Wyoming Educators' Benefit Trust

RETIREES UNDER 65 YEARS OF AGE

Medical Benefit Booklet

Effective July 1, 2025

Claims Supervisor:

An independent licensee of the Blue Cross and Blue Shield Association

WEBT RETIREES UNDER 65 YEARS OF AGE

Effective July 1, 2025

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 DOCUMENT.

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

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Díí kwe'é atah nilínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídílkidgo éí doodago háida biká anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bá$h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnil 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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INTRODUCTION

This document describes the Medical Plan (The Plan) maintained for the exclusive benefit of eligible Wyoming School District and other public entity Retirees under age 65 who were previously covered by the Wyoming Educators' Benefit Trust (WEBT). The WEBT intends to maintain this Plan indefinitely but reserves the right to terminate in accordance with the WEBT Participation Agreement. Changes in the Plan may be made in any or all parts of the Plan including, but not limited to, services covered, Deductibles, Copayments, maximums, exclusions or limitations, definitions, eligibility, etc.

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

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

GENERAL INFORMATION

NAME OF PLAN: Wyoming Educators' Benefit Trust Retirees Medical Benefit Plan

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

PLAN NUMBER: 501

TAX ID NUMBER: 74-2382896

PLAN YEAR: July 1 through June 30

PLAN SPONSOR: Wyoming Educators' Benefit Trust

SOURCE OF FUNDING: Funding for benefits is derived from the contributions of the Retirees themselves. The Plan is not insured.

PLAN ADMINISTRATOR: Wyoming Educators' Benefit Trust

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

NAMED FIDUCIARY: Wyoming Educators' Benefit Trust

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

NETWORK: Wyoming Total Choice Network

SCHEDULE OF BENEFITS

EMPLOYER NAME: Wyoming Educators' Benefit Trust Retiree Plan
EFFECTIVE DATE: July 1, 2025

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

Hospital care benefits are based on Allowable Charges.

Physician benefits are based on Allowable Charges.

$1,500 DEDUCTIBLE OPTION

Members Calendar Year Schedule of Benefits		
Deductible:	**Network**	**Non-Network**
Per Member	$1,500	$1,500
Family	$3,000	$3,000
NOTE: Pharmacy Copayments and Coinsurance do not apply to the Deductible requirements. NOTE: Cost sharing amounts which contribute to the Network or non-network Deductible amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Deductible, and vice versa).		
Coinsurance Amount:	20%	20%
Copayment Amount:	Visits to a Physician's office will be subject to a $40 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)	
NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.		

Medical Cost Share Maximum:	**Network**	**Non-Network**
Per Member	$1,500	$1,800
Family	$3,000	$3,600
Once the Medical Cost Share Maximum is met by any combination of medical Copayment and Coinsurance Amounts, Members are no longer responsible for medical Copayment and Coinsurance Amounts.		
Medical Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$3,000	$3,300
Family	$6,000	$6,600
Once the Medical Out-of-Pocket Maximum Amount is met by satisfaction of the Deductible and Medical Cost Share Maximum Amounts, medical Covered Services will be paid at 100% of the Allowable Charges for the remainder of the calendar year. NOTE: Cost sharing amounts which contribute to the Network or non-network Out-of-Pocket Maximum amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Out-of-Pocket Maximum and vice versa).		
NOTE: Non-Network emergency room (includes emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) and air ambulance are subject to the Network Deductible up to the Network Out-of-Pocket Maximum.		
Total In-Network Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$9,200	Not Applicable
Family	$18,400	Not Applicable
Once the Total In-Network Out-of-Pocket Maximum Amount has been met by satisfaction of the Deductible and any combination of Medical Cost Share Maximum Amounts and Pharmacy Out-of-Pocket Maximum Amounts, benefits will be provided at 100% of Allowable Charges for the remainder of the calendar year. Charges that exceed the Allowable Charges for non-network providers and charges for services not covered by this Plan will NOT count toward satisfaction of Members' Medical Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount. Members may be responsible for amounts over the Allowable Charges.		

$2,500 DEDUCTIBLE OPTION

Members Calendar Year Schedule of Benefits		
Deductible:	**Network**	**Non-Network**
Per Member	$2,500	$2,500
Family	$5,000	$5,000
NOTE: Pharmacy Copayments and Coinsurance do not apply to the Deductible requirements. NOTE: Cost sharing amounts which contribute to the Network or non-network Deductible amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Deductible, and vice versa).		
Coinsurance Amount:	20%	20%
Copayment Amount:	Visits to a Physician's office will be subject to a $45 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)	
NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.		
Medical Cost Share Maximum:	**Network**	**Non-Network**
Per Member	$1,500	$1,900
Family	$3,000	$3,800
Once the Medical Cost Share Maximum is met by any combination of medical Copayment and Coinsurance Amounts, Members are no longer responsible for medical Copayment and Coinsurance Amounts.		
Medical Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$4,000	$4.400
Family	$8,000	$8,800

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

NOTE: Cost sharing amounts which contribute to the Network or non-network Out-of-Pocket Maximum amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Out-of-Pocket Maximum and vice versa).

NOTE: Non-Network emergency room (includes emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) and air ambulance are subject to the Network Deductible up to the Network Out-of-Pocket Maximum.

Total In-Network Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$9,200	Not Applicable
Family	$18,400	Not Applicable

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

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

$3,500 DEDUCTIBLE OPTION

Members Calendar Year Schedule of Benefits		
Deductible:	**Network**	**Non-Network**
Per Member	$3,500	$3,500
Family	$7,000	$7,000
NOTE: Pharmacy Copayments and Coinsurance do not apply to the Deductible requirements. NOTE: Cost sharing amounts which contribute to the Network or non-network Deductible amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Deductible, and vice versa).		
Coinsurance Amount:	20%	20%
Copayment Amount:	Visits to a Physician's office will be subject to a $50 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)	
NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.		
Medical Cost Share Maximum:	**Network**	**Non-Network**
Per Member	$1,500	$2,000
Family	$3,000	$4,000
Once the Medical Cost Share Maximum is met by any combination of medical Copayment and Coinsurance Amounts, Members are no longer responsible for medical Copayment and Coinsurance Amounts.		
Medical Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$5,000	$5,500
Family	$10,000	$11,000
Once the Medical Out-of-Pocket Maximum Amount is met by satisfaction of the Deductible and Medical Cost Share Maximum Amounts, medical Covered Services will be paid at 100% of the Allowable Charges for the remainder of the calendar year.		

NOTE: Cost sharing amounts which contribute to the Network or non-network Out-of-Pocket Maximum amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Out-of-Pocket Maximum and vice versa).

NOTE: Non-Network emergency room (includes emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) and air ambulance are subject to the Network Deductible up to the Network Out-of-Pocket Maximum.

Total In-Network Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$9,200	Not Applicable
Family	$18,400	Not Applicable

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

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

$5,000 DEDUCTIBLE OPTION

Members Calendar Year Schedule of Benefits		
Deductible:	**Network**	**Non-Network**
Per Member	$5,000	$5,000
Family	$10,000	$10,000
NOTE: Pharmacy Copayments and Coinsurance do not apply to the Deductible requirements. NOTE: Cost sharing amounts which contribute to the Network or non-network Deductible amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Deductible, and vice versa).		
Coinsurance Amount:	20%	20%
Copayment Amount:	Visits to a Physician's office will be subject to a $55 Copayment per visit, after which Covered Services will be provided at 100% of the Allowable Charge without reference to the Deductible or Coinsurance. The Copayment cannot be applied toward satisfaction of the Plan's annual Deductible. Copayments will be applied to the Medical Cost Share Maximum Amount and Total In-Network Out-of-Pocket Maximum Amount. (NOTE: The Copayment does not cover the cost of medical tests or lab work. Charges for these services are subject to the Plan's Deductible and Coinsurance provisions.)	
NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.		
Medical Cost Share Maximum:	**Network**	**Non-Network**
Per Member	$1,500	$2,150
Family	$3,000	$4,300
Once the Medical Cost Share Maximum is met by any combination of medical Copayment and Coinsurance Amounts, Members are no longer responsible for medical Copayment and Coinsurance Amounts.		
Medical Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$6,500	$7,150
Family	$13,000	$14,300
Once the Medical Out-of-Pocket Maximum Amount is met by satisfaction of the Deductible and Medical Cost Share Maximum Amounts, medical Covered Services will be paid at 100% of the Allowable Charges for the remainder of the calendar year.		

NOTE: Cost sharing amounts which contribute to the Network or non-network Out-of-Pocket Maximum amount will work to satisfy the other (i.e. Network cost sharing amounts will satisfy the non-network Out-of-Pocket Maximum and vice versa).

NOTE: Non-Network emergency room (includes emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) and air ambulance are subject to the Network Deductible up to the Network Out-of-Pocket Maximum.

Total In-Network Out-of-Pocket Maximum Amount:	**Network**	**Non-Network**
Per Member	$9,200	Not Applicable
Family	$18,400	Not Applicable

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

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

Prescription Drugs (all Deductible options)	
Prescription Drug Benefit for a 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 $60.00 Copayment.
Tier 5 Drugs:	Covered Preferred specialty drugs require 20% Coinsurance.
Tier 6 Drugs:	Covered Non-Preferred specialty drugs require 20% Coinsurance.
Mail Service Pharmacy Program for a 90 day supply:	
Tier 1 Drugs:	Covered Preferred generic drugs require a $30.00 Copayment.
Tier 2 Drugs:	Covered Non-Preferred generic drugs require a $30.00 Copayment.
Tier 3 Drugs:	Covered Preferred brand drugs require an $80.00 Copayment.
Tier 4 Drugs:	Covered Non-Preferred brand drugs require a $120.00 Copayment.
The total Member cost share expenses for the Prescription Drug Benefit and the Mail Services Pharmacy Program are limited to a Pharmacy Out-of-Pocket Maximum Amount of $1,500 per Member per calendar year. Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Member cost share for covered Prescription Drugs and medicines under this benefit cannot be applied toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for Prescription Drugs and Medicines will be applied toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out-of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 4. NOTE: Non-network Pharmacies are <u>not</u> covered.	

MEDICAL BENEFITS:

Accidents
Acute Rehabilitative Services
Advanced Therapies
Allergy Services
Ambulance Services
Anesthesia Services
Blood Expenses
Chemotherapy and Radiation Therapy
Consultations
Dental Services
Diabetes Services
Extended Care Facility
Hemodialysis and Peritoneal Dialysis
Home Health Care
Hospice Benefits
Human Organ Transplants
Inherited Enzymatic Disorders
Laboratory, Pathology, X-ray, Radiology Services, and Magnetic Resonance Services
Maternity and Newborn Care
Medical Care for General Conditions
Mental Health or Substance Use Disorder Care
Outpatient Medications
Phase II Outpatient Cardiac Rehabilitation
Prescription Drugs & Medicines
Preventive Care
Private Duty Nursing Services
Rehabilitation
Reproductive Services
Room Expenses & Ancillary Services
Skilled Nursing Facility
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)
Surgical Assistants
Teladoc
Therapies (Respiratory, Physical, Occupational & Speech)

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

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

DEFINITIONS

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

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

B. *AGGREGATE DEDUCTIBLE*
A specified amount of Allowable Charges for Covered Services that Members under Adult and Dependent coverage 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. *AUTHORIZATION REVIEW*
The process of a Member formally requesting that Blue Cross Blue Shield of Wyoming approve specified healthcare services for Member. Authorization Review does not guarantee payment of benefits. An Authorization Review will be processed within 15 days and 72 hours for urgent care.

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

F. *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.

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

H. *COINSURANCE*
The portion of a Member's Allowable Charges for which they are responsible after the

Deductible has been met.

I. CONDITION

Any Accident, bodily dysfunction, illness, injury, Mental Health Disorder, pregnancy or Substance Use Disorder.

J. COPAYMENT

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

K. COVERED SERVICE

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

L. DEDUCTIBLE

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

M. DEPENDENT

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

1. Spouse. A person (of the same or opposite sex of the Employee) to whom a person is legally married to under the laws of the state or nation that were in place at the time and in the location that the marriage was entered into.
2. Civil Partner. A person (of the same or opposite sex of the Employee) with whom the Employee has entered into a civil union in a state or nation that sanctions such unions by law, and that is valid pursuant to such law at the time that the parties entered into the relationship. Civil Partners are eligible for coverage only if specifically permitted by the employer's policy.
3. Child/Children. The child or children, including newborn children, stepchildren, adopted children, children which the court has decreed support to the Employee or the Employee's covered Spouse or Civil Partner and legal wards of the Employee or the Employee's covered Spouse or Civil Partner. The limiting age for covered Children is the end of the month in which age 26 is attained unless otherwise established by the Group.
4. Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Employee, or the Employee's covered Spouse or Civil Partner for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the employer within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee, or the Employee's covered Spouse or Civil Partner, must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as

required by federal or state law as applicable.

N. DESIGNATED PROVIDER

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

O. 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.

P. ENROLLMENT DATE

The Enrollment Date means the first day of coverage.

Q. EXPERIMENTAL/INVESTIGATIONAL

A drug, device, or medical treatment or procedure is Experimental or Investigational:

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

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

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

1. Coverage will only be provided for Phase II, III, and IV cancer clinical trials;
2. The cancer clinical trial must be approved by an agency of the National Institutes of Health or, the United States Food and Drug Administration or, the Department of Veterans Affairs, or the Department of Defense;

3. Coverage is only available if Medical Care is rendered by a licensed health care provider operating within the scope of the provider's license;
4. Coverage for medical treatment shall be limited to routine patient care costs as follows:
    a. A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment;
    b. A drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal Food and Drug Administration for use in treating the patient's particular Condition.
5. Coverage shall NOT be available for:
    a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
    b. Any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;
    c. Health care services customarily paid by the sponsor of the clinical trial or study;
    d. Extraneous expenses related to the clinical trial or study including but not limited to travel, housing or other such expenses for the 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.

R. 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 use 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.

S. FORMULARY

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

T. GROUP

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

U. GROUP CONVERSION

A program designed for the Member who is no longer a covered Member of a Group health plan.

V. HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

Addresses the use and disclosure of individual's health information by entities subject to the Privacy Rule.

W. HOME HEALTH 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.

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

Y. INCURRED DATE

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

Z. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

A health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

AA. 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.

BB. MEDICAL CARE

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

CC. MEDICAL COST SHARE MAXIMUM AMOUNT

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

Copayments and Coinsurance Amounts paid for Prescription Drugs and Medicines under the Prescription Drug Benefit do not apply to the Medical Cost Share Maximum Amount.

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

DD. MEDICAL EMERGENCY

A Medical Emergency Condition is:

1. A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
   a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
   b. Serious impairment to bodily functions, or
   c. Serious dysfunction of any bodily organ or part, or
2. With respect to a pregnant woman who is having contractions if there is inadequate time to affect a safe transfer to another Hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.

EE. MEDICAL NECESSITY

1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
   a. Is medically appropriate for the symptoms, diagnosis or treatment of the Condition, illness, disease or injury;
   b. Provides for the diagnosis, direct care and treatment of the Member's Condition, illness, disease or injury;
   c. Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care;
   d. Is not primarily for the convenience of the Member, Physician or other health care provider; and
2. A medical service, procedure or supply shall not be excluded from being a Medical Necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
   a. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
   b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act.

FF. MEDICAL OUT-OF-POCKET MAXIMUM AMOUNT

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

calendar year.

Copayments and Coinsurance Amounts paid for Prescription Drugs and Medicines under the Prescription Drug Benefit do not apply to the Medical Out-of-Pocket Maximum Amount.

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

GG. MEDICAL POLICY

Policies or clinical criteria 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.

HH. MEMBER

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

II. MENTAL HEALTH OR SUBSTANCE USE DISORDER

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

JJ. NETWORK

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. Members are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. 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. Members 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.

KK. NETWORK PHARMACY

A Pharmacy which has entered into an agreement with Blue Cross Blue Shield of Wyoming or its Prescription Drug card administrator to bill Blue Cross Blue Shield of Wyoming directly for Covered Services. Blue Cross Blue Shield of Wyoming's payment will be made directly to the Network Pharmacy.

NOTE: A Pharmacy which has not entered into an agreement with Blue Cross Blue Shield of Wyoming is called non-network. When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by a non-network Pharmacy, the amount(s) a Member pays for Covered Services will generally be based on either the Host Blue's non-network Pharmacy local payment or the pricing arrangements required by applicable state law. A non-network Pharmacy will bill Members directly and the Members will be responsible for all charges.

LL. OUTPATIENT

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

MM. PHARMACY

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

NN. PHARMACY OUT-OF-POCKET MAXIMUM AMOUNT

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

OO. 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.

PP. PLAN ADMINISTRATOR

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

QQ. PRESCRIPTION DRUGS

Medications that have been approved or regulated by the Food and Drug Administration

that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber.

RR. 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.

SS. PROPHYLACTIC SURGERY

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

TT. 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.

UU. QUALIFIED PAYMENT AMOUNT

The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualified Payment

Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

VV. REHABILITATIVE ADMISSIONS

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

WW. SINGLE COVERAGE

Coverage provided for the Retiree or the Retiree's Dependent Spouse or Civil Partner only.

XX. SUBSCRIBER OR RETIREE

The person who applies for coverage.

YY. 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,
4. Other procedures as reasonably approved by Blue Cross Blue Shield of Wyoming.

ZZ. TELEMEDICINE

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

AAA. 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.

BBB. TOTAL IN NETWORK OUT-OF-POCKET MAXIMUM AMOUNT

The total Copayment, Deductible and Coinsurance Amounts for Covered Services that are a Member's responsibility during a single calendar year. Once the Member's Total In-Network Out-of-Pocket Maximum Amount is met medical Covered Services and Prescription Drug and Medicine benefits will be provided at 100% of the Allowable Charges for the remainder of the calendar year.

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

CCC. WYOMING EDUCATORS' BENEFIT TRUST (WEBT)

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

DDD. WYOMING TOTAL CHOICE PROVIDER

A healthcare provider that has entered into an agreement with Blue Cross Blue Shield of Wyoming to provide Covered Services at an agreed upon reimbursement methodology for Members in the Wyoming Total Choice Provider Network.

EEE. WYOMING TOTAL CHOICE PROVIDER NETWORK

The Wyoming Total Choice Provider Network is a comprehensive Network of Wyoming Total Choice Pharmacies and Wyoming Total Choice Providers who have agreed to provide Covered Services to Members with Wyoming Total Choice Plans and Members of health plans issued or administered by other Blue Cross and/or Blue Shield licensees that have Network Benefit Booklets comparable to the Wyoming Total Choice Benefit Booklets and who are receiving Covered Services in Blue Cross Blue Shield of Wyoming's service area, in compliance with the BlueCard® Program.

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 are established by WEBT. Funding levels are established to anticipate the required funding necessary for the operation of this Plan and may change from time to time at the sole discretion of WEBT.

B. *CONTRIBUTION REQUIREMENTS*
The Retiree pays the entire cost of the coverage.

ELIGIBILITY REGULATIONS

Retirees 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 the Retirees' and their Dependent's eligibility for benefits in accordance with this Plan.

A. ELIGIBILITY FOR RETIREES AND OTHERS

1. All retired employees of a WEBT participating Group that were continually covered under the WEBT program prior to retirement are eligible to continue coverage through the WEBT Retiree Program.
2. Prior to transferring into the WEBT Retiree Program, the eligible Retiree shall have completed any Retiree eligibility for coverage with the participating Group. Then, the Retiree will have the choice of transferring directly to the WEBT Retiree Program or completing their COBRA eligibility before transferring to the WEBT Retiree Program.
3. As long as the retired employee is covered, all spouses/civil partners and Dependents of the Retiree covered at the time of the WEBT Retiree Program election are eligible for coverage through this program.
4. If a spouse elects coverage, he/she will be set up under their own policy based upon age.
5. If an eligible Dependent child enrolls in coverage:
    a. The Dependent child will be enrolled as a Dependent on Retiree's policy until the end of month the Dependent child turns age 26.
    b. If the Retiree is over the age of 65, the Dependent child may enroll on a covered spouse/civil partner's under age 65 policy, if available.
    c. In the event the Retiree turns age 65 prior to the Dependent turning age 26, Dependent children may be transferred to a covered spouse/civil partner under age 65 policy, if available.
    d. The Dependent child coverage will terminate when the Retiree or spouse/civil partner becomes eligible for Medicare.

HOW TO ADD, CHANGE, OR END COVERAGE

A. HOW TO BEGIN COVERAGE

1. The eligible WEBT Retiree must complete an enrollment form for coverage and submit the enrollment form to WEBT within the time limit set by WEBT. WEBT must submit the electronic enrollment to Blue Cross Blue Shield of Wyoming no later than sixty (60) days after the Retiree's loss of eligibility under the School District's or other public entity's coverage for active employees.
2. Retirees will be given continuous coverage as long as the enrollment form is received by WEBT as explained above. Retirees whose enrollment forms are not received within the initial sixty (60) days as explained above will not be eligible.

B. HOW TO ADD DEPENDENTS

1. Eligible Dependents who are already covered under the Retiree's Wyoming Educators Benefit Trust self-funded program prior to retirement can be included at the time the Retiree applies for coverage in this Plan by listing their names and dates of birth on the enrollment form for coverage. If the Dependent is included on the Retiree's enrollment form the effective date of coverage for the Dependent will be the same as the Retiree's effective date.
2. To add newly acquired eligible Dependents, the Retiree should complete an enrollment form for coverage and submit the enrollment form to WEBT within the time limit set by WEBT. WEBT must submit the electronic enrollment to Blue Cross Blue Shield of Wyoming within the prescribed time period following the acquisition of the new Dependent as described below.
3. The effective date of coverage for newly acquired Dependents will be as follows:
    a. The new Spouse or Civil Partner will be effective on the date of the legally recognized marriage/civil union, provided that the enrollment form, along with documentation verifying the marriage/civil union, is received by the employer within thirty (30) days after the date of the marriage/civil union.
    b. Newborn children will be effective on the date of birth for a period of thirty-one (31) days. A completed enrollment form for the child will be required before claims will be processed. The Employee may continue coverage for the newborn child beyond the thirty-one (31)-day automatic coverage provided that the completed enrollment form for coverage of the newborn child is received by the employer within sixty-one (61) days of the child's date of birth.
    c. An adopted child or legal ward will be effective on the earlier of the date the petition for adoption is filed or the child's date of entry into the adoptive home (unless the child is in the custody of the State, in which case the effective date will be the date of entry of a final adoption decree by the court), for a period of thirty-one (31) days. A completed enrollment form for coverage for the child will be required before claims will be processed. The Employee may continue the coverage for the adopted child or legal ward beyond the thirty-one (31)-day automatic coverage provided that the completed enrollment form for the adopted child or legal ward is received by the employer within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the

effective date of coverage will be the date of entry of a final adoption decree by the court). NOTE: (1) The adoption or legal guardianship papers must accompany the enrollment form; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

C. MEMBER FRAUD AND ABUSE

1. When you enroll a family member in the plan, you represent the following:
   a. The individual is eligible under the terms of the plan; and
   b. You will provide evidence of eligibility upon request.
2. Further, you understand that:
   a. The plan is relying on your representation of eligibility in accepting the enrollment of your family members;
   b. Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
   c. Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual became ineligible for plan coverage, as determined by the Plan Administrator and subject to the plan's provisions on rescission of coverage.

D. CHANGES

1. The Retiree must notify WEBT within thirty (30) days of all changes in a Retiree's or Dependent's status, such as those resulting from marriage, civil union, divorce, dissolution or change of residence and within ninety (90) days of death. All changes must be in accordance with the ELIGIBILITY REGULATIONS section of this Plan.
2. WEBT will notify Blue Cross Blue Shield of Wyoming of any changes in Retiree's or Dependent's eligibility status within thirty (30) days of the date of change.

E. CHANGING COVERAGE OPTIONS

Employees may elect during the month of May each year to change the coverage option that they have selected. Provided an enrollment form for a change in the Deductible is completed, signed, and submitted to WEBT prior to May 31, the new coverage will be effective on July 1.

F. WHEN COVERAGE FOR THE RETIREE ENDS

1. Upon the death of the Retiree.
2. When the Plan is terminated. No continuation of coverage will be offered by the Plan.
3. At 11:59 pm on the date of termination request. Terminations occur end of month following Retiree's written request.
   a. All spouses/civil partners and Dependents will be removed from coverage when Retiree terminates except as specified in SURVIVORSHIP CONTINUATION.
4. When there is improper use of this Plan or the identification card, or when there is fraud or material misrepresentation associated with the enrollment form, or with the filing of a claim by the Member. The Employee is liable for any benefits payments made through such improper actions.
5. If the school district or public entity that the Retiree retired from cancels its coverage with the Wyoming Educators' Benefit Trust, coverage for all Retirees under the age

of 65 shall end and no Group Conversion coverage will be available. It will be the responsibility of the school district or public entity and the Retiree to arrange for continued coverage.

6. When the Retiree reaches age 65, coverage under this Plan will end unless the Retiree notifies WEBT of the intent to transfer to the plan for WEBT Retirees 65 Years and Over.

G. WHEN COVERAGE FOR DEPENDENTS ENDS

1. When the Retiree's coverage ends, except when the Retiree turns age 65 and is transferred to the plan for WEBT Retirees 65 Years and Over.
2. On the date the Dependent no longer qualifies as a Dependent as defined in this Plan.
3. The end of the month following a final divorce decree, separation or dissolution for a Spouse or Civil Partner.
4. The end of the month following the Retiree's written request to end coverage for the Dependent.
5. When a Dependent Spouse or Civil Partner reaches age 65, coverage under this Plan will end. The Spouse or Civil Partner must notify WEBT of the intent to transfer to the plan for WEBT Retirees 65 Years and Over.
6. For newborn and adopted children, at the end of the thirty-one (31) day automatic coverage period, unless a completed enrollment form for coverage of the child is received by WEBT no later than thirty (30) days after the end of that automatic coverage period.

H. SURVIVORSHIP CONTINUATION

1. In the event of the death of a Retiree enrolled spouses/civil partners, regardless of age, are allowed to continue coverage through the WEBT Retiree program.
2. If there is Dependent coverage in force, the coverage may continue for the surviving Dependents. Continuation will end on the earliest of the following:

    a. The date in which surviving Dependents become covered under any other health plan.
    b. The end of twelve months following the Retiree's death or until limiting age is attained, whichever is first.

I. ADDING MEMBERS DURING SPECIAL ENROLLMENT PERIODS

If a Retiree gains a new Dependent as a result of marriage, civil union, birth, adoption, or placement for adoption, they may be eligible for a special enrollment for themselves and their Dependents, provided they complete an enrollment form for coverage which is received by WEBT within thirty (30) days after the marriage, civil union, birth, adoption, or placement for adoption. The effective date of coverage will be:

1. In the case of marriage, the date of the legally formed marriage or civil union,
2. In the case of a Dependent's birth, the date of birth, and
3. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

4. If there are changes to local, state or federal laws that influence eligibility under this Plan, a Retiree or Dependent may become eligible for a special enrollment.
5. 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.

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

A. HOSPITALS AND FACILITY PROVIDERS

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

1. Blue Cross Blue Shield of Wyoming Network Hospitals and Facility Providers have entered into an agreement with it to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Network Hospitals and Facility Providers will be made directly to them. Members 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 Members. Members 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.

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

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.

B. PHYSICIANS AND PROFESSIONAL PROVIDERS

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

1. Blue Cross Blue Shield of Wyoming Network Physicians and Professional Providers have entered into an agreement with it to accept its Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Network Physicians and Professional Providers will be made directly to them. Members 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 Member and Members are responsible for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

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

If a Physician recommends that a 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. OUTPATIENT SURGERY

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

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

D. COPAYMENT REQUIREMENTS

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

E. DEDUCTIBLE REQUIREMENTS

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

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

1. When one Member meets one-half of the maximum Aggregate Deductible, that Member will be eligible for benefits. The remaining Members will be eligible for benefits when they have collectively satisfied the remaining balance of the maximum Aggregate Deductible.
2. When two 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 Member meets one-half of the maximum Aggregate Deductible, but all the Members collectively meet the maximum Aggregate Deductible, then all Members will be eligible for benefits.

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.

F. WHEN YOU RECEIVE HEALTHCARE IN WYOMING

The Blue Cross Blue Shield of Wyoming, Wyoming Total Choice Provider Network is a provider organization Network comprised of independent healthcare providers in the State of Wyoming (or in some circumstances from contiguous counties of neighboring states) that have entered into agreements with Blue Cross Blue Shield of Wyoming to provide healthcare services to Wyoming Total Choice Members. The Wyoming Total Choice Provider Network includes healthcare providers offering a broad range of medical services, such as family practice, internal medicine, obstetrics, gynecology and pediatrics.

In an effort to contain healthcare costs and keep premiums down, Blue Cross Blue Shield of Wyoming has negotiated with these Wyoming Total Choice Providers to provide healthcare services to Wyoming Total Choice Members for reduced charges. Regardless of the total amount of charges the Wyoming Total Choice Provider's billing statement to the Member may indicate, a Wyoming Total Choice Provider has agreed to accept the maximum allowable amount as full reimbursement for the Covered Services that the Wyoming Total Choice Provider provided to the Member. Blue Cross Blue Shield of Wyoming will pay the maximum allowable amount directly to the Wyoming Total Choice Provider on behalf of the Member. A Wyoming Total Choice Provider may still bill the Member for Member's cost sharing amounts and for any non-Covered Services. However, the Wyoming Total Choice Provider may not bill the Member for the difference between the amount of the total charges that may have been reflected on the Wyoming Total Choice Provider's billing statement to the Member and the maximum allowable amount the Wyoming Total Choice Provider has agreed to accept as reimbursement from Blue Cross Blue Shield of Wyoming for the Covered Services.

However, where a Member obtains healthcare services from a healthcare provider that has elected not to become part of the Wyoming Total Choice Provider Network, that healthcare provider may bill the Member for the total charges reflected in the healthcare provider's billing statement to the Member. Blue Cross Blue Shield of Wyoming will reimburse the maximum allowable amount for the Covered Services directly to the Member. It will be the Member's responsibility to pay this maximum allowable amount to the healthcare provider. However, in addition to any cost sharing amounts and charges for non-Covered Services that are Member's responsibility, Member will also be responsible for paying the healthcare provider for the difference between the full amount of charges reflected in the

healthcare provider's billing statement and the maximum allowable amount Blue Cross Blue Shield of Wyoming reimbursed the Member for the Covered Services. The difference may be a considerable amount of money.

Member is free to select his or her healthcare providers. Blue Cross Blue Shield of Wyoming makes no guarantee as to the availability of any healthcare provider. Blue Cross Blue Shield of Wyoming's responsibility to Member is solely to make payment for the benefits described in this benefit booklet. However, in order to receive the best value under this benefit booklet, the Member should use Wyoming Total Choice Providers whenever possible.

NOTE: A healthcare provider's Network status may change at any time without notice. Member is responsible for confirming a healthcare provider's Wyoming Total Choice Provider Network status prior to receiving any treatment or services from the provider.

How to Find Wyoming Total Choice Providers:
The Wyoming Total Choice Provider Network Directory can be accessed as follows:

For Wyoming Total Choice Providers within the U.S.:
1-888-359-6592
www.yourwyoblue.com

For Providers outside of the U.S.:
(877) 547-2903 if calling from within the U.S.
(804) 673-1177 (collect call) if calling from outside U.S.

G. PAYMENT ALLOWANCES UNDER THIS COVERAGE

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

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

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

H. CALCULATION OF OUT OF AREA PAYMENTS

Blue Cross Blue Shield of Wyoming has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a 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 "Network 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-network 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 access' Covered Services within the geographic area served by a Host Blue, Blue Cross Blue Shield of Wyoming will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network 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 Network provider. Sometimes, it is an estimated price that takes into account special arrangements with a Network 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-network 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-network providers, the amount the 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. In these situations, the Member may be liable for the difference between the amount that the non-network 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-network providers. In these situations, the Member may be liable for the difference between the amount that the non-network provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

I. NO-SURPRISES BILLING

In accordance with the requirements of federal law: 1) applicable Covered Services that are received from certain non-network healthcare providers during an emergency, or 2) applicable Covered Services that are received from certain non-network healthcare providers delivering emergency or non-emergency services at certain Network facilities, that would otherwise be Covered Services if received from a Network healthcare provider, will be covered at the same cost sharing amounts as would be applied if the services were provided by a Network 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 Network Deductible amount and Out-of-Pocket Maximum amount.

J. CONTINUITY OF CARE

1. As required by federal law, if a Member receiving Covered Services from a Network Provider experiences a change in Network status due to the following: 1) the Network

Provider's contract is terminated; 2) a change in Network participation under the Plan; or 3) the Group terminates coverage through Blue Cross Blue Shield of Wyoming, the Member may request to continue treatment with their current provider for a period of time by submitting a Continuity of Care Request Form. Patients must be undergoing treatment for a serious and complex condition, pregnancy, terminal illness, receiving Inpatient care, or be scheduled to undergo non-elective surgery to be eligible. If the request is approved, benefits will be provided at the Network level for treatment of the specific condition for a defined period of time (up to ninety (90) days). Requests must be received within thirty (30) days of the effective date of coverage termination or change in the provider's Network status for consideration.

2. As required by state law, on receipt of all necessary information documenting an authorization from the Member, previous health insurer or the Member's provider, Blue Cross Blue Shield of Wyoming will honor that approval for a minimum period of ninety (90) days if the service is considered a covered benefit under this Plan. The Member may request a transfer of authorization by submitting an Authorization Transfer Request Form.

BENEFITS

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

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

A. ACCIDENTS

DEFINITIONS- An "accident" is an unexpected traumatic incident which is identified by time and place of occurrence, identifiable by body member or part of the body affected and caused by a specific event on a single day. Examples include a blow or fall, animal bites, allergic reactions to insect bites or medication, or poisoning. Accidents are not the result of either services received (e.g. a massage), physical training (e.g. a strain from an exercise routine), an activity of daily living not resulting from a blow or fall, or an intentionally self-inflicted injury (unless the injury is the result of a medical Condition [either physical or mental] or domestic violence).

BENEFITS –

Inpatient: See ROOM EXPENSES AND ANCILLARY SERVICES.

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

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ACUTE REHABILITATIVE SERVICES

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review 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-
Benefits are provided under this section only for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain Surgery, amputations, multiple fractures, severe burns, multiple sclerosis, amyotrophic lateral sclerosis, or acquired immune deficiency syndrome.

See GENERAL LIMITATIONS AND EXCLUSIONS

C. ADVANCED THERAPIES

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

BENEFITS -

Benefits may be provided for advanced Therapy Services listed at https://www.bcbswy.com/providers/policy/. Covered Services will be subject to Deductible and Coinsurance. Services eligible for consideration of coverage include:

1. FDA-approved biologics utilizing gene therapy
2. FDA-approved biologics utilizing cellular immunotherapy
3. FDA-approved biologics utilizing regenerative medicine technologies

LIMITATIONS AND EXCLUSIONS-
Advanced Therapy Services not listed at https://www.bcbswy.com/providers/policy/ are not a covered benefit.

See GENERAL LIMITATIONS AND EXCLUSIONS

D. ALLERGY SERVICES

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

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

E. AMBULANCE SERVICES

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

BENEFITS –

The following professional ambulance services are covered when the 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. If the Member could have been safely transported by Ground Ambulance, Air Ambulance is not a Covered Service.
2. Other Transportation Services: Benefits will not be paid for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.
3. Patient Safety Requirement: If 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

F. ANESTHESIA SERVICES

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

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

BENEFITS –

Inpatient: Anesthesia services provided by a Physician or C.R.N.A. are covered when necessary for covered Surgery.

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

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

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

LIMITATIONS AND EXCLUSIONS-

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

See GENERAL LIMITATIONS AND EXCLUSIONS

G. BLOOD EXPENSES

DEFINITIONS- "Blood" expenses include the following:

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

BENEFITS –

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

H. CHEMOTHERAPY AND RADIATION THERAPY

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

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

BENEFITS –

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

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

J. DENTAL SERVICES (Medical Plan)

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

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

BENEFITS –

Hospital:

Inpatient: If a 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. Accidental injury (see limitation #1).
7. Reduction of dislocations of the temporomandibular joints as a result of an accident.

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

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

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

Physician:

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

Pediatric Dental Facility Expenses:
Facility expenses including use of a surgical suite or ambulatory surgery center and anesthesia services are covered for Members through six years of age when medically appropriate accompanying a dental procedure.

Coverage will be provided for one (1) physical evaluation or office visit for the Member prior to the procedure.

LIMITATIONS AND EXCLUSIONS-

1. Accidental Injury Benefit: Benefits will not be provided for restoring the mouth, tooth, or jaw because of injuries from biting or chewing. Benefits will be provided for accident-related dental expenses only under the following conditions:
   a. Services, supplies, and appliances must be required due to an accidental injury.
   b. Treatment must be for injuries to sound natural teeth.
   c. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
   d. The first services must be performed within 90 days after the accident.
   e. Related services must be performed within one year after the accident.
   f. All services must be performed while the Members coverage is still in effect.
2. Hazardous Medical Conditions: If, due to a hazardous medical Condition (e.g. a heart Condition or severe diabetes), hospitalization occurs for a non-covered dental procedure, benefits may be provided for Inpatient or Outpatient Hospital charges. However, benefits for the services provided by the Member's dentist or oral surgeon will be limited to those described in your Dental Plan, if applicable.
3. Restorative Services: Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
4. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
5. Physician services are not covered for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.
6. Benefits will not be provided for any Dental Services not specifically detailed above except as provided in your Dental Plan, if applicable.
7. Routine dental services such as cleaning, restoration, panoramic X-Rays are not Covered Services.

See GENERAL LIMITATIONS AND EXCLUSIONS

K. DIABETES SERVICES

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

BENEFITS –

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

Outpatient: Covered Services will be subject to Deductible and Coinsurance, benefits will be provided for equipment, supplies and Outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin using diabetes, if prescribed by a health care professional legally authorized to prescribe such items under law.

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

1. A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis, and
2. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, Condition, or treatment. This additional training shall be limited to three (3) hours per year.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

L. EXTENDED CARE FACILITY

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

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

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

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

BENEFITS –

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

Outpatient: Not covered.

Physician:

Inpatient and Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HEMODIALYSIS AND PERITONEAL DIALYSIS

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

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

BENEFITS –

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

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

N. HOME HEALTH CARE

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

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

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

1. Admittance to a Hospital or skilled nursing facility would be required if the Member did not receive home health care.
2. A plan for home care must be submitted and approved, in writing, by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the Condition for which hospitalization was required.

BENEFITS –

Inpatient: Not covered.

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

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

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

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

O. HOSPICE BENEFITS

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

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

1. An illness must be diagnosed for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief) 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.
4. Authorization Review for Inpatient services must be obtained through Blue Cross Blue Shield of Wyoming before benefits are payable.

BENEFITS –

Benefits are provided for the following:

Outpatient Home Hospice:

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

Inpatient Hospice:

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.

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

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

LIMITATIONS AND EXCLUSIONS-

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

P. HUMAN ORGAN TRANSPLANTS

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required for Human Organ Transplant Benefits, except for corneal transplants. Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization Review *before* receiving Human Organ Transplant services. Providers must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Authorization Review for the Inpatient stay. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for this healthcare service.

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

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

BENEFITS –

Hospital:

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

Physician:

Inpatient and Outpatient: Benefits will be provided for recipient expenses directly related to the transplant procedure including pre-operative and post-operative care. Benefits will also be provided for surgical costs directly related to the donation of the organ used in a covered organ transplant procedure.

LIMITATIONS AND EXCLUSIONS-

1. Benefits for transportation, meals, and lodging costs shall not exceed $10,000.
2. Coverage of these services is subject to all Blue Cross Blue Shield of Wyoming Authorization Review requirements, including the use of designated Facility Providers.
3. Donor expenses are not Covered Services if the donor is a Member but the recipient is not.
4. Donor expenses for which benefits are available from another source are not covered.

5. Services and supplies for which government funding of any kind is available are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. 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

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

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required for certain Laboratory, Pathology, X-Ray, Radiology, Magnetic Resonance Services, and related testing services. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

DEFINITIONS- "Laboratory" and "pathology" services are testing procedures required for the diagnosis or treatment of a Condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures which require the use of technical equipment for evaluation of body systems are also allowed as laboratory services. (Examples: electrocardiograms and electroencephalograms).

"X-ray", "radiology", and "magnetic resonance services" involve the use of radiology, nuclear medicine, and ultrasound equipment for the purpose of obtaining a visual image of internal body organs or structures, and the interpretation of these images.

BENEFITS –

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

LIMITATIONS AND EXCLUSIONS-

1. Unrelated services: Services which are not related to a specific illness or injury are not covered.
2. Routine Examinations: Services related to routine examinations (such as yearly physicals or screening examinations for school, camp, or other activities) are not covered except as described under PREVENTIVE CARE.
3. Weight Loss Programs: Benefits will not be paid for laboratory or X-ray services related to weight loss programs.

See GENERAL LIMITATIONS AND EXCLUSIONS

S. MATERNITY AND NEWBORN CARE

DEFINITIONS- "Maternity" services are those required by covered female Retirees or covered female Spouses or Civil Partners or Dependent daughters of Retirees for the diagnosis and care of a pregnancy and for delivery services.

Delivery services include the following:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Therapeutic or elective termination of pregnancy prior to full term to the extent permitted by state and federal law.
5. Ectopic pregnancies.

"Newborn" services include the following:

1. Routine nursery charges for a newborn well baby billed by a Hospital.
2. Routine care of a newborn well baby billed by a Physician.

NOTE: Under provisions of federal law, Group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a caesarean section, or require that a provider obtain Authorization Review for prescribing a length of stay not in excess of the above periods.

BENEFITS –

Hospital:

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

Outpatient: The following services are covered for the eligible female Member:

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).
2. Laboratory and X-ray services (See LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

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

Newborn Care:

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

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

LIMITATIONS AND EXCLUSIONS-

1. 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.

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

2. Benefits will not be provided for home births and related services; however, any services rendered in a professional setting by a Professional Healthcare 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 REPRODUCTIVE SERVICES

See GENERAL LIMITATIONS AND EXCLUSIONS

T. 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, a Hospital, or other facility for services provided in the Physician's office, the Outpatient department of a Hospital or other facility, or the Member's home, for a Condition which does not require Surgery.

BENEFITS –

Hospital:

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

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

Physician:

Inpatient: Benefits will be provided for care by a Physician in a Hospital for:

1. A Condition requiring only Medical Care, or
2. A Condition that, during an admission for Surgery, requires Medical Care not normally related to surgical care. This is only payable after approval by Blue Cross Blue Shield of Wyoming's Medical Review Department.
3. Only one medical visit per day when charged by the same Physician will be covered.

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

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

NOTE: Visits to a Physician's office will be subject to the Copayment per visit as indicated in

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

LIMITATIONS AND EXCLUSIONS-

1. Private Room Expenses: If a Member has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
2. Routine Examinations: Services related to routine examinations and immunizations (such as yearly physicals or screening examinations for school, camp or other activities) are not covered except as described under PREVENTIVE CARE.
3. Eye Care: Services will not be covered for the Condition of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

See GENERAL LIMITATIONS AND EXCLUSIONS

U. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

DEFINITIONS- "Mental Health and/or Substance Use Disorder" is a Condition requiring specific treatment primarily because the Member requires psychotherapeutic treatment, applied behavioral analysis (ABA) Therapy Services, nutritional counseling, and/or rehabilitation from a Mental Health Disorder and/or a Substance Use Disorder.

"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.

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required before ABA Therapy Services 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* receiving ABA Therapy Services. The failure to obtain Authorization Review may result in a denial or reduction in coverage for this benefit.

BENEFITS –

Inpatient:

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

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

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

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

Benefits include the psychiatric Collaborative Care Model as defined by the American Medical Association, and pursuant to Wyo. Stat. Ann. § 26-20-702.

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.
7. Nutritional counseling, education, and/or training is limited to the diagnosis of eating disorders.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. OUTPATIENT MEDICATIONS

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving these Outpatient Medications. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review 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. Certain medications require use of a preferred product. Preferred products are cost-effective, clinically appropriate treatments based on current medical guidelines and best practice standards. If a non-preferred product is used without authorization, the non-preferred product will not be a covered benefit. The Member may request access to non-preferred products not otherwise covered by Blue Cross Blue Shield of Wyoming through a request for exception. You may seek an exception by calling us at 1-800-442-2376 or by writing to Blue Cross 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.
3. Prescription Drugs related to weight loss programs are not Covered Services.
4. Prescription Drugs considered "lifestyle" drugs are not Covered Services. Examples include but are not limited to: hair loss, facial hair, wrinkles, etc.
5. Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not a Covered Service.
6. For Chemotherapy medications, please see section CHEMOTHERAPY AND RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

W. PHASE II OUTPATIENT CARDIAC REHABILITATION

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

BENEFITS –

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

X. PRESCRIPTION DRUGS AND MEDICINES

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

DEFINITIONS- "Prescription Drugs and Medicines" are those which by federal law require a written prescription for purchase. They must be listed in the United States Pharmacopeia, the National Formulary, or the Homeopathic Pharmacopeia, and must be evaluated as "probably effective" in the current edition of the American Medical Association's Drug Evaluations. All drugs and medicines must be approved by the Food and Drug Administration for the Condition for which they are prescribed and not be identified as "Experimental".

A. BENEFITS AVAILABLE THROUGH THE PRESCRIPTION DRUG BENEFIT:
Prescription Drugs and medicines for a 30 day supply and up to a 90 day supply for maintenance medications (1 Copay per 30 day supply) are covered by the Prescription Drug Benefit when purchased from a Network Pharmacy. When a Member needs a prescription filled, the Member should go to a Network Pharmacy and present his or her identification card. The Network Pharmacy will only charge for the Copayment and Coinsurance as shown in the Schedule of Benefits. The Pharmacy will be reimbursed for the remaining balance.

Benefits for Prescription Drugs and medicines for a 30 day supply purchased through a Network Pharmacy are based on Allowable Charges and payable as follows:

1. Tier 1 Drugs: Preferred generic prescription medications (Tier 1 may include some lowest net cost brand medications).

Tier 2 Drugs: Non-Preferred generic prescription medications (Tier 2 may includ some lowest net cost brand medications).

Tier 3 Drugs: Preferred brand prescription medications.

Tier 4 Drugs: Non-Preferred brand prescription medications (Tier 4 may include some ‘authorized generics’; generic-appearing medications not considered true generics by the FDA).

Tier 5 Drugs: Highest-cost Preferred specialty brand medications but some may also be generic specialty medications.

Tier 6 Drugs: Highest-cost Non-Preferred specialty brand medications but some may also be generic specialty medications.

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Member cost share for covered Prescription Drugs and Medicines under this benefit cannot be applied toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for covered Prescription Drugs and Medicines under this benefit will apply toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out-of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 4.

2. Where a prescription is ordered and a generic version is available, the prescriber does not indicate dispensing the brand-name version is medically necessary, and the Member chooses to have the brand-name version filled: Member will be required to pay the non-preferred brand tier cost share, as well as the difference in cost between the brand drug and the generic drug (referred to here as "Member Pays the Difference" (MPTD) penalty). MPTD penalty paid amount does not contribute to the Member's Out-of-Pocket annual maximum. Additionally, when the Pharmacy Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount has been reached, Member will continue to pay the MPTD penalty.
3. The maximum amount or quantity of Prescription Drugs that will be considered as eligible charges may not exceed a 90 day supply when taken in accordance with the direction of the prescriber, applying a Copayment and Coinsurance for each 30 day supply. For example, a Tier 2 Prescription Drug is filled at the Pharmacy for a 60 day supply. The Member will be responsible for two Copayments for each thirty (30) day supply.

B. BENEFITS AVAILABLE UNDER 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 for a 90 day supply purchased through the Mail Service Pharmacy Program are as follows:

1. Tier 1 Drugs: Preferred generic prescription medications. (Tier 1 may include some lowest net cost brand medications).

   Tier 2 Drugs: Non-Preferred generic prescription medications. (Tier 2 may include some lowest net cost brand medications).

   Tier 3 Drugs: Preferred brand prescription medications.

   Tier 4 Drugs: Non-Preferred brand prescription medications (Tier 4 may include some 'authorized generics'; generic-appearing medications not considered true generics by the FDA).

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Member cost share for covered Prescription Drugs and Medicines under this benefit cannot be applied toward the Deductible or Medical Cost Share Maximum Amount requirements of any other benefit of this Plan. Copayments and Coinsurance for covered Prescription Drugs

and Medicines under this benefit will apply toward the Pharmacy Out-of-Pocket Maximum Amount and the Total In-Network Out-of-Pocket Maximum Amount. NOTE: Compounded prescriptions are reimbursed under Tier 4.

2. Where a prescription is ordered and a generic version is available, the prescriber does not indicate dispensing the brand-name version is medically necessary, and the Member chooses to have the brand-name version filled: Member will be required to pay the non-preferred brand tier cost share, as well as the difference in cost between the brand drug and the generic drug (referred to here as "Member Pays the Difference" (MPTD) penalty). MPTD penalty paid amount does not contribute to the Member's Out-of-Pocket annual maximum. Additionally, when the Pharmacy Out-of-Pocket Maximum Amount or Total In-Network Out-of-Pocket Maximum Amount has been reached, Member will continue to pay the MPTD penalty.
3. The maximum amount or quantity of Prescription Drugs that will be considered as Allowable Charges may not exceed a 90 day supply when taken in accordance with the directions of the prescriber.

C. SPECIALTY DRUGS

"Specialty drugs" are generally prescribed for people with complex or ongoing medical Conditions such as multiple sclerosis, hemophilia, hepatitis, and rheumatoid arthritis. (The list of those drugs deemed specialty drugs is available from Blue Cross Blue Shield of Wyoming and is subject to change without notice.) Specialty drugs typically have one or more of the following characteristics:

1. High cost.
2. Injected or infused, but some may be taken by mouth.
3. Unique storage or shipment requirements.
4. Additional education and support required from a healthcare professional.
5. Usually not stocked at retail Pharmacies.
6. The maximum amount or quantity of specialty medications that will be considered as Allowable Charges may not exceed a 30 day supply when taken in accordance with the directions of the prescriber.
7. Tier 5 Drugs: Highest-cost Preferred specialty brand medications but some may also be generic specialty medications.

   Tier 6 Drugs: Highest-cost Non-Preferred specialty brand medications but some may also be generic specialty medications.

Coverage of Specialty medications must be authorized through Blue Cross Blue Shield of Wyoming Utilization Management review and approval prior to filling. Specialty medication prescribing office personnel are required to contact Blue Cross Blue Shield of Wyoming for both Authorization Review and referral to a preferred Pharmacy.

NOTE: Non-network Pharmacies are <u>not</u> covered.

LIMITATIONS AND EXCLUSIONS-

1. Non-Prescription Items: Drugs and medicines that can be purchased without a written prescription are not covered, even if the Physician has prescribed such "over-the-counter" medications.
2. Take-Home Drugs: Drugs and medicines which are provided as "take-home supply" by the Hospital are not covered.
3. Weight loss: Prescription Drugs and medicines related to weight loss programs are not covered.
4. Hair Loss: Prescription Drugs and medications related to hair loss are not covered.
5. Cosmetic Drugs: Prescription Drugs and medicines used for cosmetic purposes are not covered.
6. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not covered.
7. Prescription Drugs purchased from an Out-of-Network Pharmacy are not covered.
8. 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.
9. Prescription Drugs that are not on the Formulary are not covered.

See section REPRODUCTIVE SERVICES

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. PREVENTIVE CARE

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

BENEFITS –

1. When Covered Services are provided by Network providers, benefits will be provided at 100% of the Allowable Charges for Covered Services without regard to any Deductible or Coinsurance that might otherwise apply.

   When services are provided by non-network providers, benefits for Covered Services will be provided subject to the Deductible and Coinsurance provisions of this Plan.

2. In years when they are not recommended as covered by the agencies described in the DEFINITION section above, the following blood draw screenings will be covered for each covered Employee and covered Spouse or Civil Partner at 100% of the Allowable Charges without regard to any Deductible or Coinsurance that might otherwise apply to a maximum of $50 per calendar year:

   a. Hemogram or CBC
   b. Ferritin
   c. C-reactive protein (CRP)
   d. Vitamin D
   e. Blood type
   f. ColoKit
   g. Health assessment
   h. Thyroid panel

   Services must be provided by Network providers and no benefits will be provided for charges in excess of the $50 calendar year maximum. If services are provided by non-network providers, benefits for these services will be provided subject to the Deductible and Coinsurance provisions of this Plan.

3. If the Member meets the criteria established by Blue Cross Blue Shield of Wyoming, injections for Immune Prophylaxis for Respiratory Syncytial Virus (RSV) will be covered by both Network and non-network providers subject to the Deductible and Coinsurance provisions of the Plan. Blue Cross Blue Shield of Wyoming must give Authorization Review in advance of the date of services.

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-network provider, up to the amount of the provider's billed

charges.

3. Any newly publicized recommendations will be recognized as a preventive service within the time period Centers for Medicare & Medicaid Services provides.

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. PRIVATE DUTY NURSING SERVICES

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

BENEFITS –

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

1. The 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: All claims will be carefully reviewed to be sure that private duty nursing services are absolutely required. The fact that private duty nursing services are covered under this Plan does not, in itself, guarantee that benefits will be paid for any or all services.
3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the 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. REHABILITATION

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

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

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

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

BENEFITS –

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

BB. REPRODUCTIVE SERVICES

BENEFITS –

Benefits for the diagnosis and treatment of Conditions causing infertility are limited to:

1. Diagnostic and treatment services
2. Laboratory tests
3. Diagnostic tests
4. Surgical procedures
5. Prescription Drugs not otherwise excluded

LIMITATIONS AND EXCLUSIONS-

1. The services listed below are not covered as treatments for infertility or as alternatives to conventional conception:
   a. Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:
      (1) Artificial insemination (AI)
      (2) In vitro fertilization (IVF)
      (3) Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)
      (4) Intravaginal insemination (IVI)
      (5) Intracervical insemination (ICI)
      (6) Intracytoplasmic sperm injection (ICSI)
      (7) Intrauterine insemination (IUI)

   b. Cryopreservation or storage of sperm (sperm banking), eggs, or embryos,
   c. Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos.
   d. Drugs used in conjunction with ART and assisted insemination procedures.
   e. Drugs to treat infertility, other indications require prior Authorization Review.
   f. Services, procedures, and/or supplies that are related to items excluded under this section.
   g. Services, supplies, or drugs provided to individuals not enrolled in this Plan.

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. ROOM EXPENSES AND ANCILLARY SERVICES

DEFINITIONS- "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, alcoholism treatment centers, and other facilities 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: Benefits will be provided for room expenses and covered ancillary services.

Authorization Review: If a Member's Physician recommends that the 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. See AUTHORIZATION REVIEW under HOW BENEFITS WILL BE PAID.

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

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

LIMITATIONS AND EXCLUSIONS-

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

See GENERAL LIMITATIONS AND EXCLUSIONS

DD. SKILLED NURSING FACILITY

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

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

BENEFITS –

Inpatient and Outpatient: Benefits will be provided to a maximum of ninety (90) days per Member per calendar year 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

EE. SUPPLIES, EQUIPMENT AND APPLIANCES

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

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

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

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

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

BENEFITS –

1. Durable medical equipment - Benefits will be paid for the rental or purchase of Medically Necessary durable medical equipment, whichever is less expensive. When a purchase is covered, benefits will also be paid for repair, maintenance, replacement, and adjustment.
2. Medical supplies, including but not limited to:

    a. Colostomy bags and other supplies for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers and burns.
    d. Syringes and needles for administering covered drugs, medicines, or insulin.
    e. Hyperalimentation.

3. The following Prosthesis and Orthopedic Appliances, 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.
i. Cochlear implants and bone-anchored hearing aids (BAHAs).

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review 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 - Benefits will be provided for oxygen and the equipment needed to administer it.
6. 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 Network Pharmacy:

   Tier 1: Preferred generic prescription equipment and supplies (Tier 1 may include some lowest net cost brand equipment and supplies).
   Tier 2: Non-Preferred generic prescription equipment and supplies (Tier 2 may include some lowest net cost brand equipment and supplies).
   Tier 3: Preferred brand prescription equipment and supplies.
   Tier 4: Non-Preferred brand prescription equipment and supplies (Tier 4 may include some 'authorized generics'; generic-appearing equipment and supplies not considered true generics by the FDA).

   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 Performance 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 ordered includes more features than needed for the Condition being treated, benefits will be paid only up to the Allowable Charge for the item that would have met medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars."). Deluxe equipment is covered only when additional features are required for effective medical treatment, or to allow the Member to operate the equipment without assistance.
2. Durable Equipment: Items such as air conditioners, purifiers, humidifiers, dehumidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self- help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical Condition.
3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered except for cochlear implants and bone-anchored hearing aids (BAHAs).
4. Hospital Beds: Benefits will not be provided for Hospital beds (including waterbeds or other floatation mattresses).
5. Medical Supplies: Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid or available over the counter are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics, non-rigid braces.)
6. Special Braces: Benefits will not be provided for special braces or special equipment.
7. Diabetic supplies purchased from a non-network Pharmacy are not Covered Services under this Agreement. Payment for diabetic supplies from a non-network Pharmacy will be the sole responsibility of the Subscriber/Member.
8. 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

FF. 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.

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required for certain Surgeries. This includes but is not limited to Obesity and Weight Loss Surgery, Orthognathic Surgery, Cosmetic Surgery, Reconstructive Surgery, Prophylactic Surgery, and Gender Reassignment Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

DEFINITIONS- "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 will be provided for the room expenses and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject to the Coinsurance after the Deductible as indicated in the Schedule of Benefits.

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

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

Physician:

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

NOTE: Covered Services performed as an Inpatient in the Hospital will be subject the Coinsurance after the Deductible as indicated in the Schedule of Benefits.

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

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

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

Prophylactic Surgery:

The following Prophylactic Surgeries will be a Covered Service:

1. Mastectomy
2. Oophorectomy
3. Hysterectomy

Gender Reassignment Surgery:

Treatment, services and supplies for, or leading to, Gender Transition will be payable as any other illness or injury. Related Prescription Drug expenses will be payable through the plan’s Prescription Drug program.

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.

   Cosmetic procedures related to gender reassignment, 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

Benefits for a cosmetic Surgery procedure and related expenses are allowed only when reconstructive Surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Benefits for reconstructive Surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic Surgery must have occurred after the Member's original effective date and continuous coverage must be maintained from the date of birth, accident or disease treatment.

NOTE: Subject to Authorization Review, 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.

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 main Surgery. Additional benefits will not be paid for these procedures.
4. Obesity and Weight Loss: Benefits will be paid for Surgery required as the result of obesity only when authorized on the basis of the Condition specified in section on GENERAL LIMITATIONS AND EXCLUSIONS.
5. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.
6. Private Room Expenses: If a Member has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room

is available.

7. Sterilization Procedures: Such Surgeries and related expenses will be covered. Reversals of sterilization procedures are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

GG. SURGICAL ASSISTANTS

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

BENEFITS –

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

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

LIMITATIONS AND EXCLUSIONS-

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

See GENERAL LIMITATIONS AND EXCLUSIONS

HH. TELADOC

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

BENEFITS –

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

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

II. THERAPIES
(RESPIRATORY, PHYSICAL, OCCUPATIONAL & SPEECH)

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

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

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

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

BENEFITS –

Hospital:

Inpatient: When provided by a Hospital and related to improvement of the Condition for which the Member is admitted, the following types of therapy are covered:
1. Physical therapy provided by a registered physical therapist or Physician.
2. Respiratory therapy.
3. Occupational therapy.
4. Speech therapy.

Outpatient: When provided by a Hospital or Facility Provider, the following types of therapy are covered:
1. Physical therapy provided by a registered physical therapist or Physician.
2. Respiratory therapy.
3. Occupational therapy.
4. Speech therapy.

Physician:

Inpatient: When provided by a Physician, the following types of therapy are covered in lieu of one medical day if charged by the same Physician:
1. Physical therapy provided by a registered physical therapist or Physician.
2. Respiratory therapy.
3. Occupational therapy.

4. Speech therapy.

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:
1. Physical therapy provided by a registered physical therapist or Physician.
2. Respiratory therapy.
3. Occupational therapy.
4. Speech therapy.

NOTE: Benefits for Outpatient physical therapy (physiotherapy), occupational therapy and speech therapy are limited to a combined maximum of thirty (30) treatments per illness or injury per Member. Additional visits will be covered based on Medical Necessity.

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

LIMITATIONS AND EXCLUSIONS -
Voice lessons and voice therapy are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS AND EXCLUSIONS

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

A. ACUPUNCTURE

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

B. ALTERNATIVE MEDICINE

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

C. AUTHORIZATION REVIEW

Authorization Review is required prior to obtaining healthcare services as required by this Benefit Booklet or Medical Policy. Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization Review.

D. AUTOPSIES

Services related to autopsies are not covered.

E. BIOFEEDBACK

Services related to biofeedback are not covered.

F. COMPLICATIONS OF NON-COVERED SERVICES

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

G. COSMETIC SURGERY

Cosmetic Surgery: "Cosmetic Surgery" is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic Surgery does not become reconstructive Surgery because of psychiatric or psychological reasons.

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving Cosmetic Surgery. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

Cosmetic procedures related to gender reassignment, including the following, are not Covered Services:

1. Abdominoplasty
2. Blepharoplasty
3. Body contouring, such as lipoplasty
4. Brow lift
5. Calf implants
6. Cheek, chin, and nose implants
7. Injection of fillers or neurotoxins
8. Face lift, forehead lift, or neck tightening
9. Facial bone remodeling for facial feminizations
10. Hair removal
11. Hair transplantation
12. Lip augmentation
13. Lip reduction
14. Liposuction
15. Pectoral implants for chest masculinization
16. Rhinoplasty
17. Skin resurfacing
18. Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's Apple)
19. Voice modification Surgery

Benefits for a cosmetic Surgery procedure and related expenses are allowed only when reconstructive Surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Benefits for reconstructive Surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic Surgery must have occurred after the Member's original effective date and continuous coverage must be maintained from the date of birth, accident or disease treatment.

NOTE: Subject to Authorization Review, 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 Review 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 Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated

Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

H. 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.

I. 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.

J. 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.

K. EAR WAX

Services for the removal of ear wax are not covered.

L. EDUCATIONAL PROGRAMS

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

M. ENVIRONMENTAL MEDICINE

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

N. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

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

O. EYE CARE

Benefits will not be provided for the Conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

P. FOOT CARE SERVICES

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

Q. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Genetic molecular testing is not covered except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

As used herein, "genetic molecular testing" means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

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

R. GOVERNMENT INSTITUTIONS AND FACILITIES

Services and supplies furnished by a facility operated by, for, or at the expense of a federal, state, or local government or their agencies are not covered except as required by the federal, state, or local government. Benefits shall not be excluded when provided by, and when charges are made for such services by, a Wyoming tax-supported institution, providing the institution establishes and actively utilizes appropriate professional standard review organizations according to Section 35-17-101, Wyoming Statutes, 1977, as amended, or comparable peer review programs, and the operation of the institution is subject to review according to federal and state laws.

S. HAIR LOSS

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

T. HOSPITALIZATIONS

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

U. HYPNOSIS

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

V. ILLEGAL SERVICES

Services that are in violation of applicable state or federal law are not Covered Services.

W. LATE ENROLLEES

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

X. 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 ordinarily residing in the Member's household.

Y. 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.

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

Benefits will not be paid for any claims related to medical services or supplies that a 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.

AA. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

BB. OBESITY AND WEIGHT LOSS

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 Plan is limited to a lifetime maximum of one (1) per Member.

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

CC. ORTHOGNATHIC SURGERY

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

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

IMPORTANT NOTE: Authorization Review 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 Review *before* receiving these healthcare services. Authorization Review may include the required use of Designated Providers who have demonstrated high quality, cost efficient care. The failure to obtain Authorization Review may result in a denial or reduction in coverage for the healthcare service.

DD. PAYMENT IN ERROR

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

EE. PERSONAL COMFORT OR CONVENIENCE

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

FF. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Services rendered by a physician's assistant or nurse practitioner when the sponsoring Physician sees the patient or becomes directly involved in the medical service being

provided are not covered. (A sponsoring Physician is a licensed Physician approved to sponsor a physician assistant by the State Board of Medical Examiners.)

GG. 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.

HH. PROPHYLAXIS/PROPHYLACTIC MEDICINE

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

II. REHABILITATIVE ADMISSION

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

JJ. REPORT PREPARATION

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

KK. RESEARCH STUDIES

Benefits for research studies (studies that involve testing drugs, technologies, tools, devices, and techniques on volunteers) are not Covered Services.

LL. ROUTINE HEARING EXAMINATIONS

Except as indicated under PREVENTIVE CARE and for cochlear implants and bone-anchored hearing aids (BAHAs), 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 unless it is for cochlear implants and bone-anchored hearing aids (BAHAs).

MM. ROUTINE PHYSICALS

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

NN. SERVICES AFTER COVERAGE ENDS

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

OO. SERVICES NOT IDENTIFIED

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

PP. SERVICES PRIOR TO THE EFFECTIVE DATE

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

QQ. 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.

RR. 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.

SS. TAXES

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

TT. 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.

UU. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

VV. THERAPIES

Benefits will not be provided for special therapies except as described under the Therapies section of this Plan. Such non-covered Services include (but are not limited to): recreational and sex therapies, Z therapy, 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.

WW. TIMELY FILING OF CLAIMS

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

XX. TRAVEL EXPENSES

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

YY. UNRELATED SERVICES

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

ZZ. WAR

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

AAA. WEIGHT LOSS PROGRAMS

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

GENERAL PROVISIONS

A. ASSIGNMENT OF BENEFITS

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

D. CLERICAL ERROR

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

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

E. COORDINATION OF BENEFITS

Members often have other coverage providing duplicate benefits. In the event of other coverage, Blue Cross Blue Shield of Wyoming will not duplicate benefits if otherwise provided for (or should have been provided had the 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 (1) coverage shall be applicable to any Benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage. If the Agreement is determined to be secondary payer, the sum of the benefits payable by the primary payer plus the sum of the benefits payable under this Agreement shall not exceed the amount payable under this

Agreement had this Agreement been determined to be the primary payer.

BCBSWY determines which coverage is primary according to Wyoming Law: Chapter 10 – Coordination of Benefits, Wyoming Insurance Department regulations. For more information relating to how the primary payor is determined, please visit: https://rules.wyo.gov/Search.aspx?mode=1. Navigate to Agency - Insurance Department, General Agency Board or Commission Rules, Chapter 10 Coordination of Benefits.

F. 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.

G. DISCLOSURE OF A MEMBER'S MEDICAL INFORMATION

All Protected Health Information (PHI) maintained by the Plan Sponsor or Blue Cross Blue Shield of Wyoming is confidential. Any PHI about a Member that is obtained 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 the Claims Supervisor 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.

H. EXECUTION OF PAPERS

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

I. GENERAL INFORMATION ABOUT FILING CLAIMS

Blue Cross Blue Shield of Wyoming identification cards indicate the type of coverage 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.

J. LIMITATION OF ACTIONS

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

K. NOTICE OF DISCRETIONARY CLAUSE

This benefit Plan contains a discretionary clause. Determinations made by the Plan Administrator pursuant to the discretionary clause do not prohibit or prevent a Member 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 Member seeks judicial review of the Plan Administrator's determinations of eligibility of benefits, the payment of benefits, or interpretations of the terms and conditions applicable to the benefit Plan.

L. MEMBER'S LEGAL OBLIGATIONS

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

M. PHYSICAL EXAMINATION AND AUTOPSY

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

N. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

O. 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.

P. 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.

Q. 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.

R. 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.

S. 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 Blue Cross Blue Shield of Wyoming's membership records.

T. 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 Retiree 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.

U. SUBROGATION

If another person or entity, through an act or omission, has caused a Member to suffer a Condition, and if WEBT has paid Benefits for that Condition under the terms of this Plan, the Member agrees that WEBT 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 WEBT has paid Benefits for that injury under the terms of this Plan, the Member agrees that WEBT shall be subrogated and succeed to any of Member's rights of recovery for expenses incurred. WEBT'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 WEBT in full for Benefits WEBT has paid to or on behalf of the Member. WEBT's share of any recovery extends only to the amount of Benefits WEBT has paid or will pay to or on behalf of the Member or Member's heirs, administrators, legal representatives, parents (if Member is a minor), successors, or

assignees. This is WEBT's right of recovery.

2. WEBT is entitled under its right of recovery to be reimbursed for the Benefit payments it has made to or on behalf of the 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. WEBT's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3. WEBT will not reduce its share of any recovery unless, in the exercise of its discretion, it agrees in writing to a reduction (a) because the 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 WEBT with its right of recovery. The Member must not take any action that may prejudice WEBT's right of recovery.
5. If the Member does not seek damages for his or her Condition, the Member must permit WEBT 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 WEBT promptly that the Member has made a claim against another party for a Condition that WEBT has paid or may pay Benefits. Member must also seek recovery for WEBT's Benefit payments and liabilities, and the Member must tell WEBT about any recoveries the Member obtains, whether in or out of court. WEBT may seek a first priority lien on the proceeds of the Member's claim in order to reimburse itself to the full amount of Benefits it has paid or will pay.

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

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

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

1. When a third party injures the 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 Plan.

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

V. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Agreement not more than forty-five (45) days or with respect to services in a non-network emergency department of a Hospital or with respect to emergency services in a non-network Independent Freestanding Emergency Department not later than thirty (30) days after receipt of a Claim for Benefits 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 Agreement. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Agreement, the 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.

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

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

X. WRITTEN NOTICE OF CLAIM

1. Proof of claim must be furnished to Blue Cross Blue Shield of Wyoming at its office at 4000 House Avenue, Cheyenne, Wyoming 82003-2266.
2. Benefits will not be provided under the Plan unless proper notice (proof) is furnished to Blue Cross Blue Shield of Wyoming that Covered Services have been rendered to a Member. Written notice must be submitted to Blue Cross Blue Shield of Wyoming within twelve (12) months after completion of the Covered Service. An expense will be considered incurred on the date the service or supply was rendered. The notice must include the data necessary for Blue Cross Blue Shield of Wyoming to determine benefits.
3. Failure to give notice to Blue Cross Blue Shield of Wyoming within the time

specified above will not invalidate nor reduce any claim for benefits if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible, but in no event later than one (1) year from the Incurred Date.

Y. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY, AUTHORIZATION REVIEW, 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 legal representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of an Authorization Review of services or a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's authorized legal representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized legal representative of its determination within a reasonable period of time, but no later than seventy-two (72) hours after receiving the request.

2. Non-emergency Services
   The Member and/or the Member's authorized legal representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of an Authorization Review of services or Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's authorized legal representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized legal representative of its determination within a reasonable period of time, but no later than thirty (30) days after receiving an Authorization Review of services request or sixty (60) days after receiving a benefit determination request.

   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 seventy-two (72) hours notice to assemble the documents pertaining to an appeal.

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

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

When filing a request for an external review, the 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 require it, and in any event within seventy-two (72) hours, where:

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

   The Member's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Ave., PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred

twenty (120) days of the date on the Notice of Appeal Rights.

2. Experimental/Investigational 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 seventy-two (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 for his or her claims or Authorization Review denial 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 one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

AA. FINAL CLAIMS DETERMINATION BY PLAN ADMINISTRATOR

After all applicable internal and external claims review procedures have been exhausted, the Member and/or the Member's authorized representative may make a final written appeal regarding the denial of a claim to the Plan Administrator at the following address for a final determination:

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

BB. 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)

CC. EXTRAORDINARY CIRCUMSTANCES

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 under certain extraordinary circumstances (such as pandemics, states of emergency, etc.). 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 Review 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.