.

GENERAL PROVISIONS

The following general provisions apply to all benefits and exclusions described in this Plan.

A. *ASSIGNMENT OF BENEFITS*

All benefits stated in this Plan are personal to the Member. Neither those benefits nor the payments to the Member may be assigned to any person, corporation, or entity. Any attempted assignment shall be void. Although Blue Cross Blue Shield of Wyoming may make direct payment to the Member's healthcare providers at its election, this payment will not constitute an assignment of benefits under this Agreement or any waiver of this provision.

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 Members 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 this 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, and the character and extent of medical services for which claim is made. The Plan Sponsor reserves the right to request further information to make decisions whether this section is met or not.

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. *COMPLIANCE WITH HITECH ACT*

This Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provisions of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby

incorporated into the Plan as of the date that the Plan is required to comply with such guidance. The Plan Administrator will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

F. COORDINATION OF BENEFITS

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Members 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 Member 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 on the following priorities:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision.
2. Group coverage will be primary over an individual policy with a non-duplication provision.
3. Coverage of a plan, which covers the patient as an Employee will be primary over a plan covering the patient as a Dependent.
4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payer. If a plan does not have this provision, the primary payer will be determined by the provision of the plan not having this paragraph.
5. The above applies for children, except in situations where the parents are separated or divorced.
 - a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the plan covering the child as a Dependent of the parent without custody.
 - b. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the step-parent will be determined before the benefits of a 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.

6. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the patient for a longer period of time shall be primary payer.

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

G. DISCLAIMER OF LIABILITY

The Plan Sponsor has no control over any diagnosis, treatment, care, or other service provided to a Member by any provider, and is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

H. DISCLOSURE OF A MEMBER'S MEDICAL INFORMATION

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

1. Upon a written, dated, and signed authorization by the Member or prospective Member 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 Member or prospective Member 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 Member or prospective Member and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent, subject to Federal and State Law.

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.

I. 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.

J. FIDUCIARY STATUS

The third party administrator is not a fiduciary with respect to making claims determinations or interpreting terms of the Plan.

K. GENERAL INFORMATION ABOUT FILING CLAIMS

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

1. Always carry their identification card and present it to the Hospital, Facility Provider, Physician or Professional Provider whenever the Member receives treatment. However, this presentation shall not be construed as a solicitation of services by Blue Cross Blue Shield of Wyoming from the Healthcare Provider.
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 immediately in the event the Identification Card is lost or stolen..

L. LEGAL ENTITY

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator." This is needed to establish that the Plan and the employer are distinct legal entities, meaning the employer is completely separate entity from the benefit plan.

M. 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.

N. 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 claimant 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 claimant 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.

O. MEMBER'S LEGAL OBLIGATIONS

The Member is liable for any actions which may prejudice the Plan Sponsor's rights under this Plan. If the Plan Sponsor must take legal action to uphold its rights, then it can require the Member to pay its 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.

P. PHYSICAL EXAMINATION AND AUTOPSY

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

Q. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

R. PRESCRIPTION DRUG EXCEPTION REQUEST

Unless excluded, the Member may request access to clinically appropriate drugs not otherwise covered by Blue Cross Blue Shield of Wyoming through a request for exception. For information about sending this request, please go to bcbswy.com/providers/rxtools. This is limited to the Prescription Drug Benefit purchased through a Pharmacy. In these cases, Blue Cross Blue Shield of Wyoming will notify the Member, the prescribing physician and/or the facility of its coverage determination.

NOTE: If there are no drugs within a specific drug class included within the formulary list, the entire class is considered excluded for the purpose of the Prescription Drug coverage exception request.

S. PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

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 Members. 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 Members 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 dis-enrolled from the Plan.

However, in some instances, it may be necessary for the Group to have access to a Member'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 Member's PHI for purposes of administering the Plan, the Plan hereby restricts the Group's use or disclosure of a Member'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 Member's PHI except as permitted by this Benefit Booklet or as required by law.
4. The Group will ensure that its agents, including subcontractors, to whom it provides a Member's PHI, agree to the same restrictions and conditions that apply to the Group with respect to a Member's PHI.

5. The Group will not use or disclose a Member's PHI for any actions or decisions related to a Member's employment or in connection with any other Employee related benefits made available to a Member.
6. The Group will promptly report to the Plan any use or disclosure of a Member'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 Member'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 Member'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 Member'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 Member'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 Member'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 Member'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 Member'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 Member'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 Member'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.

T. 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 Member, and with the agreement of the affected Member.

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

U. SELECTION OF DOCTOR

Any Member 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.

V. SENDING NOTICES

All notices to the Member are considered to be sent to and received by the Member when deposited in the United States Mail with postage prepaid and addressed to the Member at the latest address appearing on the membership records.

W. 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.

X. SUBROGATION

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

1. All recoveries the Member obtains (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse the Plan in full for benefits the Plan has paid to or on behalf of the Member. The Plan's share of any recovery extends only to the amount of Benefits the Plan has paid or will pay to or on behalf of the Member or Member's

heirs, administrators, legal representatives, parents (if Member is a minor), successors, or assignees. This is the Plan's right of recovery.

2. The Plan is entitled under its right of recovery to be reimbursed for the Benefit payments it has made to or on behalf of the Member even if the Member has not been "made whole" for all of his or her damages in the recoveries that the Member has received. The Plan's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3. The Plan 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 Member did not receive the full amount of damages that Member claimed or (b) because the Member had to pay attorneys' fees.
4. The Member must cooperate in doing what is reasonably necessary to assist the Plan with its right of recovery. The Member must not take any action that may prejudice the Plan's right of recovery.
5. If the Member does not seek damages for his or her Condition, the Member must permit the Plan to initiate recovery on Member's half (including the right to bring suit in Member's name). This is called subrogation.

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

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

NOTE: The Plan will pay the costs of any Covered Services the Member receives that are in excess of any recoveries made.

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

1. When a third party injures the Member, for example, in an automobile accident or through medical malpractice.
2. When the Member is injured on a premises owned by a third party.
3. When the Member is injured and Benefits are available to Member or Member'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

Member to treat those benefits as secondary to this Agreement.

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

Y. 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 or other documentation 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 45-day claim payment time will not commence until all such necessary records or documentation are received by Blue Cross Blue Shield of Wyoming from any source.

Z. 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. The Plan Sponsor will not be liable under this Plan unless proper notice (proof) is furnished to Blue Cross Blue Shield that Covered Services have been rendered to a Member. Written notice must be submitted to Blue Cross Blue Shield of Wyoming within twelve (12) months after completion of services that are covered under this Plan. The notice must include the data necessary for Blue Cross Blue Shield of Wyoming to determine benefits. An expense will be considered incurred on the date the service or supply was rendered.
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, and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

AA. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY, AUTHORIZATION, AND NON-EMERGENCY SERVICES

If an Employer is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and a Member is not satisfied with the results of the processing of his or her claim, request for authorization review, the Member may make a written appeal. When making the request for review or reconsideration, include the Employer, agreement and claim numbers.

1. Emergency Services

The Member and/or the Member's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a claim for benefits. Upon receipt of an appeal from a Member and/or a Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the

Member'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. Authorization review and Non-emergency Services

The Member and/or the Member's authorized representative have up to one hundred and eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a Hospital admission, authorization of services, or claim for benefits. Upon receipt of an appeal from a Member and/or a Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member'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.

Members should mail or hand deliver their requests to:

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

Members have the right to be represented by an attorney or other duly authorized representative at any stage of their appeal. Members 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 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, Members will receive a written response and explanation within 45 days of Blue Cross Blue Shield of Wyoming's receiving their request for review.

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

If Blue Cross Blue Shield of Wyoming denies the Member'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 Member 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 Member must submit a request for external review within 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 45 days of receiving the request.

When filing a request for an external review, the Member will be required to authorize the release of any medical records of the Member 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 Member 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 timeframe for the completion of a standard review would seriously jeopardize the Member's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Member'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 Member 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 Member's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Ave, PO Box 2266, Cheyenne, WY 82003-2266 within 120 days of the date on the Notice of Appeal Rights.

2. All Other Denials

Expedited Review: The Member may be entitled to an expedited review when his or her medical Condition or circumstances require it, and in any event within 72 hours, where:

- a. The timeframe for the completion of a standard review would seriously jeopardize the Member's life or health or would jeopardize his or her ability to regain maximum function; or
- b. The Member'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 Member'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. The State of Wyoming may require a fee to be submitted with all external review requests as noted in the Notice of Appeal Rights.

CC. WYOMING INSURANCE DEPARTMENT

Members may also have rights under Wyoming Insurance Law. For more information about those rights, Members 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)

DD. COVID 19 (EFFECTIVE MARCH 1, 2020 THROUGH THE END OF THE COVID-19 PUBLIC HEALTH EMERGENCY DECLARATION)

In accordance with guidance or mandates from federal, state, or local authorities, administrative bodies, or regulatory agencies; there may be a temporary change to the way services are rendered and paid due to COVID 19. These temporary changes may include but are not limited to the following:

1. Reductions or waivers of Member cost-sharing on related office visits, Hospital stays, diagnostics, Prescription Drugs, or other treatment.
2. Extension of benefits to include coverage of services that are otherwise not a benefit of the plan.
3. Expansion of benefits for Telemedicine.
4. Waivers of prior authorization requirements on certain services.
5. Allowing for early Prescription Drug refills, extended supplies, and coverage of new medications
6. Providing coverage for care to be rendered at alternative treatment facilities.