FREMONT COUNTY GOVERNMENT

Summary Plan Description

Original Effective Date
July 1, 2014
Restated July 1, 2017

Claims Supervisor:

BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross and Blue Shield Association

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

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

यदि तपाई आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ,Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा 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 nílínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídíłkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bą́ą́h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnil 800-442-2376.

Non-Discrimination Notices

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

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

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

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

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

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

FREMONT COUNTY GOVERNMENT
July 1, 2017

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.

TABLE OF CONTENTS

APPROVAL

BENEFIT DOCUMENT

ACKNOWLEDGMENT OF RECEIPT AND APPROVAL

The Benefit Document for Fremont County

Government is approved.

Restated date is July 1, 2017.

INTRODUCTION

This document describes the Medical and Dental Plan (The Plan) maintained for the exclusive benefit of the Employees of Fremont County. This Plan represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, and amends and replaces any prior statement of health coverage contained in the Plan or any predecessor to the Plan. The Employer intends to maintain this Plan indefinitely, but reserves the right to terminate or change the Plan at any time and for any reason. Changes in the Plan may be made in any or all parts of the Plan including, but not limited to, services covered, Deductibles, Copayments, maximums, exclusions or limitations, definitions, eligibility, etc.

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

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

GENERAL INFORMATION

NAME OF PLAN: Fremont County Medical and Dental Benefit Plan

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

PLAN NUMBER: 501

TAX ID NUMBER: 83-6000107

PLAN YEAR: July 1 – June 30

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

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

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

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

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

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

SCHEDULE OF BENEFITS

EMPLOYER NAME: Fremont County
EFFECTIVE DATE: July 1, 2015

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

OPEN ENROLLMENT: The Open Enrollment Period for this group is November 1 through November 30 for an effective date of January 1.

Participants Calendar Year Schedule of Benefits				
Cost-Sharing Amounts:	**Participant's Responsibility for Covered Services**			
	Plan A		**Plan B**	
	Network Providers	**Non-Network Providers**	**Network Providers**	**Non-Network Providers**
Deductible:				
Single Coverage	$800	$1,600	$2,500	$5,000
Two Adult, Adult & Dependent and Family Coverages	$1,600	$3,200	$5,000	$10,000
Out-of-Pocket Maximum Amount:				
Single Coverage	$5,800	$11,600	$6,250	$12,500
Two Adult, Adult & Dependent & Family Coverages	$9,100	$18,200	$12,500	$25,000
Any Deductible, Coinsurance and Copayments (except for Prescription Drugs) which Participants pay for medical Covered Services will be applied toward both their Network and Non-network Deductibles and Out-of-Pocket Maximums.				

Covered Services		
Benefit Description:	**Participant's Responsibility for Covered Services:**	
	Network Providers	**Non-Network Providers**
Supplemental Accident Benefit – within 90 days of accident:	Paid at 100% for the first $300. After the first $300 Covered Services subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum Amount.	Paid at 100% for the first $300. After the first $300 Covered Services subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum Amount.

Hospital Services:		
Room and Board:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Intensive Care Unit:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Emergency Room Services:	Subject to $250 emergency room Copayment per Participant per visit. After Copayment subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (The ER Copayment will be waived if the Participant is admitted directly into the Hospital from the Emergency Room.)	
Outpatient and Ambulatory Surgical Facility:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Urgent Care Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Skilled Nursing Facility:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to a maximum of 60 days per confinement.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to a maximum of 60 days per confinement.)
Physician Services:		
Inpatient Visits:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Office Visits:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Surgery:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Second Surgical Opinion:	Paid at 100% Deductible waived.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.

Ambulance Service:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	
Cardiac Rehabilitation:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 20 outpatient visits per incident.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 20 outpatient visits per incident.)
Chemotherapy and Radiation Treatment:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Diabetes Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Diabetes Education paid at 100% Deductible Waived. Limited to a maximum of 5 visits per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Diabetes Education limited to a maximum of 5 visits per Participant per calendar year.)
Diagnostic Lab and X-ray:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Durable Medical Equipment, Orthotics and Prosthetics:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Fremont County Health Department:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum (Includes any eligible expenses rendered and billed by the Fremont County Health Department including, but not limited to, immunizations and flu shots.)	
Home Health Care:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Home Infusion Therapy:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Hospice Care:	Subject to Deductible then paid at 100%	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.

Inherited Enzymatic Disorders:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Mental Health Treatment:		
Inpatient Services: (Maximum visits is combined maximum with Substance Use Disorder Care)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 10 days maximum per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 10 days maximum per Participant per calendar year.)
Intensive Outpatient Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Each day counts as ½ day toward the inpatient maximum.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Each day counts as ½ day toward the inpatient maximum.)
Outpatient Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 25 visits maximum per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 25 visits maximum per calendar year.)
Additional Mental Illness and Intellectual Disability Benefit: (This is a Covered Service only for inpatient treatment in a tax supported institution in the State of Wyoming.)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to $500 Lifetime maximum.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to $500 Lifetime maximum.)
Occupational Therapy: (Outpatient)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 40 visits maximum per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 40 visits maximum per calendar year.)
Organ Transplants:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Physical Therapy: (Outpatient)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 40 visits maximum per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 40 visits maximum per calendar year.)

Pregnancy:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Some services paid at 100% Deductible waived. See section T. PREVENTIVE CARE.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Preventive Care:		
Routine Wellness Care:	Paid at 100% Deductible waived	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Registered Dietician:	Paid at 100% Deductible waived. (Limited to 5 visits Per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 5 visits Per Participant per calendar year.)
Rehabilitation Therapy: (Inpatient)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 30 days per Participant per calendar year; or 60 days Per Participant per calendar year in the case of a spinal cord or head Injury or due to stroke.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 30 days per Participant per calendar year; or 60 days Per Participant per calendar year in the case of a spinal cord or head Injury or due to stroke.)
Routine Well Newborn Nursery Care: (while Hospital confined at birth)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.
Skilled Nursing Facility:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 60 days per Participant per confinement.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 60 days per Participant per confinement.)
Speech Therapy: (Outpatient)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 25 visits per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 25 visits per Participant per calendar year.)

Spinal Manipulation Chiropractic services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 15 visits per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 15 visits per Participant per calendar year.)
Substance Use Disorder Care:		
Inpatient Services: (Maximum visits is combined maximum with Mental Health Treatment.)	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 10 days per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 10 days per Participant per calendar year.)
Outpatient Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum. (Limited to 25 visits per Participant per calendar year.)	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum. (Limited to 25 visits per Participant per calendar year.)
Teladoc Consultation Benefit:	$10 Copayment per consultations	
Travel Medical Benefits: (Only to selected medical facilities for eligible procedures. See section DD. TRAVEL MEDICAL BENEFITS.)	Subject only to Coinsurance Amount of 20%. Benefit maximum of $200 per day & $2500 per calendar year.	Subject only to Coinsurance Amount of 30%. Benefit maximum of $200 per day & $2500 per calendar year.
Other Covered Services:	Subject to Deductible and Coinsurance Amount of 20% up to the Out-of-Pocket Maximum.	Subject to Deductible and Coinsurance Amount of 30% up to the Out-of-Pocket Maximum.

Note: The maximums listed above are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar year maximum is 60 days total which may be split between Network and Non-Network providers.

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

CASE MANAGEMENT

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a Participant's health care needs, using

communication and available resources to promote quality, cost effective outcomes. Blue Cross Blue Shield of Wyoming will utilize case management techniques when appropriate to insure optimal results for all parties involved in particular healthcare cases.

QUALIFYING FOR THE DISEASE MANAGEMENT PRESCRIPTION INCENTIVE

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

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

1. Under the care of a Physician with a diagnosis of hypertension, hyperlipidemia, diabetes, or asthma;

2. Annual visit with the Physician to renew prescriptions covered by the program. Signed Physician statements are required annually by the Wellness Program;

3. Meeting with the Wellness Program Coordinator quarterly;

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

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

PRESCRIPTION DRUG BENEFITS

Outpatient Prescription Drugs will be administered by Magellan Rx. For further information please contact Magellan Rx toll-free (800) 424-0472 or through their web address at **www.MagellanRx.com**.

Participants can find a copy of a claim form on Magellan Rx website and can mail to the following address for reimbursement:

Magellan Rx Management
4801 E Washington St, Suite 100
Phoenix, AZ 85034

Retail Pharmacy – Administered by Magellan Rx -Limited to a 30-day supply

Generic drugs

Copayment..... $10

Preferred Brand Name Drugs

Copayment..... $35 plus cost difference if generic drug available

Non-Preferred Brand Name drugs

Copayment..... $50 plus cost difference if generic drug available

Specialty drugs

Copayment..... $100

Retail Pharmacy – Administered by Magellan Rx - Limited to a 90-day supply

Generic drugs

Copayment..... $25

Preferred Brand Name Drugs

Copayment..... $87.50 plus cost difference if generic drug available

Non-Preferred Brand Name drugs

Copayment..... $125 plus cost difference if generic drug available

Specialty drugs

Copayment..... $250

Mail Order – Administered by Magellan Rx - Limited to a 90-day supply

Generic drugs

Copayment..... $25

Preferred Brand Name Drugs

Copayment..... $87.50 plus cost difference if generic drug available

Non-Preferred Brand Name drugs

Copayment..... $250 plus cost difference if

generic drug available

Specialty drugs

Copayment..... $200

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

DEFINITIONS

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

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

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

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

D. *ANNIVERSARY DATE*
The date each year on which the Group may renew its coverage for the next twelve (12) months.

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

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

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

H. *COINSURANCE*
A percentage of the cost of Covered Services that is a Participant's responsibility after the Deductible has been met. Blue Cross Blue Shield of Wyoming calculates a Participant's Coinsurance Amount off of the Allowable Charges. In the case of services obtained out of Blue Cross Blue Shield of Wyoming's service area, a local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require a Coinsurance calculation that is not based on the discounted price the provider has agreed to accept from the Host Plan, but is, instead, based on the provider's full billed charges. This may result in a higher or, in some cases, lower Coinsurance payment for certain claims incurred when outside of Blue

Cross Blue Shield of Wyoming's service area. Because of the many different arrangements between the host Plans and their providers, it is not possible to give specific information for each out-of-area provider.

I. CONDITION

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

J. COPAYMENT

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

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

M. DEPENDENT

An Employee's Dependents are the following:

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

Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Employee for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to Blue Cross Blue Shield of Wyoming within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and

dependency upon the Employee must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.

N. DIAGNOSTIC SERVICE

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

O. ENROLLMENT DATE

The Enrollment Date for timely entrants means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date for late entrants will be the effective date of coverage.

P. EXPERIMENTAL/INVESTIGATIONAL

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

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

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

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

1. Coverage will only be provided for Phase I, II, III, and IV cancer and other life threatening disease or condition clinical trial;
2. The cancer or other life threatening disease or condition clinical trial must be approved by an agency of the National Institutes of Health or, the United States Food and Drug Administration or, the Department of Veterans Affairs, or the Department of Defense;
3. Coverage is only available if medical care is rendered by a licensed health care provider operating within the scope of the provider's license;
4. Coverage for medical treatment shall be limited to routine patient care costs as follows:
    a. A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment or treatment for other life threatening diseases or conditions;
    b. A drug provided to a patient during a cancer or other life threatening disease or condition clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal Food and Drug Administration for use in treating the patient's particular condition.
5. Coverage shall NOT be available for:
    a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
    b. Any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;
    c. Health care services customarily paid by the sponsor of the clinical trial or study;
    d. Extraneous expenses related to the clinical trial or study including but not limited to travel, housing or other such expenses for the Participant or the Participant's family or companions;
    e. Any item or service solely provided to satisfy a need for data collection or analysis or related to the clinical management of the patient;
    f. Any costs for management of research relating to the trial or study.

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

Q. FACILITY OTHER PROVIDER

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

1. Substance Use Disorder Treatment Center or Facility is a detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism, or a Facility Other Provider which is primarily engaged in providing detoxification and rehabilitation treatment for substance use disorders.
2. Ambulatory Surgical Facility is a Facility Other Provider, with an organized staff of Physicians, which:
    a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis,
    b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility,
    c. does not provide inpatient accommodations, and
    d. is not, other than incidentally, a facility used as an office or clinic for the private

practice of a Physician, or Professional Other Provider.

3. Freestanding Dialysis Facility is a Facility Other Provider other than a Hospital which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
4. Outpatient Psychiatric Facility is a Facility Other Provider which for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness on an outpatient basis.
5. Psychiatric Hospital is a Facility Other Provider which for compensation from its patients, is primarily engaged in providing rehabilitation care services on an inpatient basis. Psychiatric rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
6. Skilled Nursing Facility is a Facility Other Provider which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:
   a. minimal care, custodial care, ambulatory care, or part-time care services, or
   b. care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.
7. Hospice is a Facility Other Provider that offers a coordinated program of home care for a terminally ill patient and the patient's family.
8. Other medical facilities not specifically listed above.

R. FAMILY COVERAGE

Coverage that includes the Employee, the Employee's eligible spouse, and one or more eligible dependent children.

S. FORMULARY

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

T. GROUP

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

U. HOME HEALTH AGENCY

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

V. HOSPITAL

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

1. Is a duly licensed institution.

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

W. INPATIENT

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

X. LATE ENROLLEE

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

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

Y. MEDICAL CARE

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

Z. MEDICAL EMERGENCY

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, in the case of a pregnant woman, her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any body organ or part.

AA. MEDICAL NECESSITY

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

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

BB. MENTAL ILLNESS

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

CC. NETWORK

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

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

NOTE: A Hospital, Facility Other Provider, Physician, or Professional Other Provider who has not entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan is called Non-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 Participant 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 Other Provider may bill Participants directly and payments will be made directly to the

Participant. If Participants choose a Non-network Hospital or Facility Other Provider, they may be billed directly and payments may be made directly to the Participant. Participants will be responsible to Non-network providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

DD. OPEN ENROLLMENT PERIOD
The period of time as set forth in the Schedule of Benefits.

EE. OUT OF POCKET MAXIMUM
A specified amount of Deductible, Coinsurance and Copayments paid by the Participant for Covered Services within a calendar year. The Out of Pocket Maximum does not include non-covered amounts or charges in excess of Blue Cross Blue Shield of Wyoming's Allowable Charge Charges. When the Out of Pocket Maximum is reached, the level of benefits is increased as specified in the Schedule of Benefits.

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

GG. PARTICIPANTS
The Employee and the Employee's covered Dependents.

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

II. 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.

JJ. PLAN ADMINISTRATOR
Fremont County.

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

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

1. Chiropractor is a Board Qualified and licensed Doctor of Chiropractic who treats disease by manipulation of the joints of the body.
2. Clinical Psychologist is a licensed clinical psychologist. When there is no licensure

law, the psychologist must be certified by the appropriate professional body.

3. Dentist includes, and only includes, a dentist duly licensed to practice by the state in which the services shall have been provided.
4. Optometrist is a person (O.D.) who measures the eye's refractive powers, performs medical eye examinations and fits glasses to correct ocular defects.
5. Physical Therapist is a licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.
6. Physician Assistant is an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a licensed Wyoming Physician and must be certified by the state to practice.
7. A Nurse Practitioner is a registered nurse who performs primary care patient services such as acts of medical diagnosis or prescription of medical therapeutic or corrective measures and is licensed and certified by the state.

MM. PROTECTED HEALTH INFORMATION (PHI)

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

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

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

NN. REHABILITATIVE ADMISSIONS

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

OO. SINGLE COVERAGE

Coverage provided for the Employee only.

PP. 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,

QQ. THERAPY SERVICE

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

1. Radiation Therapy is the treatment for malignant diseases and other medical

conditions by means of X-ray, radon, cobalt, betatron, telecobalt, and telecesium, as well as radioactive isotopes.

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

RR. TWO ADULT COVERAGE

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

SS. WAITING PERIOD

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

FUNDING LEVELS AND CONTRIBUTIONS

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

A. *HOW FUNDING LEVELS ARE ESTABLISHED AND CHANGED*

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

B. *CONTRIBUTION REQUIREMENTS*

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

ELIGIBILITY REGULATIONS

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

A. ELIGIBILITY

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

    a. Fremont County Library
    b. Fremont County Museum
    c. Fremont County Weed and Pest
    d. Fremont County Fire Board
    e. Fremont County Fair Board

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

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

    NOTE: The following are not eligible for coverage.

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

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

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

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

B. DEPENDENT ELIGIBILITY

1. All Dependents of the covered Employee, retiree or elected County official as defined by the Plan are eligible. NOTE: Covered retirees may NOT add to their coverage a spouse or child who was not already covered under this Plan at the time of the retiree's retirement.
2. Dependents of deceased retirees are eligible. Dependents who were covered at the time of the retiree's death may remain on the Plan as long as there is not a lapse in payments and they continue to make the payments. In the event the spouse remarries, neither the child(ren) nor spouse may remain on the Plan. Child(ren) may not remain on the Plan after both the retiree and spouse have died. In addition, coverage for the child(ren) will end when the spouse becomes Medicare eligible or on December 31 of the year when the child(ren) reaches age 26.
3. Dependents of the covered Employee who enter the armed forces on full-time duty are eligible for continuation of coverage in this Plan, regardless of whether the eligible employee elects to retain coverage for him/herself. See CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT under the section on HOW TO ADD, CHANGE, OR END COVERAGE.
4. Covered spouses age 65 and over must choose from the following,

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

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

HOW TO ADD, CHANGE, OR END COVERAGE

A. HOW TO ADD EMPLOYEES

1. The eligible Applicant should complete an application for coverage which should be received by the Group within thirty-one (31) days of either:

   a. The date of hire (for new Employees) or
   b. The day they assume their official duties (for elected County officials).

   The employer will then forward the application to BCBSWY.
   NOTE: Former Employees who are being rehired are not subject to the Waiting Period and must submit their applications within thirty-one (31) days of their rehire date.

   NOTE: Former Employees who were covered by the Plan when termination occurred and who are rehired and meet the eligibility criteria for coverage within 13 weeks of their termination date are not subject to the Waiting Period and are eligible for coverage the first of the month coinciding with or following the day the Employee completes one hour of service.
2. Based on the completeness and acceptability of the application, the effective date of coverage will be the first of the month following completion of the sixty (60) day Waiting Period for new Employees and elected officials.
   NOTE: Employees who have been on COBRA coverage and who recover from their illness or injury and return to work are exempt from the Waiting Period.
3. If an application is not submitted as described above, the Applicant will be considered a Late Enrollee. Late Enrollees are eligible to enroll during the Group's annual Open Enrollment Period (November 1-30). Provided the application is received by the Employer during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.
4. In addition to the methods of application described above, an Applicant may also be eligible to apply for coverage during a special enrollment period. (See ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS below.)

B. HOW TO ADD DEPENDENTS

1. Eligible Dependents can be added at the time the Applicant applies for coverage by including their names and dates of birth on the application and checking the appropriate box. If the Dependent is included on the application, the effective date of coverage will be the same as that of the Employee or official.
2. To add eligible Dependents who were not included on the original application, a new application is required. If the application for coverage is received by the Employer within thirty-one (31) days of the Dependent's initial date of eligibility, the effective date will be the first of the month following receipt of the application. Eligible Dependents who are considered to be Late Enrollees because their application was not received by the Employer within thirty-one days of their initial date of eligibility are eligible to apply for coverage during the Group's annual Open Enrollment Period (November 1-30). Provided the application is received by

the Employer during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.

3. To add newly acquired eligible Dependents, the Applicant should complete an application for coverage and forward it to the employer immediately. The application must be received by the employer within the prescribed period following the acquisition of the new Dependent as described below.
4. The effective date of coverage for newly acquired Dependents will be as follows:
   a. The new spouse will be effective on the date of marriage providing an application is received either prior to the date of marriage, or within thirty-one days after the date of marriage.
      NOTE: Eligible individuals must submit their enrollment forms prior to the effective date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.
   b. If the Employee has Adult and Dependent, Two Adult or Family Coverage, coverage for a newborn child will be automatic beginning on the date of birth and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The eligible Employee may continue coverage for the newborn child beyond the 31- day automatic coverage provided that the completed application for coverage of the newborn child is received by the Employer within sixty (60) days of the child's date of birth. If such application is received and accepted by the Employer, the eligible Employee's contribution will be adjusted and payable to account for the newborn's coverage after the automatic thirty-one (31) day coverage period. <u>If the eligible Employee does not have dependent coverage, coverage of the newborn child is not automatic</u>.
   c. To add an adopted child or legal ward, the adoption or legal guardianship papers must accompany the application for coverage if the Employee has Adult and Dependent, Two Adult or Family Coverage. Coverage for an adopted child will be automatic beginning on the date of birth and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The eligible Employee may continue coverage for the adopted child beyond the 31-day automatic coverage provided that the completed application for coverage of the adopted child is received by the Employer within sixty (60) days of the date the petition for adoption is filed or the date of entry into the home, whichever is earlier. If such application is received and accepted by the Employer, the eligible Employee's contribution will be adjusted and payable to account for the newborn's coverage after the automatic thirty-one (31) day coverage period. <u>If the eligible Employee does not have Adult and Dependent, Two Adult or Family Coverage, coverage of the newborn child is not automatic</u> and a completed application for coverage of the adopted child or legal ward must be received by the Employer within thirty-one (31) days of the earlier of the date of adoption or placement for adoption, (unless the child is in the custody of the State, in which case the application must be received by the Employer within thirty-one (31) days of the date of entry of a final adoption decree by the court), and coverage will be effective as of that date.

NOTE: If a new application is not received by the Employer within the prescribed

periods as described above or during a special enrollment period, the Dependent will be considered a Late Enrollee. Late Enrollees are eligible to apply during the group's annual Open Enrollment Period (November 1-30) provided the application is forwarded to the Employer during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on January 1.

C. CHANGES

1. The Employee or elected County official shall notify the Employer within thirty-one (31) days of all changes in the Participant's status, such as those resulting from marriage, divorce, birth, adoption, or change of residence and within ninety (90) days of death or entrance into, or return from, the armed services. These changes will be made only upon approval by the Employer. All changes must be in accordance with the ELIGIBILITY REGULATIONS section of this Plan.
2. If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, they may be eligible for coverage if the Employee completes an application which is received by the Employer within sixty (60) days after the termination. The effective date of coverage will be the first of the month following receipt of the application.
3. If the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP), they may be eligible for coverage if the Employee requests coverage within sixty (60) days after eligibility is determined. The effective date of coverage will be the first of the month following receipt of the application.

D. WHEN COVERAGE UNDER THIS PLAN ENDS

1. When the Employee or elected County official leaves employment or otherwise becomes ineligible, coverage will terminate on the last day of the month following thirty-one (31) days from the date on which the Participant terminated (Except as described below under COBRA.)
   NOTE: Accrued vacation time and sick leave will not extend coverage beyond the first of the month following the last day of employment.
2. When an Employee or elected County official is on a leave of absence and once all earned accrued leave has been exhausted, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.
3. Upon the death of the Employee or elected County official. NOTE: Dependents of deceased covered retirees may continue to be covered as described under the section on ELIGIBILITY REGULATIONS.
4. When the Plan is terminated. No continuation of coverage will be offered by Blue Cross Blue Shield of Wyoming.
5. By the Employee's or elected County official's request. Coverage ends on the first of the month following receipt of the written request.
6. When there is improper use of this Plan or the identification card, or when there is fraud or material misrepresentation associated with the application, or with the filing of a claim by the Participant. The Employee or elected County official is liable for any benefits payments made through such improper actions.
7. When the covered retiree becomes eligible for Medicare.

8. Active Employees or elected County officials age 65 and over must choose from the following:

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

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

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

E. WHEN COVERAGE FOR DEPENDENTS ENDS

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

1. When the Employee's, elected County official's, or retiree's coverage ends. However, the eligible Dependent may apply for a continuation of coverage as described below under COBRA. (NOTE: Dependents who were covered at the time of a retiree's death may remain on the Plan as long as there is not a lapse in payments and they continue to make the payments. In the event the surviving spouse remarries, neither the child(ren) nor the spouse may remain on the Plan. Child(ren) may not remain on the Plan after both the retiree and spouse have died. In addition, coverage for the child(ren) will end either when the spouse becomes Medicare eligible or on December 31 of the year when the child(ren) reaches age 26.)
2. December 31st of the year in which a dependent child attains age 26.

   Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Employee or elected County official for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to Blue Cross Blue Shield of Wyoming within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee or elected County official must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.
3. When no longer qualifying as a Dependent as defined in this Plan.

4. The first of the month following a final divorce decree or separation for a dependent spouse.
5. When the Employee, elected County official, or retiree notifies the Employer in writing to end coverage for a Dependent. Coverage ends on the first of the month following receipt of the written request.
6. Covered spouses who turn age 65 have a choice of either:
   a. Retaining coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary coverage, or
   b. Choosing the federal Medicare program as their primary coverage, in which case coverage under this Plan will terminate.
7. When an Employee or elected County official is on a leave of absence and once all earned accrued leave has been exhausted, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.

F. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) Participants may qualify for continued coverage under this Plan for a specified period of time after coverage would normally terminate. Such continued benefits may last for up to 18, 24, 29 or 36 months, depending on the "Qualifying Event".

1. Participants who lose their coverage under this Plan may be eligible for a continuation of coverage as follows:
   a. When the Employee's employment is terminated (except for termination due to gross misconduct), or suffers a reduction in work hours (resulting in loss of coverage), the Employee is still eligible for continuation of coverage under the Plan.
   b. The Employee has the right to remain in the Plan at his or her own expense.
   c. The employer must notify Blue Cross Blue Shield of Wyoming within thirty-one (31) days after an Employee terminates or has a reduction in work hours resulting in the loss of eligibility for health coverage. Blue Cross Blue Shield of Wyoming will notify the Employees of their continuation of coverage rights within 14 days of receiving notification from the employer or Employee. The Employee then must sign and return the COBRA election form to Blue Cross Blue Shield of Wyoming within sixty (60) days of either the date of the letter containing the form or the effective date of the COBRA continuation coverage, whichever is later. NOTE: Employees who do not apply for coverage within 60 days as described are <u>not</u> later eligible to apply during the annual Open Enrollment period.
   d. The period of continuation of coverage for the Employee under the original group plan is 18 months (24 months for an Employee who leaves the job and enters the Armed Forces on a full time basis, or up to a maximum of 29 months if an Employee is disabled at the time of termination), or to the time of either coverage under another group health plan or entitlement to Medicare, whichever occurs first.
   e. Continuation of coverage can be canceled only upon 1) abolition of all health plans by the employer, 2) the Employee's failure to make timely payment of monthly contributions, 3) the Employee's entitlement to

Medicare, and 4) the Employee's coverage under another group health plan via remarriage.

2. Dependents who lose their coverage under the Plan may be eligible for a continuation of coverage as follows:
   a. Individuals covered as Dependents are entitled to elect to remain in the Plan after coverage otherwise would end. The period of continuation of coverage is 36 months (18 months in the case of the Employee's termination or reduction in work hours resulting in loss of coverage), for (1) surviving spouses and children of
   deceased Employees, (2) separated, divorced or Medicare ineligible spouses and children of current Employees, and (3) children of current Employees who lose their dependent status under the terms of this Plan as specified above. NOTE: The period of continuation of coverage is 24 months if the Employee left the job and entered the Armed Forces on a full-time basis.
   b. Dependents have the right to remain in the Plan at their own expense.
   c. The Employee or covered Dependent must notify Blue Cross Blue Shield of Wyoming within 60 days of the date of the loss of eligibility of the covered Dependent. Blue Cross Blue Shield of Wyoming will then notify Dependents of their rights to continuation of coverage within 14 days of Blue Cross Blue Shield of Wyoming's notification by the Employee or Dependent. These Dependents will then have 60 days to elect continuation of coverage under the Plan. (NOTE: If the Employee or covered Dependent fails to report the Dependent's loss of eligibility within 60 days as described, the Dependent loses the right to continuation of coverage.)
   d. The period of continuation of coverage is 18, 24, 29 or 36 months as stated above, or to the time of either coverage under another group health plan or entitlement to Medicare, whichever occurs first.
3. A lifetime continuation shall be available to a retiree or the Dependent of a retiree in the event of the following Qualifying Event: (1) the employer's filing of a bankruptcy proceeding under Title 11 of United States Code. Continued coverage must be offered when coverage is substantially reduced within one year before or after the filing for bankruptcy. Retirees and widows or widowers of retirees who die before the bankruptcy filing are also covered by lifetime continuation coverage. Surviving spouses and dependent children of retirees who die after the bankruptcy filing may elect an additional thirty-six (36) months of continuation coverage.
4. Other coverage options besides COBRA Continuation Coverage:
   a. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
5. Qualified Beneficiary
   a. In general, you, your spouse, and any Dependent child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary". In addition, any Dependent child

who is born or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary". Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

6. Qualifying Event
   a. If you are a covered Employee, you, your spouse, and/or Dependent child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:
      1. Your hours of employment are reduced; or
      2. Your employment ends for any reason other than gross misconduct.
7. You, your spouse, and/or Dependent child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA continuation coverage. You, your spouse, and Dependent Child have an independent right to elect COBRA continuation coverage. You and/or your spouse may elect coverage on behalf of either one of you and parents may elect on behalf of their Dependent child.
8. If you are the Spouse and/or Dependent child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:
   a. Your spouse/parent – Employee dies;
   b. Your spouse/parent – Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
   c. You/your parents become divorced or legally separated.
9. Your spouse and/or Dependent child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such spouse and/or Dependent child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA continuation coverage and their obligation to provide such notice.

G. FAMILY AND MEDICAL LEAVE ACT

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

1. For the care of the employee's child (birth or placement for adoption or foster care);
2. For the care of an employee's spouse, son or daughter, or parent who has a serious health condition; or
3. For a serious health condition that makes the employee unable to perform his/her job.

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

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

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

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

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

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

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

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

H. ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS

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

1. If at the time of initial eligibility, Employees or Dependents decline coverage under this Plan because of other group health insurance coverage, they may be eligible for a special enrollment, provided they request enrollment within thirty-one (31) days after the other health insurance coverage ends. To qualify for this special enrollment, the Employees or Dependents must have lost their other coverage due to either:
   a. The termination of employer contributions,
   b. The Employee's or Dependent's loss of eligibility due to divorce, death, legal separation, termination of employment, or reduction in work hours, or
   c. The exhaustion of group continuation coverage if the Employee or Dependent had been on group continuation coverage at the time of initial eligibility.

   The Employee must complete an application for coverage which must be forwarded to the Employer within thirty-one (31) days after the Employee's or Dependent's other coverage ends. The effective date under this Plan will be the 1st of the month following receipt by the Employer of a substantially complete application.
2. If Employees gain a new Dependent as a result of marriage, birth, adoption, or placement for adoption, they may be eligible for a special enrollment for themselves and their Dependents, provided they complete an application for coverage which is forwarded to the Employer within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption. The effective date of coverage will be:
   a. In the case of marriage, the date of marriage,
      NOTE: Eligible individuals must submit their enrollment forms prior to the effective date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.
   b. In the case of a Dependent's birth, the date of birth, and
   c. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.
3. If the Employee or any Dependents dropped coverage under this Plan due to the Employee's entrance into the armed forces on full-time duty. The Employee and any Dependents being added to the coverage must complete an application for coverage which must be forwarded to the Employer within thirty-one (31) days after the date of termination of the Employee's full-time duty status. The effective date of coverage under this Plan for all such Applicants will be the date

of application, assuming receipt by the Employer of a substantially complete application.

4. If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, they may be eligible for coverage if the Employee completes an application which is forwarded to the Employer within sixty (60) days after the termination. The effective date of coverage will be the first of the month following receipt of the application for coverage.
5. If the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP), they may be eligible for coverage if the Employee requests coverage within sixty (60) days after eligibility is determined. The effective date will be the first of the month following receipt of the application for coverage.

HOW BENEFITS WILL BE PAID

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

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

A. HOSPITALS AND FACILITY OTHER PROVIDERS

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

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

PRE-ADMISSION REVIEW

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

PRE-CERTIFICATION

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

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

B. *PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS*

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

1. Network Physicians and Professional Other Providers have entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Network Physicians and Professional Other Providers will be made directly to them. Employees are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Payment for Covered Services provided to Participants by Non-network Physicians or Professional Other Providers will be made to the Employee and Employees are responsible for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

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

C. *COPAYMENTS FOR EMERGENCY ROOM VISITS*

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

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

D. DEDUCTIBLE REQUIREMENTS

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

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

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

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

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

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

COMMON ACCIDENT DEDUCTIBLE

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

1. If one family member meets the individual Deductible, then the other family members will become eligible for covered services related to the accident during the same member's calendar year. The other family members will not have to meet any additional Deductible requirements for charges related to the accident.

2. The common accident Deductible cannot be collectively met by all family members.

E. PAYMENT ALLOWANCES UNDER THIS COVERAGE

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

Network Providers

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

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

Non-network Providers

1. Covered Services will be subject to 30% Coinsurance and any applicable Copayments until Participants have reached the Out of Pocket Maximum for Non-network providers shown on the Schedule of Benefits, then
2. Covered Services will be reimbursed at 100% of the Allowable Charge over the Out of Pocket Maximum per calendar year for Non-network providers until the end of the calendar year.

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

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

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

F. CALCULATION OF OUT OF AREA PAYMENTS

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

Typically, when accessing Covered Services outside Blue Cross Blue Shield of Wyoming's service area, the Participant will obtain the Covered Services from Physicians, Professional Other Providers, Hospitals and Facility Other Providers that

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

1. BlueCard® Program
   Under the BlueCard® Program, when a Participant accesses Covered Services within the geographic area served by a Host Blue, Blue Cross Blue Shield of Wyoming will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

   Whenever a Participant access' Covered Services outside Blue Cross Blue Shield of Wyoming's service area and the claim is processed through the BlueCard® Program, the amount the Participant pays for Covered Services is calculated based on the lower of:
   a. The billed charges for the Participant's Covered Services; or
   b. The negotiated price that the Host Blue makes available to Blue Cross Blue Shield of Wyoming.

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

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

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

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

   a. Participant's Liability Calculation
      When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by Non-participating Providers, the amount the Participant pays for Covered Services will generally be based on either the Host Blue's Non-participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Participant may be liable for the difference between the amount that the Non-participating Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.
   b. Exceptions
      In certain situations, Blue Cross Blue Shield of Wyoming may use other payment bases, such as billed charges, the payment Blue Cross Blue Shield of Wyoming would make if the Covered Services had been obtained within its service area, or a special negotiated payment, as permitted under Inter-Plan Programs' policies, to determine the amount Blue Cross Blue Shield of Wyoming will pay for Covered Services rendered by Non-participating Providers. In these situations, the Participant may be liable for the difference between the amount that the Non-participating Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

BENEFITS

The following pages describe the various services and supplies that the Plan covers and to what extent these items are covered on an inpatient or outpatient basis by different types of providers.

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

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

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

A. ACCIDENTS

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

BENEFITS –

Inpatient: See ROOM EXPENSES AND ANCILLARY SERVICES.

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

See SUPPLEMENTAL ACCIDENT BENEFIT for additional information relating to accidents.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

SUPPLEMENTAL ACCIDENT BENEFIT

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

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

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

1. If one family member meets the individual Deductible, then the other family members will become eligible for covered services related to the accident during the same member's calendar year. The other family members will not have to meet any additional Deductible requirements for charges related to the accident.

2. The common accident Deductible cannot be collectively met by all family members.

LIMITATIONS AND EXCLUSIONS –

See GENERAL LIMITATIONS AND EXCLUSIONS

B. AMBULANCE SERVICES

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

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

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

LIMITATIONS AND EXCLUSIONS–

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

C. ANESTHESIA SERVICES

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

BENEFITS–

Inpatient and Outpatient: Anesthesia services provided by a Physician or C.R.N.A. are covered when necessary for covered Surgery. Allowances are determined by the type of Surgery and the amount of time necessary for anesthesia services.

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS

D. BLOOD EXPENSES

DEFINITION - "Blood" expenses include the following:

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

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

LIMITATIONS AND EXCLUSIONS–

1. General: The "limitations and exclusions" that apply to SURGERY benefits also apply to blood expense.

See GENERAL LIMITATIONS AND EXCLUSIONS

E. CARDIAC REHABILITATION

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

BENEFITS –

Inpatient: Not covered.

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

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS

F. CONSULTATIONS

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

BENEFITS–

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

Second Surgical Opinion: Benefits will be provided only for the office visit and consultation in connection with a voluntary second opinion.

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

LIMITATIONS AND EXCLUSIONS–

1. Staff Consultations: Consultations that are required by rules and regulations of a Hospital or other facility are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. DENTAL SERVICES

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

BENEFITS–

Pre-certification is required before benefits are payable for non-accidental dental related services.

Hospital:

Inpatient: If a Participant is hospitalized for at least eighteen (18) hours for one of the following reasons, benefits will be provided as shown under ROOM EXPENSES AND ANCILLARY SERVICES, when Covered Services are provided by a Hospital:

1. Excision of exostoses of the jaw, hard palate, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a prosthesis).
2. Surgical correction of accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis not originating in the teeth or gums.
5. Incision of accessory sinuses, salivary glands or ducts.
6. Reduction of dislocations of the temporomandibular joints.
7. Accidental injury (see limitation #1).
8. Removal of impacted teeth.

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

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

Physician:

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

LIMITATIONS AND EXCLUSIONS–

1. Accidental Injury Benefit: Benefits will not be provided for restoring the mouth, tooth, or jaw because of injuries from biting or chewing. Benefits will be provided for accident-related dental expenses only under the following conditions:

a. Services, supplies, and appliances must be required due to an accidental injury.
b. Treatment must be for injuries to sound natural teeth.
c. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
d. Related services must be performed within one year after the accident.

2. Hazardous Medical Conditions: If, due to a hazardous medical condition (e.g. a heart condition), a Participant must be hospitalized for a non-covered dental procedure, he or she may receive benefits for inpatient Hospital charges. However, benefits for the services provided by the dentist or oral surgeon will still be limited to those described under the Dental Expenses, if applicable.
3. Pre-certification: Before benefits will be allowed for hazardous medical conditions, Blue Cross Blue Shield of Wyoming must give written authorization of such benefits in advance of the date the Participant is hospitalized. A Physician other than a dentist or oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. Psychiatric reasons for admissions will not be considered hazardous medical conditions. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, benefits will be allowed only if written authorization is given by Blue Cross Blue Shield of Wyoming in advance of the date services are performed.
4. Restorative Services: Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
6. Physician services are not covered for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.
7. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under the Dental Expenses, if applicable.

See GENERAL LIMITATIONS AND EXCLUSIONS

DENTAL EXPENSE RIDER

Deductible Requirements: Dental expense benefits are subject to a separate Dental Deductible. The Deductible is $50.00 per Participant with a maximum Aggregate Deductible of $150.00 for Adult and Dependent Coverage and Family Coverage. The Deductible does not apply to Preventive and Diagnostic Services.

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

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

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

1. Extractions (except extractions for orthodontics).
2. Oral Surgery (excluding procedures covered under the medical portion of this contract).
3. Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).
4. Periodontal treatment, diseases of gums. (Periodontal benefits limited to a lifetime maximum of $1,000 per Participant. This lifetime maximum does not apply to Participants age 19 and under. This maximum does not apply toward the $2,000 Dental Expense Rider calendar year maximum.)
5. Endodontic treatment (Pulp infection and root canal therapy).
6. Injection of antibiotic drugs.
7. Space maintainers.

PROSTHODONTIC TREATMENT: Payment for Prosthodontic Treatment is limited to 80% of Allowable Charges, subject to the Dental Deductible. Participant is responsible to provide payment for the remaining 20% of the Allowable Charges.

1. Initial installation of fixed bridgework.*
2. Initial installation of partial or full removable dentures.*
3. Inlays, onlays, crowns.
4. Gold fillings.
5. Repair or replacement or addition to crowns and inlays including recementing where necessary because of:
    a. One or more teeth extracted after existing denture or bridgework was installed.
    b. Existing denture or bridgework was installed five (5) years prior to its replacement and cannot be made serviceable.
6. Replacement or alteration of full or partial denture or fixed bridgework, if required due to change due to an accidental injury requiring oral surgery, or oral surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue. The surgery must take place while covered under this Plan and must be finished within twelve (12) months after the surgery. Replacement of a full denture, if needed due to a change in the structure of the mouth, if made more than five (5) years after the initial installation of such dentures or bridgework, and more than two (2) years after the effective date of the Participant's benefits.

* Teeth must be extracted while covered under the Plan and work must be completed within twelve (12) months of the extraction.

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

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

Orthodontic Treatment that is Medically Necessary is available for Participants under the age of 19 and is not subject to any maximums stated above. To be eligible for any Medically Necessary Orthodontic Treatment covered under this provision, the Participant receiving the treatment must have been enrolled as a Dependent under this Agreement for an entire continuous 24 month period prior to receiving the Medically Necessary Orthodontic Treatment.

TREATMENT IN PROGRESS: Benefits are not provided for treatment received prior to the Participant's effective date of coverage. If a course of treatment is started prior to, and completed after, the effective date of dental coverage. Blue Cross Blue Shield of Wyoming will reimburse a pro-rated portion of the Allowable Charge for the Covered Services provided after the effective date of dental coverage.

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

MAXIMUM BENEFITS: Except as provided above for Orthodontic Treatment, the maximum benefits for Covered Services under this Dental Expense Rider for each Participant are $2,000.00 per calendar year. (NOTE: This Maximum Benefit provision does not apply to Participants under the age of 19.)

Benefit Payments:

1. Payment for Covered Services will normally be made directly to the participating dentist providing the service or supply on the basis of Allowable Charges. An explanation of benefits will be forwarded to the Employee.

2. If the estimated charges exceed five hundred dollars ($500.00), a pre-certification estimate of charges is required and should be handled as follows:

    a. The dentist should complete the claims form outlining the services to be performed, including the charges to be made, and forward it to Blue Cross Blue Shield of Wyoming at the address shown on the claim form.
    b. After review by Blue Cross Blue Shield of Wyoming, the claim form will be returned to the dentist indicating the coverage available.
    c. When the work is completed the dentist should indicate on the claim form:
        1) The specific service performed;
        2) Identify the tooth, or teeth, involved in the procedure;
        3) The date the specific service was completed;
        4) The actual charges for the service or supply.
    d. The claim form should be forwarded to Blue Cross Blue Shield of Wyoming for processing.

3. Alternate Procedures: Often there are several ways to treat a particular dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in decisions about the use of precious metals versus amalgam. Before the alternate procedures provision is used, dental consultants for Blue Cross Blue Shield of Wyoming will review the claim to verify that an alternate method of treatment would meet professional standards. If so, the payment is based on the less costly procedure if the result meets the accepted standards of dental practice. If the more costly procedure is performed, the Employee will be responsible for the excess amount over the benefits allowed for the less costly procedure.

LIMITATIONS AND EXCLUSIONS

1. Pre-certification: Before benefits will be allowed for hazardous medical conditions, Blue Cross Blue Shield of Wyoming must give written authorization of such benefits in advance of the date the Participant is hospitalized. A Physician other than a dentist or

oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. Psychiatric reasons for admissions will not be considered hazardous medical conditions. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, benefits will be allowed only if written authorization is given by Blue Cross Blue Shield of Wyoming in advance of the date services are performed.

2. Restorative Services: Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.

3. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.

4. Dentures and Bridgework: Benefits will not be provided for replacement of existing dentures or bridgework, except in the following cases:
   a. When existing partial dentures, full removable dentures or fixed bridgework cannot be made serviceable and were installed five years before replacement, and/or
   b. When replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while individual is covered.
   c. When replacement is required due to change due to an accidental injury requiring oral surgery, or oral surgery which involves changing the position of muscle attachments, or removing a tumor, cyst, torus or excess tissue.

5. Gold or other precious metals used in restorative or prosthodontic procedures will be payable at the semi-precious allowance.

6. General Exclusions: Benefits will not be provided for the following:
   a. Replacement of stolen or lost prosthetic devices
   b. Missed appointments.
   c. Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.
   d. Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth)
   e. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.
   f. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.
   g. Extra sets of dentures or other prosthetic devices or appliances.
   h. Temporary or treatment dentures.

7. Any limitations under this Dental Expense Rider on annual or calendar year maximums do not apply to Participants under the age of 19.

8. To be eligible for any Medically Necessary Orthodontic Treatment covered under this

Agreement, the Participant must be under the age of 19 and have been enrolled as a Dependent under this Agreement for an entire and continuous 24 month period prior to receiving the Medically Necessary Orthodontic Treatment.

See GENERAL LIMITATIONS AND EXCLUSIONS

H. DIABETES SERVICES

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

BENEFITS–

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

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

LIMITATIONS AND EXCLUSIONS–

See GENERAL LIMITATIONS AND EXCLUSIONS

I. HEMODIALYSIS AND PERITONEAL DIALYSIS

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

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

BENEFITS –

Pre-certification is required before dialysis benefits are payable.

Hemodialysis and peritoneal dialysis are covered when a Physician treats a Participant as an Inpatient, in the outpatient department of a Hospital or other facility, or in the Participant's home. The Plan will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Physician and required for therapeutic use.

LIMITATIONS AND EXCLUSIONS–

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

BENEFITS–

Pre-certification is required before benefits are payable.

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

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

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS.

K. HOME HEALTH CARE

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

To obtain benefits, the Participant must meet all of the following conditions:
1. The Participant would have to be admitted to a Hospital or skilled nursing facility if he or she did not receive home health care.
2. The Participant's home health care must be ordered by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the condition for which hospitalization was required.

BENEFITS–

Pre-certification is required before benefits are payable.

Inpatient: Not covered.

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

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

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

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

L. HOSPICE BENEFITS

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

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

1. The Participant must experience an illness for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
3. The attending Physician must refer the Participant to the program and must be in agreement with the plan for treatment of the Participant's condition.

BENEFITS–

Pre-certification is required before benefits are payable.

Benefits are provided for the following:

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

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

Bereavement counseling sessions for covered family members during the six (6) months following the death of the terminally ill patient. The Plan will provide benefits up to $25.00 for each bereavement counseling session for covered family members up to a limit of fifteen (15) sessions.

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

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HUMAN ORGAN TRANSPLANTS

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

1. Heart Transplants
2. Liver Transplants
3. Heart-Lung Transplants
4. Pancreas Transplants
5. Kidney Transplants
6. Corneal Transplants

BENEFITS–

Pre-certification is required before benefits are payable.

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. Transportation, meals, lodging: The cost of transportation, meals, and lodging related to a human organ transplant are not covered.
2. Coverage of these services is subject to all pre-admission review and pre-certification requirements, including the use of designated facility providers.
3. Services and supplies for which government funding of any kind is available are not covered.
4. Donor expenses are not Covered Services if the donor is a Participant but the recipient is not.
5. Donor expenses for which benefits are available from another source are not covered.
6. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

N. INHERITED ENZYMATIC DISORDERS

BENEFITS-

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

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

LIMITATIONS AND EXCLUSIONS-

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

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

BENEFITS–Benefits will be provided for Covered Services provided by a Hospital or Facility Other Provider, or by a Physician, independent pathology laboratory, or independent radiology laboratory. Routine pap smears will be paid as indicated under PREVENTIVE CARE.

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

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

Benefits for pre-admission testing will be reimbursed after the Deductible has been satisfied. Pre-admission testing that is repeated in the Hospital will not be paid unless medically necessary.

LIMITATIONS AND EXCLUSIONS–

1. Unrelated services: Services which are not related to a specific illness or injury are not covered.
2. Routine Examinations: Services related to routine examinations (such as yearly physicals or screening examinations for school, camp, or other activities) are not covered except as described under PREVENTIVE CARE.
3. Weight Loss Programs: The Plan will not pay for laboratory or X-ray services related to weight loss programs.
4. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.
5. Venipuncture/Handling Fee: Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.

See GENERAL LIMITATIONS AND EXCLUSIONS

P. MATERNITY AND NEWBORN CARE

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

Delivery services include the following:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Therapeutic termination of pregnancy prior to full term. Elective termination is covered only in the case of rape or incest.
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 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

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

BENEFITS–

Hospital:

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

Outpatient: The following charges are covered:

1. Delivery in the outpatient department of a Hospital or other facility.
2. Pathology and X-ray services (see LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

Physician: The following services are covered when obtained by an eligible female Participant and billed by a Physician:

1. Delivery services (pre- and post-natal medical care is included in the allowance for delivery services. Certain pre-natal services as required by law will be covered at 100% of Allowable

Charges without reference to the Deductible.)

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

Newborn Care:

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

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

LIMITATIONS AND EXCLUSIONS–

1. Artificial conception: The Plan will not pay for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.
2. Genetic and chromosomal testing or counseling: Genetic molecular testing is not covered except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. MEDICAL CARE FOR GENERAL CONDITIONS

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

"Outpatient Medical Care" expenses are those billed by a Physician, Hospital, or Other Facility Provider for Covered Services rendered in the provider's office, the outpatient department of a Hospital or Other Facility Provider, or in the Participant's home, for a condition which does not require Surgery.

BENEFITS–

Hospital:

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

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

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

Physician:

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

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

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

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

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS

R. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

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

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

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

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

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

BENEFITS–

Mental Health Care

Inpatient:

Hospital: Benefits will be based on the Allowable Charges.

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

Intensive Outpatient:

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

Other Outpatient or Office:

Benefits will be based on the Allowable Charges.

Substance Use Disorder Care

NOTE: Detoxification is covered only if followed by either an inpatient stay in a Hospital or residential chemical dependency treatment facility, or by an outpatient treatment program within fourteen (14) days of the receipt of the detoxification services.

Inpatient:

Hospital: Benefits will be based on the Allowable Charges.

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

Outpatient:

Benefits will be based on the Allowable Charges.

NOTE: Network Providers have agreed to accept Blue Cross Blue Shield of Wyoming's Allowable Charges as payment in full and will not bill Participants for amounts that exceed Blue Cross Blue Shield of Wyoming's Allowable Charges. Reimbursement for care rendered by a provider not participating with Blue Cross Blue Shield of Wyoming will be made directly to Participants on the same basis as if the provider were Network. Participants may be responsible for amounts that exceed Blue Cross Blue Shield of Wyoming's Allowable Charges. Charges in excess of the Allowable Charges will not apply toward the Deductible or Coinsurance Maximum.

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS

S. PRESCRIPTION DRUGS AND MEDICINES

"Prescription Drugs and medicines" are drugs and medicines, including insulin, prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an illness or injury, including prescription vitamins, oral contraceptives, contraceptive devices (including hormonal implants), and contraceptive injections.

BENEFITS -

Outpatient Prescription Drugs will be administered by Magellan Rx. For further information please contact Magellan Rx toll-free (800) 424-0472 or through their web-address at www.MagellanRx.com**.**

Participants can find a copy of a claim form on Magellan Rx website and can mail to the following address for reimbursement:

Magellan Rx Management
4801 E Washington St Suite 100
Phoenix, AZ 85034

LIMITATIONS AND EXCLUSIONS–

See GENERAL LIMITATIONS AND EXCLUSIONS

T. PREVENTIVE CARE

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

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

BENEFITS –

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

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

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

B. Birth through age 21:

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

C. Participants age 6 and older:

1. Routine physical examination (office visit) – males 1 per calendar year
2. Well-woman preventive care visits as medically appropriate
3. Adult aortic aneurysm screening for male Participants ages 65-75– lifetime maximum of 1 screening
4. Alcohol misuse screening and behavioral counseling intervention – 1 visit per calendar year for Participants age 6-17; unlimited for Participants age 18 and older
5. Asymptomatic bacteriuria screening – pregnant women only
6. Hepatitis B virus infection screening – pregnant women only
7. Rh (D) incompatibility screening – pregnant women only
8. Osteoporosis screening once every 2 calendar years – females age 65 and older unless at risk, then age 60 and older
9. Iron deficiency anemia screening – pregnant women only
10. Sexually transmitted disease (STD) screening:

    a. Chlamydial infection screening – males age 16-18 and females age 6 and older
    b. Gonorrhea infection screening – males age 16-18 and females age 6 and older
    c. Syphilis infection screening – pregnant women and men and women at risk

11. Counseling for sexually transmitted infections
12. Screening for diabetes in pregnant women 24-28 weeks gestation
13. HPV Testing – 30 yrs of age every 3 years
14. Screening & counseling for interpersonal & domestic violence
15. Lactation support & counseling services – 2 visits per pregnancy
16. Breast Pump – 1 pump per pregnancy (manual or electric pump from a Participating home medical equipment provider only). Prior approval is required for Hospital grade pumps.
17. Counseling and screening for HIV
18. Contraceptive methods & management (medical) – female sterilizations; IUD inserted or removed & inserted on the same day; injections used to prevent conception
19. Diagnostic screening procedure for HIV testing for at risk Participants and pregnant women
20. Type 2 diabetes mellitus screening
21. Immunizations as recommended by the CDC
22. Colorectal cancer screening for Participants age 50 through 75:

    a. Fecal occult blood test – 1 per calendar year
    b. Colonoscopy (including related services) – 1 every 10 years OR
    c. Sigmoidoscopy (including related services) – 1 every 5 years

23. Colonoscopy services to include preliminary office visit and polyp removal &

pathology

24. Bowel prep medications required for the preparation of a Preventive colonoscopy – cover generic bowel prep medications at 100%, brand will continue to take cost-share
25. Cervical cancer screening and related office visit – 1 per calendar year
26. PSA test – 1 per calendar year for Employee and covered spouse only
27. Mammogram screenings –for Employee and covered spouse only
28. Tobacco cessation counseling – 8 visits per calendar year
29. Lipid disorders screening (1) every 5 calendar years
30. BRCA testing and genetic counseling if appropriate for females whose family history is associated with an increased risk for breast and ovarian cancer
31. Screening for lung cancer (screening with low-dose computed tomography [LDCT]) – 1 per calendar year for Participants age 55 through 80
32. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors – 12 per calendar year
33. Screening for high blood pressure in adults – cover Ambulatory Blood Pressure Monitoring (ABPM) for diagnostic confirmation before starting treatment at 100%
34. Routine prenatal services are covered at 100%

D. Biometric screenings:

Benefits for biometric screening performed during Fremont County's Employer Sponsored Health Fair (or by an individual provider in the event the Participant cannot attend the Health Fair) will be provided at 100% of the Allowable Charges with a maximum of one (1) screening per calendar year. Benefits are limited to the covered Employee and covered spouse and tests done for biometric screening will not count against other Preventive Care maximums. NOTE: If biometric screening provided by an individual provider (rather than by the Employer Sponsored Health Fair) is not coded as a "health fair service", the screening will be subject to the Plan's annual Deductible and Coinsurance provisions.

E. Prescription Drugs – Must be filled as a prescription and submitted through Magellan Rx Management:

1. Medications for risk reduction of primary breast cancer in women 35 years of age and older:

    a. Generic drugs require no Copayment and no preventive diagnosis is required.
    b. Brand drugs are subject to any applicable Copayment and Coinsurance provisions unless the brand drug is both prescribed for preventive use and there is a demonstrated need for use of the brand rather than a generic drug. In that case, any applicable Copayment and Coinsurance would be waived.

2. Aspirin – limited to 81 mg only

    a. Ages 45 – 79 for adults
    b. For the prevention of morbidity and mortality from preeclampsia – pregnant women

LIMITATIONS AND EXCLUSIONS –

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

See GENERAL LIMITATIONS AND EXCLUSIONS

U. PRIVATE DUTY NURSING SERVICES

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

BENEFITS–

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

1. The Participant's condition would ordinarily require that the Participant be placed in an intensive or coronary care unit, but the Hospital does not have such facilities, or
2. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Participant's condition.
3. The private duty nurse is not employed by the Hospital or Physician and is not a resident of the household or a relative of the Participant.

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS–

1. Alternative Care: Benefits will not be provided for nursing services which ordinarily would be provided by Hospital staff or its intensive care or coronary care units.
2. Claims Review: Blue Cross Blue Shield of Wyoming will review all claims for appropriateness and Medical Necessity.
3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the Participant or the Participant's family. (Examples: bathing, feeding, exercising, homemaking, moving the Participant, giving medication, or acting as a companion or sitter.) In other words, services which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. REHABILITATION

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

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

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

"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–

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

Inpatient: Benefits will be provided to a maximum of thirty (30) days per Participant per calendar year. In the case of a spinal cord or head injury, or a cerebral vascular accident (CVA or stroke), benefits are increased to a maximum of sixty (60) days per Participant per calendar year.

Outpatient: Benefits will be provided for physical therapy (maximum of forty [40] visits per Participant per calendar year), occupational therapy (maximum of forty [40] visits per Participant per calendar year) and speech therapy (maximum of twenty-five [25] visits per Participant per calendar year).

LIMITATIONS AND EXCLUSIONS–

Cardiac rehabilitation: For information on cardiac rehabilitation, see CARDIAC REHABILITATION.

See GENERAL LIMITATIONS AND EXCLUSIONS

W. ROOM EXPENSES AND ANCILLARY SERVICES

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

"Ancillary services" are those services and supplies (in addition to room services) that Hospitals and Other Facility Providers bill for and regularly make available to Participants when such services are provided for the treatment of the condition for which the Participant requires care. Such services include, but are not limited to:

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

BENEFITS–

Inpatient:

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

Outpatient: Ancillary services billed by a Hospital or Facility Other Provider are covered. For additional outpatient benefits, see the following sections:

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

LIMITATIONS AND EXCLUSIONS–

1. Medical Care for General Conditions: All benefits for room expenses and ancillary services related to general conditions are paid according to MEDICAL CARE FOR GENERAL CONDITIONS.
2. Mental Health or Substance Use Disorders: All benefits for room expenses and ancillary services related to these conditions are paid according to the section of this Plan titled MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.
3. Personal or Convenience Items: Benefits will not be provided for services and supplies provided for personal convenience which are not related to the treatment of the Participant's condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

4. Private Room Expenses: If the Participant has a private room in a Hospital, Allowable Charges under the Plan are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

See GENERAL LIMITATIONS AND EXCLUSIONS

X. SKILLED NURSING FACILITY

DEFINITION - A facility other provider which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to Participants requiring convalescent and rehabilitation care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

1. Minimal care, custodial care, ambulatory care, or part-time care services, or

2. Care or treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis.

BENEFITS –

Pre-certification is required before benefits are payable.

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

1. Care is provided under the recommendation and general supervision of a Physician;

2. Care begins within fourteen (14) days after discharge from a required Hospital confinement of at least three (3) days in length for which room and board benefits are paid;

3. Care is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital confinement; and

4. The care provided is not custodial care.

Inpatient: Payment is to be made for daily charges for room and board and general nursing services in a licensed, skilled nursing facility to a maximum of sixty (60) days per confinement per Participant.

Outpatient: Not covered.

Physician

Inpatient and Outpatient: Not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. SUPPLIES, EQUIPMENT AND APPLIANCES

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

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

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

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

BENEFITS–

1. Durable medical equipment–Benefits will be provided for either the rental or the purchase of durable medical equipment, whichever is less expensive. When a purchase is authorized, benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment. Durable medical equipment includes, but is not limited to, portable humidifiers and whirlpool attachments.
2. Medical supplies, including but not limited to:
   a. Colostomy bags and other supplies for their use.
   b. Catheters.
   c. Dressings for cancer, diabetic and decubitus ulcers and burns.
   d. Syringes and needles for administering covered drugs, medicines, or insulin.
3. The following prosthesis and orthopedic appliances are covered, as well as fitting, adjusting, repairing, and replacement due to wear, or a change in the Participant's condition which makes a new appliance necessary.
   a. Artificial arms or legs.
   b. Leg braces, including attached shoes.
   c. Arm and back braces.
   d. Cervical collars.
   e. Surgical implants.
   f. Artificial eyes.
   g. Pacemakers
   h. Breast prosthesis and special bras.
4. One set of prescription glasses, intraocular lenses or contact lenses is covered when necessary to replace the human lens lost through intraocular Surgery or ocular injury. Replacement is covered if the Participant’s Physician recommends a change in prescription.
5. Oxygen – The Plan will pay for oxygen and the equipment needed to administer it.
6. Breast pumps as indicated under PREVENTIVE CARE. Pre-certification is required for any Hospital grade breast pumps.
7. Wigs – when hair loss is the result of radiation or chemotherapy.
8. Hospital beds when deemed medically appropriate by Blue Cross Blue Shield of Wyoming’s case management team.

LIMITATIONS AND EXCLUSIONS–

1. Deluxe or Luxury Items: If the supply, equipment, or appliance which the Participant orders includes more features than are warranted for the Participant's condition, the Plan will allow only up to Allowable Charges for the item that would have met the Participant's medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars.")

   Deluxe equipment is covered only when additional features are required for effective medical treatment, or to allow the Participant to operate the equipment without assistance.

2. Durable Medical Equipment: Items such as air conditioners, purifiers, dehumidifiers, exercise equipment, waterbeds, biofeedback equipment, and self-help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical condition.
3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered.
4. Medical Supplies: Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics.)
5. Special Braces: Benefits will not be provided for special braces or special equipment.

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. SURGERY

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

BENEFITS–

Hospital:

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

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

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.

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

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

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.

   Coverage of cosmetic surgery is subject to all pre-admission review and pre-certification requirements, including the use of designated facility providers.

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

NOTE: Subject to Pre-certification, any Participant who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

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

2. Dental Surgery: For a complete description of benefits allowed for dental services, see DENTAL SERVICES.
3. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the primary Surgery. Additional benefits are not allowed for these procedures.
4. Obesity and Weight Loss: Benefits will be provided for Surgery required as the result of obesity only as specified in GENERAL LIMITATIONS AND EXCLUSIONS.
5. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.
6. Private Room Expenses: If the Participant has a private room in a Hospital, Allowable Charges under the Plan are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.
7. Sterilization Procedures: Sterilization procedures and related expenses will be covered. See PREVENTIVE CARE for certain Sterilization Procedures covered at 100% of the Allowable Charges without regard to Deductible, Copayment or Coinsurance that might otherwise apply. Reversals of sterilization procedures are not covered.
8. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

AA. SURGICAL ASSISTANTS

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

BENEFITS–

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

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

LIMITATIONS AND EXCLUSIONS–

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

See GENERAL LIMITATIONS AND EXCLUSIONS

BB. TELADOC

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

BENEFITS –

TelaDoc phone consultations are provided as a covered benefit.

GENERAL LIMITATIONS AND EXCLUSIONS

1. Charges for phone or video consultations with a Physician or other provider are not covered unless the employer is contracted with a service providing such consultations.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. THERAPIES
(CHEMOTHERAPY, RADIATION, RESPIRATORY)

DEFINITIONS-"Chemotherapy" is drug therapy administered as treatment for conditions of certain body systems.

"Radiation therapy" is the treatment for malignant diseases and other medical conditions by means of X-ray, radon, cobalt, betatron, telecobalt, and telecesium, as well as radioactive isotopes.

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

BENEFITS–

Pre-certification is required before benefits are payable for chemotherapy and radiation therapy.

Hospital:

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

1. Chemotherapy.
2. Radiation therapy.
3. Respiratory therapy.

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

1. Chemotherapy (drug and administration charges).
2. Radiation therapy.
3. Respiratory therapy.

Physician:

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

1. Chemotherapy.
2. Radiation therapy.
3. Respiratory therapy.

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

1. Chemotherapy (drug and administration charges).

2. Radiation therapy.
3. Respiratory therapy.

LIMITATIONS AND EXCLUSIONS–

1. Physical, occupational and speech therapy: Benefits will not be provided for physical, occupational or speech therapy services (except as described under REHABILITATION).
2. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

DD. TRAVEL MEDICAL BENEFIT

A "travel medical benefit" is available when Participants travel for cardiac care, cancer care, knee and hip replacement, spine surgery, and transplants covered under this Plan when provided by a Blue Distinction Center in Colorado, Utah, or Montana, or for cancer treatment at the University of Texas MD Anderson Center, the Johns Hopkins Kimmel Cancer Center in Maryland, or the Taussig Cancer Institute at the Cleveland Clinic in Ohio.

BENEFIT-

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

   To receive this benefit the following steps must be completed:

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

2. Travel expenses for the Participant and one companion. Travel expenses are limited to $200 per day for food, lodging and travel (limited to a maximum of $2,500 per participant per calendar year).

   To receive this benefit the following steps must be completed:

   a. Confirm your procedure is eligible by calling Blue Cross Blue Shield of Wyoming at 1-800-442-2376.
   b. Find a Blue Distinction Center: **bcbs.com/why-bcbs/blue-distinction**
   c. Travel with one companion is allowed. Receive up to $200 per day for: food, lodging, and travel (limited to $2500 per calendar year per Participant)
   d. Retain travel receipts and mail to:

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

LIMITATIONS AND EXCLUSIONS-

See GENERAL LIMITATIONS AND EXCLUSIONS

EE. VISION SERVICES

DEFINITIONS - "Vision Care" expenses are those billed by a Physician or Other Professional Provider for the routine care of the eye and the prescribing of corrective lenses.

BENEFITS –

1. The following Covered Services performed by a licensed Physician, Optician, Optometrist or Ophthalmologist will be payable as shown in the Schedule of Vision Benefits below:

    a. Vision examinations, limited to one exam per calendar year.
    b. Lenses, limited to one pair of lenses per calendar year.
    c. Frames, limited to repair of existing frames and/or purchase of one set of new frames, per two (2) calendar years.
    d. Contact lenses, providing there were no benefits paid for frames or (non-contact) lenses during the same period.

2. Schedule of Benefits is as follows:

Calendar year Deductible – applies only to the vision exam Per Participant	$25
Vision Examination (including refractions)	100% after Deductible
Calendar year maximum benefit	1 routine exam
Lenses	100%, no Deductible applies
Calendar year maximum benefit	1 pair of lenses
Benefit Allowances (per pair):	
Single	$65
Bifocal	$100
Trifocal	$110
Contact Lenses Calendar year maximum benefit	$115
Frames	100%, no Deductible applies
Maximum Benefit per 2 calendar years	$100; for repair of existing frames and/or purchase of one new set of frames

LIMITATIONS AND EXCLUSIONS–

1. Benefits are not provided for expenses for which the Participant would not legally have to pay if there were no coverage.
2. Non-prescription sunglasses are not covered.

3. Expenses which are payable under any other part of this Plan are not covered.
4. Expenses for any injury or illness due to employment with any employer or self-employment are not covered.
5. Benefits are not provided for corneal resurfacing procedures or radial keratotomy. (An exception may be made when corrective lenses cannot be used.)

See GENERAL LIMITATIONS AND EXCLUSIONS

QUALIFYING FOR THE DISEASE MANAGEMENT PRESCRIPTION INCENTIVE

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

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

1. Under the care of a Physician with a diagnosis of hypertension, hyperlipidemia, diabetes, and/or asthma;

2. Annual visit with the Physician to renew prescriptions covered by the program. Signed Physician statements are required by the Wellness Program;

3. Meeting with the Wellness Program Coordinator quarterly;

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

A. ACUPUNCTURE

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

B. ALTERNATIVE MEDICINE

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

C. ARTIFICIAL CONCEPTION

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

D. AUTOPSIES

Services related to autopsies are not covered.

E. BIOFEEDBACK

Services related to biofeedback are not covered.

F. CLINICAL TRIALS

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

G. COMPLICATIONS OF NON-BENEFIT SERVICES

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

H. CONVALESCENT CARE

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

I. COSMETIC SURGERY

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

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

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

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

J. CUSTODIAL CARE

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

K. DIAGNOSTIC ADMISSIONS

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

L. DOMICILIARY CARE

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

M. EAR WAX

Services for the removal of ear wax are not covered.

N. EDUCATIONAL PROGRAMS

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

O. 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.

P. EXPENSES INCURRED IN CERTAIN TAX SUPPORTED INSTITUTIONS

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

Q. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Procedures which are experimental or investigational in nature as defined in DEFINITIONS are not covered.

R. FELONIES OR ILLEGAL ACTS

Any injury or illness sustained during, or resulting from, the commission of, or attempt to, commit a felony, or to which a contributing cause was the Participant's being engaged in an illegal occupation or any illegal act, will not be covered.

S. FOOT CARE SERVICES

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

T. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

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

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

U. 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.

V. HAIR LOSS

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

W. 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.

X. HYPNOSIS

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

Y. LEARNING DISABILITIES

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

Z. LEGAL PAYMENT OBLIGATIONS

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

AA. MANAGED CARE PROVISIONS

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

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

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

of such medical services or supplies), in exchange for the Participant's agreement to seek or receive such medical services or supplies.

CC. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

DD. OBESITY AND WEIGHT LOSS

Obesity in itself is not considered an illness or disease, and 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 Participant is twice or more the ideal weight, or 100 pounds or more above the ideal weight, whichever is greater. This is determined by accepted standard weight tables for frame, age, height, and sex.
2. The condition of morbid obesity must be of at least five years duration.
3. Non-surgical methods of weight reduction must have been unsuccessfully attempted for at least five years under a Physician's supervision.
4. Pre-certified by Blue Cross Blue Shield of Wyoming.

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

EE. OVER THE COUNTER MEDICATIONS

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

FF. PAYMENT IN ERROR

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

GG. PERSONAL COMFORT OR CONVENIENCE

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

HH. 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.)

II. PRE-ADMISSION REVIEW (PRIOR AUTHORIZATION)

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

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

JJ. PRE-CERTIFICATION (PROSPECTIVE REQUEST)

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

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

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

KK. PROCEDURES RELATED TO STUDIES

Procedures related to studies are not covered except as expressly allowed by this Agreement. This includes any drugs and medicines, technologies, treatments, procedures, or services provided as a part of, or related to, any program, protocol, project, trial, or

study in which the patient consent and/or protocol states that the program, protocol, project, trial, or study:

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

LL. 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.

MM. REPORT PREPARATION

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

NN. ROUTINE HEARING EXAMINATIONS

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

OO. ROUTINE PHYSICALS

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

PP. SELF-INFLICTED INJURIES

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

QQ. SERVICES AFTER COVERAGE ENDS

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

RR. SERVICES NOT IDENTIFIED

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

SS. SERVICES OUTSIDE THE UNITED STATES

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

TT. SERVICES PRIOR TO THE EFFECTIVE DATE

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

UU. SUBLUXATION

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

VV. TAXES

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

WW. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

XX. THERAPIES

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

YY. TOBACCO DEPENDENCY

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

ZZ. TRAVEL EXPENSES

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

AAA. UNRELATED SERVICES

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

BBB. WAR

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

CCC. WEIGHT LOSS PROGRAMS

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

DDD. WORKERS COMPENSATION

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

GENERAL PROVISIONS

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

A. ASSIGNMENT OF BENEFITS

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

B. CHANGE TO THE PLAN

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

C. CLAIM FORMS

Blue Cross Blue Shield of Wyoming shall furnish either to the person making a claim (claimant), or to the Employer, for delivery to the person making a claim, the forms it usually furnishes for filing claims for benefits. If such forms are not furnished within fifteen (15) days of the filing of notice of claim, the claimant shall be deemed to have complied with the requirements of this Plan as to notice of claim upon submitting, within the time fixed in the Plan for filing notice of claim, written proof covering the date(s) medical services were rendered, and the character and extent of medical services for which claim is made. The Plan sponsor reserves the right to request further information to make decisions whether this section is met or not.

D. CLERICAL ERROR

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

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

E. COMPLIANCE WITH HITECH ACT

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

Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

F. COORDINATION OF BENEFITS

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Participants often have other coverage providing duplicate benefits. In the event of other coverage, the Plan will not duplicate benefits if otherwise provided for (or should have been provided had the Participant elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage, and the coverage secondarily liable shall then pay for Covered Services the unpaid balance, not exceeding its aggregate coverage or 100% of any Allowable Charges (whichever is greater), based on the following priorities:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision.
2. Group coverage will be primary over an individual policy with a non-duplication provision.
3. Coverage of a plan, which covers the patient as an Employee will be primary over a plan covering the patient as a Dependent.
4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payer. If a plan does not have this provision, the primary payer will be determined by the provision of the plan not having this paragraph.
5. The above applies for children, except in situations where the parents are separated or divorced.
    a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the plan covering the child as a Dependent of the parent without custody.
    b. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the step-parent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.
    c. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.
6. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the patient for a longer period of time shall be primary payer.

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

G. DISCLAIMER OF LIABILITY

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

H. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION

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

1. Upon a written, dated, and signed authorization by the Participant or prospective Participant or by a person authorized to provide consent for a minor or an incapacitated person;
2. If the data or information does not identify either the Participant or prospective Participant or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
3. Pursuant to statute or court order for the production or discovery of evidence; or
4. In the event of a claim or litigation between the Participant or prospective Participant and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent.
5. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: Commissioners, County Attorney, Deputy Attorney, Deputy Clerk, Deputy Treasurer, County Clerk, Payroll, Financial Assistant, Wellness Program Coordinator, and Executive Health Insurance Committee.

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

I. EXECUTION OF PAPERS

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

J. GENERAL INFORMATION ABOUT FILING CLAIMS

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

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

K. 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.

L. NOTICE OF DISCRETIONARY CLAUSE

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

M. PARTICIPANT'S LEGAL OBLIGATIONS

The Participant is liable for any actions which may prejudice the Plan sponsor's rights under this Plan. If the Plan sponsor must take legal action to uphold its rights, then it can require the Participant to pay its legal expenses, including attorney's fees and court costs. Unless the court finds that the losing party's(ies') position was not frivolous or that the losing party(ies) litigated his (their) position on a reasonable basis.

N. PHYSICAL EXAMINATION AND AUTOPSY

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

O. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

P. PRIVACY OF PROTECTED HEALTH INFORMATION

The Group is the plan sponsor of this group health plan (Plan) within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Group also administers the Plan for the benefit of the Plan and its Participants. In order for the Group

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

However, in some instances, it may be necessary for the Group to have access to a Participant's PHI in order to administer the plan. To avoid any conflict of interest that may be caused by the Group having access to a Participant's PHI for purposes of administering the Plan, the Plan hereby restricts the Group's use or disclosure of a Participant's PHI (whether it is in an electronic or paper format) as follows:

1. The Group must ensure it takes the steps necessary to reasonably and appropriately safeguard all PHI it creates, receives, maintains or transmits on behalf of the Plan.
2. The Group must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
3. The Group will neither use nor further disclose a Participant's PHI except as permitted by this Benefit Document or as required by law.
4. The Group will ensure that its agents, including subcontractors, to whom it provides a Participant's PHI, agree to the same restrictions and conditions that apply to the Group with respect to a Participant's PHI.
5. The Group will not use or disclose a Participant's PHI for any actions or decisions related to a Participant's employment or in connection with any other Employee related benefits made available to a Participant.
6. The Group will promptly report to the Plan any use or disclosure of a Participant's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
7. The Group will make available to the Plan any PHI necessary to comply with the Participant's right to access his/her PHI.
8. The Group will make available to the Plan any PHI necessary to amend and/or incorporate any amendments to PHI as required by law.
9. The Group will document disclosures it makes of a Participant's PHI and make this disclosure information available to the Plan in order to allow the Plan to provide an accounting of disclosures as required by law.
10. The Group will make its internal practices, books, and records relating to its use and disclosure of a Participant's PHI available to the U. S. Department of Health and Human Services as necessary to determine compliance with federal law.
11. The Group will, where feasible, return or destroy a Participant's PHI and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Group must limit further uses or

disclosures of a Participant's PHI to those purposes that make the return or destruction of the information infeasible.

12. The Group will ensure adequate separation between itself and the Plan in accordance with 45 C.F.R. §§164.504(f)(2)(iii) and 164.314(b)(2)(ii). Only the following Employees or classes of Employees will be given access to a Participant's PHI: The designated group contact and Employees in charge of benefit administration. These Employees' or classes of Employees' access to and use of a Participant's PHI is limited to the administrative functions that the Group performs for the Plan. Any issues relating to the Group's non-compliance of these requirements shall be handled pursuant to the requirements set out under HIPAA and other applicable federal and state law.

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

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 Participant, and with the agreement of the affected Participant.

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

R. SELECTION OF DOCTOR

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

S. SENDING NOTICES

All notices to the Participant are considered to be sent to and received by the Participant when deposited in the United States Mail with postage prepaid and addressed to the Participant at the latest address appearing on Blue Cross Blue Shield of Wyoming's membership records.

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

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

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

U. SUBROGATION

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

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

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

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

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

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

1. When a third party injures the Participant, for example, in an automobile accident or through medical malpractice.
2. When the Participant is injured on a premises owned by a third party.
3. When the Participant is injured and Benefits are available to Participant or Participant's dependents, under any law or under any type of insurance, including, but not limited to:
   a. No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by the Participant to treat those benefits as secondary to this Agreement.
   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 Plan not more than forty-five (45) days after receipt of written proof of the claim and supporting evidence. Such supporting evidence may include, but not be limited to, medical records required for claim analysis and payment in accordance with this Plan. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Plan, the 45-day claim payment time will not commence until all such necessary records are received by Blue Cross Blue Shield of Wyoming from any source.

W. WRITTEN NOTICE OF CLAIM

1. Proof of claim must be furnished to Blue Cross Blue Shield of Wyoming at its office at 4000 House Avenue, Cheyenne, Wyoming 82003-2266.

2. The Plan sponsor will not be liable under this Plan unless proper notice (proof) is furnished to Blue Cross Blue Shield that Covered Services have been rendered to a Participant. Written notice must be given within twelve (12) months after completion of services that are covered under this Plan. The notice must include the data necessary for Blue Cross Blue Shield of Wyoming to determine benefits. An expense will be considered incurred on the date the service or supply was rendered.
3. Failure to give notice to Blue Cross Blue Shield of Wyoming within the time specified above will not invalidate nor reduce any claim for benefits if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

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

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

1. Emergency Services

   The Participant and/or the Participant's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's denial of a claim for benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 72 hours after receiving the request.

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

2. Pre-Admission Review, Pre-Certification and Non-emergency Services

   The Participant and/or the Participant's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's denial of a Hospital admission, pre-certification of services, or claim for benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 45 days after receiving the request.

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

Participants should mail or hand deliver their requests to:

BLUE CROSS BLUE SHIELD OF WYOMING

4000 House Avenue
PO Box 2266
Cheyenne, WY 82003-2266

Participants have the right to be represented by an attorney or other duly authorized representative at any stage of their appeal. Participants or their representative have the right to review documents that pertain to their appeal. These documents are on file in the office of Blue Cross Blue Shield of Wyoming at the above address. Blue Cross Blue Shield of Wyoming will need at least 72 hours notice to assemble the documents pertaining to an appeal.

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

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

If Blue Cross Blue Shield of Wyoming denies the Participant's request for the provision of, or payment for, a health care service or course of treatment on the basis that it is not medically necessary, or on another similar basis, the Participant may have a right to have the adverse determination reviewed by health care professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice. The Participant must submit a request for external review within 120 days after receipt of the claims denial to Blue Cross Blue Shield of Wyoming's appeals office. For a standard external review, a decision will be made within 45 days of receiving the request.

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

1. Medical Necessity Denials

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

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

To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial: Request form, release for records, a health care professional's statement of medical necessity and any other

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

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

2. All Other Denials

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

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

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

Z. WYOMING INSURANCE DEPARTMENT

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