CYCLONE DRILLING

Plan Document and Summary Plan Description

Original Effective Date
October 1, 2001

Restated Effective Date
October 1, 2025

Claims Supervisor:

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

CYCLONE DRILLING

Restated October 1, 2025

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

ESTABLISHMENT OF THE PLAN

Cyclone Drilling (the "Employer" or the "Plan Sponsor") has adopted this restated Plan Document and Summary Plan Description effective as of October 1, 2025, for the Cyclone Drilling Medical Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of October 1, 2001.

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

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE OF NON-DISCRIMINATION PRACTICE

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

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

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

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

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

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

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

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

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

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

TABLE OF CONTENTS

APPROVAL

BENEFIT BOOKLET

ACKNOWLEDGMENT OF RECEIPT AND APPROVAL

The Benefit Booklet for Cyclone Drilling

is approved.

Effective date is October 1, 2025.

INTRODUCTION

This document describes the Medical Plan (The Plan) maintained for the exclusive benefit of the Employees of Cyclone Drilling. This plan represents both the Plan Booklet and Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, as amended from time to time. 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. Cyclone Drilling is the fiduciary of this Plan.

GENERAL INFORMATION

NAME OF PLAN: Cyclone Drilling Medical Benefit Plan

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

PLAN NUMBER: 501

TAX ID NUMBER: Cyclone Drilling 83-0222580
Cyclone Trucking 83-0312349
Squaw Valley Apartments 83-0287981
PP&J (disregarded entity wholly owned by Cyclone Drilling) 20-0141994

PLAN YEAR: October 1-September 30

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/ PLAN SPONSOR: Cyclone Drilling
PO Box 908
Gillette, WY 82717
307-682-4161

AGENT FOR SERVICE OF LEGAL PROCESS: Cyclone Drilling
PO Box 908
Gillette, WY 82717
307-682-4161

NAMED FIDUCIARY: Cyclone Drilling
PO Box 908
Gillette, WY 82717
307-682-4161

NETWORK: PPO Participating Network
www.yourwyoblue.com
307-634-1393 or 800-442-2376

CLAIMS SUPERVISOR: Blue Cross Blue Shield of Wyoming (BCBSWY)
4000 House Avenue
PO Box 2266
Cheyenne, WY 82003
307-634-1393 or 800-442-2376
www.yourwyoblue.com

COBRA ADMINISTRATOR: Rocky Mountain Reserve
PO Box 2440
Omaha, NE 68103
1-888-722-1223

ERISA: This Plan is subject to ERISA

SCHEDULE OF BENEFITS

EMPLOYER NAME: Cyclone Drilling
GROUP NUMBER: 10358485 et al
EFFECTIVE DATE: October 1, 2025

PROBATIONARY PERIODS: 30 days for drillers & night supervisors, 60 days for all other employees except tool pushers & supervisors, who are effective on the date of hire (See DEFINITIONS section for definition of PROBATIONARY PERIOD.)

OPEN ENROLLMENT: The Open Enrollment Period for this group is September 1 through September 30 annually for an effective date of October 1.

Hospital care benefits are based on Allowable Charges.

Physician benefits are based on Allowable Charges.

Member's Calendar Year Cost Sharing Amounts		
Cost-Sharing Amounts	**Member's Responsibility for Covered Services**	
Deductible: Participating & Non-Participating Deductibles cross-accumulate.	**Participating**	**Non-Participating**
Single Coverage	$1,000	$1,500
Family Coverage	$2,000	$3,000
NOTE: The Prescription Drug Benefit Copayments and Coinsurance cannot be applied to the Deductible.		
Coinsurance Amount (All classes of coverage)**:** Participating & Non- Participating Coinsurance cross accumulates.	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied

Out-of-Pocket Maximum Amount:	Participating	Non-Participating
Single Coverage	$2,000	$3,000
Family Coverage	$4,000	$6,000
Once the Out-of-Pocket Maximum Amount is met, benefits will be paid at 100% of Allowable Charges for the remainder of the calendar year.		
NOTE: Charges that exceed the Allowable Charges for non-Participating providers and charges for services not covered by this Plan will NOT count toward satisfaction of Members' Deductible or Out-of-Pocket Maximum Amount. Members may be responsible for amounts over the Allowable Charges.		

Benefits	Participating	Non-Participating
Accidents	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Acute Rehabilitative Services *Authorization Review required	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Allergy Services *Certain services require Authorization Review	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Ambulance Services (Air and Ground)	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied. Medical emergencies subject to 40% after the Deductible has been satisfied
Anesthesia Services	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Anesthesia Services performed in a Physician's office or at an Ambulatory Surgical Facility	20% after the Deductible has been satisfied	40% after the Deductible has been satisfied
Blood Expenses	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Cardiac Rehabilitation (Phases I & II only)	40% after the Deductible has been satisfied. Limited to a maximum of 36 visits per Member per benefit period.	60% after the Deductible has been satisfied. Limited to a maximum of 36 visits per Member per benefit period.
Chemotherapy and Radiation Therapy *Certain services require Authorization Review	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Consultations	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied

Dental Services *Certain Dental Services require Authorization Review	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Diabetes Services	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Emergency Room (includes emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department)	40% after the Deductible has been satisfied	40% after the Participating Deductible has been satisfied
Hemodialysis and Peritoneal Dialysis	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
High Dose Chemotherapy and/or Radiation Therapy with Bone Marrow Transplant and/or Peripheral Stem Cell Support	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Home Health Care	40% after the Deductible has been satisfied. Limited to a maximum of 180 days per Member per calendar year.	60% after the Deductible has been satisfied. Limited to a maximum of 180 days per Member per calendar year.
Hospice (Inpatient) *Authorization Review required	20% after the Deductible has been satisfied	40% after the Deductible has been satisfied
Hospice (Outpatient)	20% after the Deductible has been satisfied	40% after the Deductible has been satisfied
Hospitalization *Authorization Review required	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Human Organ Transplants	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Inherited Enzymatic Disorders	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Laboratory, Pathology, X-Ray, Radiology, & Related Testing Services *Certain services require Authorization Review	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Maternity and Newborn Care	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Medical Care for General Conditions	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied

Mental Health or Substance Use Disorder	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Office Visit- Primary Care	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Office Visit - Specialist	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Office Visit – Urgent Care	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Prescription Drugs	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Preventive Care	Covered at 100%	Covered at 100% if done at a health fair
Private Duty Nursing Services *Authorization Review required	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Room Expense and Ancillary Services	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Skilled Nursing Facility *Authorization Review required	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Spinal Manipulations	40% after the Deductible has been satisfied. Limited to eight (8) visits per Member per calendar year.	60% after the Deductible has been satisfied. Limited to eight (8) visits per Member per calendar year.
Supplies, Equipment and Appliances *Some items require Authorization Review	40% after the Deductible has been satisfied. Diabetic supplies purchased through a Participating Pharmacy are subject to the Prescription Drug cost sharing amounts outlined below. Diabetic supplies purchased through a non-Participating Pharmacy are not covered out of network.	60% after the Deductible has been satisfied. Diabetic supplies purchased through a non-Participating Pharmacy are not covered out of network.
Surgery (Inpatient/Outpatient) *Authorization Review required for Inpatient Hospitalization *Some Surgical Procedures may require Authorization Review, refer to the Benefits section under SURGERY for details.	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied

Surgery (Inpatient/Outpatient) performed in a Physician's office or at an Ambulatory Surgical Facility *Authorization Review required for Inpatient Hospitalization *Some Surgical Procedures may require Authorization Review, refer to the Benefits section under SURGERY for details.	20% after the Deductible has been satisfied	40% after the Deductible has been satisfied
Surgical Assistants	40% after the Deductible has been satisfied	60% after the Deductible has been satisfied
Therapy (Occupational, Physical and Speech)	40% after the Deductible has been satisfied. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year.	60% after the Deductible has been satisfied. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year.
Prescription Drug Benefit	**Participating**	**Non-Participating**
Generic	$5 Copayment and 50% as Coinsurance – Retail (30 days) $15 Copayment and 50% as Coinsurance – Mail (90 days)	Not Covered
Preferred Brand	$10 Copayment and 50% as Coinsurance – Retail (30 days) $30 Copayment and 50% as Coinsurance – Mail (90 days)	Not Covered
Non-preferred Brand	$10 Copayment and 50% as Coinsurance – Retail (30 days) $30 Copayment and 50% as Coinsurance – Mail (90 days)	Not Covered

Paydhealth	Drugs listed on the Paydhealth drug list require Authorization Review. Covered Persons using drugs included on the Paydhealth drug list must enroll in the Paydhealth Select Drugs and Products Program. Contact the Paydhealth contact center for additional information at 877-869-7772. Failure to meet authorization criteria, including enrollment in the Paydhealth Select Drugs and Products Program when applicable, will result in a cost containment penalty equal to a 100% reduction in benefits payable.
Out-of-Pocket non-compliance penalties for drugs included on the Paydhealth drug list do not contribute to meeting the Deductible or Out-of-Pocket Maximum Amount.	

This coverage provides benefits for many Covered Services, including those listed below. Benefit levels may vary. Please see sections on HOW BENEFITS WILL BE PAID and BENEFITS for a more complete explanation of the benefits.

MEDICAL BENEFITS:

Accidents
Acute Rehabilitative Services
Allergy Services
Ambulance Services
Anesthesia Services
Blood Expenses
Cardiac Rehabilitation
Chemotherapy and Radiation Therapy
Consultations
Diabetic Services
Home Health Care
Hospice Benefits
Hemodialysis and Peritoneal Dialysis
Human Organ Transplant
Inherited Enzymatic Disorders
Laboratory, Pathology, X-ray, and Radiology Services
Maternity & Newborn Care
Medical Care for General Conditions
Mental Health or Substance Use Disorder Care
Podiatry Services
Prescription Drugs & Medicine

Preventive Care
Room Expenses & Ancillary Services
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)
Surgical Assistants
Therapies (Respiratory, Occupational, Speech, Physical Therapy)

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

THIS COVERAGE ALSO INCLUDES THE FOLLOWING:

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

DEFINITIONS

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

A. ADULT AND DEPENDENT COVERAGE

Coverage provided to the Employee and one or more eligible Dependent children.

B. ADVERSE BENEFIT DETERMINATION

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for , a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

C. AGGREGATE DEDUCTIBLE

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

D. 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.

E. ANNIVERSARY DATE

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

F. AUTHORIZATION REVIEW

The process of a Member formally requesting that Blue Cross Blue Shield of Wyoming approve specified healthcare services for Member. Authorization Review does not guarantee payment of benefits. An Authorization Review will be processed within 15 days and 72 hours for urgent care.

G. BILLING SERVICE DATE

The date used in assigning effective dates and issuing billings.

H. BLUECARD® PROGRAM

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

I. CLAIMS SUPERVISOR

Blue Cross Blue Shield of Wyoming.

J. COINSURANCE

A percentage of the cost of Covered Services, as described below, that is a Member's responsibility after the Deductible has been met. Blue Cross Blue Shield of Wyoming calculates a Member's Coinsurance Amount off of the Allowable Charges. In the case of services obtained out of Blue Cross Blue Shield of Wyoming's service area, a local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require a Coinsurance calculation that is not based on the discounted price the provider has agreed to accept from the Host Plan, but is, instead, based on the provider's full billed charges. This may result in a higher or, in some cases, lower Coinsurance payment for certain claims incurred when outside of Blue Cross Blue Shield of Wyoming's service area. Because of the many different arrangements between the host Plans and their providers, it is not possible to give specific information for each out-of-area provider. (NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.)

K. CONDITION

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

L. COPAYMENT

A specified dollar amount payable by the Member for certain Covered Services. Copayments do not accumulate toward the Member's satisfaction of the Deductible. (NOTE: Prescription Drug and Medicine benefits are subject to separate Copayment requirements.)

M. COVERED SERVICE

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

N. DEDUCTIBLE

A specified amount of expense for Covered Services that the Member must pay within a calendar year before benefits are provided.

O. DEPENDENT

An Employee's Dependents are the following:

1. Legal spouse shall not be one who is legally separated from the Employee.
2. The children, including newborn children, stepchildren, adopted children, Dependents which the court has decreed support to the Employee and legal wards of the Employee or the Employee's spouse. The limiting age for covered children is the end of the month in which age 26 is attained.

   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.

P. DESIGNATED PROVIDER

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

Q. DIAGNOSTIC SERVICE

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

R. 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.

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

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

T. FACILITY PROVIDER

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

1. Substance Use Disorder Treatment Center or Facility is a detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism, or a Facility Provider which is primarily engaged in providing detoxification and rehabilitation treatment for Substance Use Disorders.
2. Ambulatory Surgical Facility is a Facility Provider, with an organized staff of Physicians, which:
   a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis,
   b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility,
   c. does not provide inpatient accommodations, and
   d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician, or Professional Provider.
3. Freestanding Dialysis Facility is a Facility Provider other than a Hospital which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
4. Outpatient Psychiatric Facility is a Facility Provider which for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Health Disorder on an outpatient basis.
5. Psychiatric Hospital is a Facility Provider which for compensation from its patients, is primarily engaged in providing rehabilitation care services on an inpatient basis. Psychiatric rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
6. Skilled Nursing Facility is a Facility Provider which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:
   a. minimal care, custodial care, ambulatory care, or part-time care services, or
   b. care or treatment of Mental Health Disorder, alcoholism, drug use or pulmonary tuberculosis.
7. Hospice is a Facility Provider that offers a coordinated program of home care for a terminally ill patient and the patient's family.
8. Other medical facilities not specifically listed above.

U. FAMILY COVERAGE

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

V. FORMULARY

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

W. GENETIC INFORMATION

Information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

X. 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.

Y. HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

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

Z. 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.

AA. HOSPITAL

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

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

h. place for the treatment of Mental Health Disorder,
i. place for the treatment of alcoholism or drug use,
j. place for the provision of hospice care,
k. place for the provision or rehabilitative care,
l. place for the treatment of pulmonary tuberculosis.

BB. INCURRED

The date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

CC. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

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

DD. INITIAL MEASUREMENT PERIOD

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

EE. INITIAL STABILITY PERIOD

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

FF. INPATIENT

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

GG. 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.

HH. LEAVE OF ABSENSE

A period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Employer, and as provided for in the Employer's rules, policies, procedures and practices where applicable.

II. LEGAL SEPARATION

Legal Separation shall mean an arrangement to remain married but live apart, following a court order.

JJ. LEGALLY EMPLOYED

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

KK. MEASUREMENT PERIOD

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

LL. MEDICAL CARE

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

MM. MEDICAL EMERGENCY

A Medical Emergency Condition is:

1. A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
    b. Serious impairment to bodily functions, or
    c. Serious dysfunction of any bodily organ or part, or
    d. With respect to a pregnant woman who is having contractions: if there is inadequate time to effect a safe transfer to another Hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.
2. Emergency Services means, with respect to an Emergency Medical Condition:
    a. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

b. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

NN. MEDICAL NECESSITY

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

OO. MEDICAL POLICY

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

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

PP. MEMBERS

The Employee and the Employee's covered Dependents.

QQ. MENTAL HEALTH OR SUBSTANCE USE DISORDER

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

RR. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPEA)

This legislation signed into United States law on September 26, 1996 that requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a Group health plan or health insurance issuer offering coverage in connection with a Group health plan. The Mental Health Parity and Addiction Equity Act does not require a Plan to offer Mental Health Benefits.

SS. OPEN ENROLLMENT PERIOD

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

TT. OUT-OF-POCKET MAXIMUM AMOUNT

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

There are separate Out-of-Pocket Maximum Amounts for Participating and non-Participating Allowable Charges. Amounts credited toward the satisfaction of one type of Out-of-Pocket Maximum Amount will also work toward the satisfaction of the other type of Out-of-Pocket Maximum Amount.

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

UU. OUTPATIENT

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

VV. PARTICIPATING

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

NOTE: A Hospital, Facility Provider, Physician, or Professional Provider who has not entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross

Blue Shield plan is called non-Participating. When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by such non-Participating providers, the amount(s) a Member pays for Covered Services will generally be based on either the Host Blue's non-Participating provider local payment or the pricing arrangements required by applicable State Law. In some instances, a non-Participating Physician or Professional Provider may bill Members directly and payments will be made directly to the Member. Similarly, if Members choose a non-Participating Hospital or Facility Provider, they may be billed directly and payments may be made directly to the Member. Members will be responsible to non-Participating providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

WW. PARTICIPATING PHARMACY

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

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

XX. PHARMACY

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

YY. 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.

ZZ. PLAN ADMINISTRATOR

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

AAA. PRESCRIPTION DRUGS

Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber.

BBB. PROBATIONARY/WAITING PERIOD

A length of time (e.g. 0, 30, 60 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.

CCC. PROFESSIONAL PROVIDER

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

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

DDD. PROPHYLACTIC SURGERY

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

EEE. PROTECTED HEALTH INFORMATION (PHI)

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

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

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

FFF. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A judgment, decree or order issued by a court, domestic relations magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act (for Medicaid purposes). It requires that the child(ren) named in the order have the right to receive benefits from their parent through any group medical plan under which the parent is enrolled, whether

or not the parent has family coverage. The required contribution for coverage will be that of family coverage. The QMCSO must contain:

1. the name and last known mailing address of the Member;
2. the name and mailing address of each child (alternate recipient) covered by the order;
3. a reasonable description of the type of coverage to be provided by the Group health plan to each alternate recipient or the manner in which coverage will be determined;
4. the period of time to which the order applies; and
5. the identification of each plan to which the order applies.

GGG. QUALIFYING PAYMENT AMOUNT

The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

HHH. REHABILITATIVE ADMISSIONS

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

III. SINGLE COVERAGE

Coverage provided for the Employee only.

JJJ. SUBSCRIBER OR EMPLOYEE

The person who applies for coverage.

KKK. SURGERY

1. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examination and other invasive procedures,
2. The correction of fractures and dislocations,
3. Usual and related pre-operative and post-operative care,
4. Other procedures as reasonably approved by Blue Cross Blue Shield of Wyoming.

LLL. TELEMEDICINE

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

MMM. THERAPY SERVICE

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

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

NNN. TWO ADULT COVERAGE

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

FUNDING LEVELS AND CONTRIBUTIONS

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

A. *HOW FUNDING LEVELS ARE ESTABLISHED AND CHANGED*

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

B. *CONTRIBUTION REQUIREMENTS*

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

ELIGIBILITY REGULATIONS

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

A. ELIGIBILITY

1. A full-time Legally Employed Employee of the employer who regularly works thirty (30) or more hours of service per week will be eligible to enroll for coverage under this Plan once he/she completes an orientation period and any applicable Probationary Period. Participation in the Plan will begin as of the first day of the month following completion of both the orientation period and the Probationary Period, provided all required election and enrollment forms are properly submitted to the Plan Administrator. The employer will assess the need for an orientation period based on the particular position involved, the experience of the Employee, and the amount of training required. The decision about the length of the orientation period required will be made at time of hire so that the employer and the Employee can evaluate whether the employment situation is satisfactory for each party and then training can take place. The orientation period will not exceed one month calculated by adding one calendar month to the first date the Employee completes at least one hour of service with the employer, and then subtracting one calendar day. Based on the previously mentioned criteria, the orientation period could be as little as zero days. An example of when coverage may be effective if an Employee requires the maximum one month orientation period follows: If an Employee's start date is February 21, a one month orientation period would end March 20. A 60 day Probationary Period would then begin on March 21 and end on May 19. Coverage would begin on June 1.

2. The Employee must have deductions made for Federal Income Taxes and Social Security by the employer.

3. Directors/Partners/Owners are eligible only if they are also bona fide Employees as provided above.

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

   NOTE: The following are not eligible for coverage:

   a. Directors, partners, owners who do not work 30 hours or more per week
   b. Independent contractors
   c. Volunteers or non-compensated employees

NOTE: If Member enrolls in Medicare due to turning age 65 and are still actively working, Group coverage will be primary.

4. Determining Full-Time Employee Status for Ongoing Employees:
In determining whether an ongoing Employee is classified as a full-time Employee, the employer has set forth a standard measurement period of 12 months followed by a standard stability period of 12 months. If during the standard measurement period, the ongoing Employee is determined to be a full-time Employee, the Plan will have a 30 day administrative period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process. An Employee who has been determined to be a full-time Employee during his or her measurement period will be offered coverage that is effective as of the first day of the Employee's stability period (and coverage will be added to such full-time Employee's eligible Dependents).

   a. Determining Full-Time Employee Status for New Variable Hour, Seasonal, or Part-Time Employees:
   In determining whether a new variable hour, seasonal, or part-time Employee will be considered as a full-time Employee during the initial stability period, the employer has set forth an initial measurement period of 12 months followed by an initial stability period of 12 months. If during the initial measurement period, the Employee is determined to be a full-time Employee, the Plan will have a 30 day administrative period to notify the Employee of his or her eligibility to enroll in the Plan and to complete the enrollment process (and the eligibility of the Employee's eligible Dependents).

   An Employee who has been determined to be a full-time Employee during his or her measurement period will be offered coverage that is effective as of the first day of the Employee's stability period (and coverage will be added to such full-time Employee's eligible Dependents). Notwithstanding any other provision to the contrary, the combined length of the initial measurement period and the administrative period for a new Employee who is a part-time or variable hour Employee may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one hour of service with the employer.

   b. Material Change in Position or Employment Status for New Variable Hour, Seasonal, or Part-Time Employee:
   An Employee who, during his or her initial measurement period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least 30 hours of service per week for the employer will be treated as a full-time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents beginning on the earlier of:

      (i) The 4th full calendar month following the change in employment status; or

(ii) The first day of the initial stability period (but only if the Employee averaged at least 30 hours of service per week or, if elected by the employer on a reasonable and consistent basis, 130 hours of service per calendar month) during the initial measurement period)

NOTE: An Employee in his or her stability period who has been rehired by the employer is treated as a new Employee for the employer on his or her most recent reemployment date only if more that thirteen (13) consecutive weeks have passed since the Employee was last credited with an hour of service with the employer (or with any affiliated company organization that is required to be treated as the same employer for purposes of Code Section 4980H).

B. DEPENDENT ELIGIBILITY

1. All Dependents of the covered Employee as defined by the Plan are eligible.

2. 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.

3. A child for whom you are required to provide healthcare coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

4. For newly married individuals, an enrollment form must be submitted within thirty (30) days from the date of marriage for coverage to be effective on the date of the marriage. Eligible individuals must submit their enrollment forms prior to the effective dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins. Otherwise, coverage will begin the first of the month following the date the enrollment form is submitted. In any case, the enrollment form must be submitted within thirty (30) days from the date of marriage or the spouse must wait until the next open enrollment.

5. If covered spouses enroll in Medicare due to turning age 65 and are still actively working, Group coverage will be primary.

C. MEASUREMENT AND STABILITY PERIODS

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

Under the Affordable Care Act Safe Harbors, an Employee can drop coverage due to a reduction in hours during a stability period that leads to an inability to pay the monthly

Employee contribution. As an employer, if an Employee's payment is late, employer must provide the Employee with a 30-day grace period in order to make the payment. If the Employee does not make the payment within the grace period, the employer is not required to provide coverage for the period for which the contribution is not timely paid and may terminate coverage.

The Employee's revocation of the election of coverage under the Group health plan must correspond to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

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

D. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

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

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

HOW TO ADD, CHANGE, OR END COVERAGE

A. HOW TO ADD EMPLOYEES

1. The Employee should complete an electronic enrollment for coverage which must be submitted to the Employer within thirty (30) days of the end of any applicable Probationary Period. If there is no Probationary Period, the electronic enrollment must be received within thirty (30) days of the date of hire.

2. Based on the completeness and acceptability of the electronic enrollment, the effective date of coverage will be as follows:

   a. Drillers and night supervisors: First of the month following the thirty (30) day Probationary Period.
   b. All other Employees (except tool pushers and supervisors): First of the month following the sixty (60) day Probationary Period.
   c. Tool pushers and supervisors: Date of hire.

   NOTE: The Plan acknowledges that enrolling Employees prior to the sixty (60) day Probationary Period is discriminatory. If they are highly compensated Employees, they will be subject to imputed income on the entire premium for the difference in the Probationary Periods.

3. If an electronic enrollment is not submitted as described above, the Employee will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the Group's annual Open Enrollment Period (September 1-30). Provided the electronic enrollment is received by the Employer <u>during</u> the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on October 1.

4. In addition to the methods of electronic enrollment described above, an Employee may also be eligible to apply for coverage during a special enrollment period. (See ADDING MEMBERS DURING SPECIAL ENROLLMENT PERIODS below.)

B. REHIRE PROVISION

After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 13 weeks after your termination date, your coverage will take effect on the first day you report for employment with the Employer, or as soon as administratively practicable. The waiting period will be waived.

If your coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and Plan maximums.

If you were not covered under the Plan on the date of your termination because you declined the offer of coverage and you are rehired less than 13 weeks after your termination date, you will not receive an offer of new coverage until the earlier of the beginning of your next Stability Period or the next open enrollment period. If you are rehired by the Employer

more than 13 weeks after your termination date, you will be treated as a new Employee and will be required to satisfy the waiting period.

C. HOW TO ADD DEPENDENTS

1. Eligible Dependents can be added at the time the Employee applies for coverage by including their names and dates of birth on the electronic enrollment. If the Dependent is included on the Employee's electronic enrollment, the effective date of coverage will be the same as that of the Employee.

2. To add eligible Dependents who were not included on the original electronic enrollment, a new electronic enrollment is required. If the electronic enrollment for coverage is received by the employer within thirty (30) days of the Dependent's initial date of eligibility, the effective date will be the first of the month following receipt of the electronic enrollment. Eligible Dependents who are considered to be Late Enrollees because their electronic enrollment was not received by the Employer within thirty (30) days of their initial date of eligibility are eligible to apply for coverage during the Group's annual Open Enrollment Period (September 1-30). Provided the electronic enrollment is received by the Employer during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on October 1.

3. To add newly acquired eligible Dependents, the Employee should complete an electronic enrollment for coverage and submit it to the Employer immediately. The electronic enrollment 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 electronic enrollment is received prior to the date of marriage. If the electronic enrollment is received within thirty (30) days after the date of marriage, coverage will be effective on the first day of the following month.
    b. Newborn children will be effective on the date of birth for a period of thirty-one (31) days. A completed electronic enrollment for the child will be required before claims will be processed. The Employee may continue coverage for the newborn child beyond the 31-day automatic coverage provided that the completed electronic enrollment the Employer Cross Blue Shield of Wyoming within sixty-one (61) days of the child's date of birth.
    c. An adopted child or legal ward will be effective on the earlier of the date the petition for adoption is filed or the child's date of entry into the adoptive home (unless the child is in the custody of the State, in which case the effective date will be the date of entry of a final adoption decree by the court), for a period of thirty-one (31) days. A completed electronic enrollment for coverage for the child will be required before claims will be processed. The Employee may continue the coverage for the adopted child or legal ward beyond the 31-day automatic coverage provided that the completed electronic enrollment for the adopted child or legal ward is received by

the Employer within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the effective date of coverage will be the date of entry of a final adoption decree by the court). NOTE: (1) The adoption or legal guardianship papers must accompany the electronic enrollment; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

NOTE: If a new electronic enrollment 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 (September 1-30). Provided the electronic enrollment is submitted to the Employer during the Open Enrollment Period, a Late Enrollee will have coverage under this Plan on October 1.

D. CHANGES

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

E. WHEN COVERAGE UNDER THIS PLAN ENDS

1. When the Employee leaves employment or otherwise becomes ineligible, coverage will terminate the first of the month following the last day of eligibility. (Except as described below under COBRA.)

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

2. When an Employee is on a leave of absence, unless such leave of absence is granted pursuant to the Family and Medical Leave Act of 1993.

3. Upon the death of the Employee.

4. When the Plan is terminated. No continuation of coverage will be offered by Blue Cross Blue Shield of Wyoming.

5. By the Employer's request. Coverage ends on the next Billing Service Date following receipt of the 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 electronic enrollment, or with the filing of a claim by the Member. The Employee is liable for any benefits payments made through such improper actions.

7. If Member enrolls in Medicare due to turning age 65 and are still actively working, Group coverage will be primary

8. The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below.

F. WHEN COVERAGE FOR DEPENDENTS ENDS

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

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

2. The end of the month 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 for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the Employer within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Employee 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 next Billing Service Date following a final divorce decree or separation for a Dependent spouse.

5. When the Employer notifies Blue Cross Blue Shield of Wyoming to end coverage for a Dependent. Coverage ends on the next Billing Service Date following receipt of the request.

6. For newborn and adopted children, at the end of the 31-day automatic coverage period, unless a completed electronic enrollment for coverage of the child is submitted to the Employer no later than thirty (30) days after the end of that automatic coverage period.

7. If covered spouses enroll in Medicare due to turning age 65 and are still actively working, Group coverage will be primary.

G. RETROACTIVE TERMINATION OF COVERAGE

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) 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 (30) days advance written notice to you, or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, your coverage may be retroactively terminated in cases where Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

H. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "Qualifying Event".

1. Qualifying Beneficiary

   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 to 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.

2. Qualifying Event

   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:

   a. Your hours of employment are reduced or
   b. Your employment ends for any reason other than your gross misconduct.

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.

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. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you 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 you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

3. Extension of 18-Month Continuation Coverage Period
If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after 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 obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

4. Notice Requirement

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

a. Name and address of the covered Employee or former employee;
b. Name and address of your Spouse, former Spouse and any Dependent Children;
c. Description of the qualifying event; and
d. Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

a. Name of person deemed disabled;
b. Date of disability determination; and
c. Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in the General Information section of this document.

5. Termination of COBRA Continuation Coverage
   COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

   a. The date the Plan Sponsor ceases to provide any Group health plan coverage;
   b. The date on which the qualified beneficiary fails to pay the required contribution;
   c. The date that the qualified beneficiary first becomes, after the date of election, covered under any other Group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or
   d. The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

6. Payment for COBRA Continuation Coverage
   Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

7. Additional Information
   Additional information about the Plan and COBRA continuation coverage is available from the COBRA Administrator, who is identified on the General Plan Information page of this Plan.

8. Current Addresses
   In order to protect your rights and the rights of your family, you should keep the Plan Administrator informed of any changes in the addresses of family members.

9. Other Coverage Options Besides COBRA Continuation Coverage
   Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other Group health plan coverage

options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

a. When the Employee's employment is terminated (except for termination due to gross misconduct) or suffers a reduction in work hours (resulting in loss of coverage), the Employee is still eligible for continuation of coverage under the Plan.
b. The Employee has the right to remain in the Plan at his or her own expense.
c. The employer must notify Blue Cross Blue Shield of Wyoming within 30 days after an Employee terminates or has a reduction in work hours resulting in the loss of eligibility for health coverage. Rocky Mountain Reserve will notify the Employees of their continuation of coverage rights within 14 days of receiving notification. The Employee then must sign and return the COBRA election form to Rocky Mountain Reserve 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 not later eligible to apply during the annual Open Enrollment period.
d. The period of continuation of coverage for the Employee under the original Group plan is 18 months (24 months for an Employee who leaves the job and enters the Armed Forces on a full time basis, or up to a maximum of 29 months if an Employee is disabled at the time of termination), or to the time of either coverage under another Group health plan or entitlement to Medicare, whichever occurs first.
e. Continuation of coverage can be canceled only upon 1) abolition of all health plans by the employer, 2) the Employee's failure to make timely payment of monthly contributions, 3) the Employee's entitlement to Medicare, and 4) the Employee's coverage under another Group health plan.

10. Can I enroll in Medicare instead of COBRA continuation coverage after my Group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

a. The month after your employment ends; or
b. The month after Group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B

is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

11. 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.
    e. If subject to ERISA, in the case of a Group health plan, within the meaning of section 607(1) of the Act, subject to the continuation coverage provisions of Part 6 of Title I of ERISA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning premiums, notice and election requirements and procedures.

I. FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) generally applies only to groups of 50 or more Employees:

1. Under the FMLA, Employees may be eligible for continued coverage under this Plan while on unpaid leave for the reasons described below.

2. If the Employee has to attend to any of the following family needs, the Employee may be eligible for unpaid FMLA leave for up to a maximum period of 12 work weeks during any 12-month period:

    a. The birth or adoption of a child,
    b. The placement of a child in the Employee's custody for foster care,
    c. The care of a spouse, child, or parent with a serious health Condition, or
    d. The Employee's own serious health Condition which makes it impossible to perform the functions of the job.
    e. A "qualifying exigency" (as defined by the Department of Labor) and caused by the call up of an Employee's immediate family member (spouse, child, or parent), including reservist or member of the National Guard, to active duty in the armed forces.

    This period will include any period of family or medical leave provided under any state or local law.

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

4. Eligible Employees are those who:

    a. Have been employed for at least 12 months by the employer, and
    b. Have worked for at least 1,250 hours with the employer during the previous 12 months, and
    c. Have been employed at a worksite where 50 or more Employees are employed by the employer within 75 miles of that worksite, and
    d. Are covered for benefits under this Plan.

5. Blue Cross Blue Shield of Wyoming must be notified within thirty (30) days of the beginning of any FMLA leave for a covered Employee. Blue Cross Blue Shield of Wyoming must also be notified of the conclusion of the leave period(s).

6. As long as monthly contributions are paid, coverage for the benefits provided under this Plan will be continued for Members while the Employee is on FMLA leave. Coverage for the Members will be on the same basis as that provided for any other similarly situated members.

7. The employer may grant an FMLA leave request and continue contributions for the Employee's coverage under appropriate personnel rules.

8. If the Employee does not return to work after the FMLA leave, the employer may recover from the Employee that portion of the funding paid by the employer on the Employee's behalf in order to maintain the coverage, except if the Employee fails to return because of a serious health Condition or circumstances beyond the Employee's control.

J. CONTINUATION OF COVERAGE UNDER USERRA

You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

K. ADDING MEMBERS 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 30 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 electronic enrollment for coverage which must be submitted to the Employer within 30 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 electronic enrollment.

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 electronic enrollment for coverage which is submitted to the Employer within 30 days after the marriage, birth, adoption, or placement for adoption. The effective date of coverage will be:

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

3. If the Employee or any Dependents dropped coverage under this Plan due to the Employee's entrance into the armed forces on full-time duty. The Employee and any Dependents being added to the coverage must complete an electronic enrollment for coverage which must be submitted to the Employer within thirty (30) days after the date of termination of the Employee's full-time duty status. The effective date of coverage under this Plan for all such Subscribers will be the date of electronic enrollment, assuming receipt by the Employer of a substantially complete electronic enrollment.

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 electronic enrollment which is submitted 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 electronic enrollment 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 electronic enrollment for coverage.

6. Special enrollment periods required under Federal or State Law:
   If there is a conflict between this Agreement and applicable Federal or State Law, Federal or State Law controls.

L. MARKETPLACE SPECIAL ENROLLMENTS

1. Employees and Dependents may participate in open enrollment in the health coverage marketplace.
2. The Employee is eligible for a special enrollment period to enroll in a qualified health plan through the marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual enrollment period; and the revocation of the election of coverage under the Plan corresponds to the intended enrollment of the Employee and any Dependents who cease coverage due to the revocation in a qualifying health plan through a marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
3. The Plan may rely on the reasonable representation of an Employee who has an enrollment opportunity for a qualified health plan through a marketplace, that the Employee and Dependent have enrolled or intend to enroll in a qualified health plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

M. STATUS CHANGE EVENT

Generally, your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or Status Change Event (as permitted by the Employer's Section 125 Plan). If a Status Change Event occurs, you may make a new election under the Plan provided your new election is consistent with the Status Change Event.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

NOTE: Newborns and adopted children and legal wards will be exempt from this rule and will adhere to the guidelines listed previously.

HOW BENEFITS WILL BE PAID

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

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

A. HOSPITALS AND FACILITY PROVIDERS

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

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

2. Payment for Covered Services provided to Members by non-Participating Hospitals or Facility Providers may be made to the Employee. Employees are responsible to non-Participating providers of services for all charges, regardless of the Allowable Charge or the amount of payment made under this Plan.

3. For a list of providers, please visit www.yourwyoblue.com.

AUTHORIZATION REVIEW

If a Physician recommends that a Member be hospitalized (for any non-maternity or non-emergency Condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's Authorization Review program.

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

1. ABA Therapy Services
2. Acute Rehabilitative Services

3. Breast reconstructive Surgery
4. Certain Allergy Services
5. Certain Anesthesia Services
6. Certain Chemotherapy and Radiation Therapy (including Physician's office)
7. Certain Dental Services
8. Certain Laboratory, Pathology, X-Ray, & Radiology Services
9. Certain Prescription Drugs
10. Certain Prosthetic and/or Orthopedic Appliances
11. Certain Supplies, Equipment, and Appliances
12. Cosmetic Surgery
13. Extended care facility/transitional or swing bed care (Inpatient admission)
14. Genetic Molecular Testing
15. Hospice Benefits (Inpatient)
16. Hospital Benefits
17. Hospital grade breast pumps
18. High dose chemotherapy and/or radiation therapy with allogeneic or autologous bone marrow transplant or peripheral stem cell support
19. Human Organ Transplants
20. Inherited enzymatic disorders counseling
21. Non-accidental dental related medical services
22. Obesity and weight loss Surgery
23. Orthognathic Surgery
24. Outpatient surgical services
25. Prophylactic Surgery
26. Reconstructive Surgery
27. Skilled nursing facility

B. PHYSICIANS AND PROFESSIONAL PROVIDERS

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

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

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

If a Physician recommends that a Member be hospitalized (for any non-maternity or non-emergency Condition), services MUST be submitted in advance to Blue Cross Blue Shield

of Wyoming. See AUTHORIZATION REVIEW under HOSPITAL AND FACILITY PROVIDERS above.

C. COVERAGE OF MEDICAL EMERGENCIES

Covered Services provided for Medical Emergencies as defined in the DEFINITIONS section will always be paid as Participating benefits, even when provided by non-Participating providers. However, Members will be responsible for paying any amounts above the Allowable Charges if a non-Participating provider is used. Charges in excess of the Allowable Charges will not apply toward the Deductible or Out of Pocket Maximum Amount.

D. CONTINUITY OF CARE

If a Member receiving Covered Services from a Participating Provider experiences a change in network status due to the following: 1) the Participating Provider's contract is terminated; or 2) a change in network participation under the Plan, the Member may request to continue treatment with their current provider for a period of time by submitting a Continuity of Care Request Form. Patients must be undergoing treatment for a serious and complex Condition, pregnancy, terminal illness, receiving Inpatient care, or be scheduled to undergo non-elective surgery to be eligible. If the request is approved, benefits will be provided at the Participating level for treatment of the specific Condition for a defined period of time (up to ninety (90) days). Requests must be received within thirty (30) days of the effective date of coverage termination or change in the provider's Participating status for consideration.

E. DEDUCTIBLE REQUIREMENTS

Under Single Coverage, the Deductible amount for each calendar year is shown on the Schedule of Benefits.

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

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

All Deductible amounts paid by a Member for Covered Services will be applied toward satisfaction of both the Participating and non-Participating Deductible and Out of Pocket Maximum Amounts.

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

NOTE: The Deductible does not apply to PREVENTIVE CARE.

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

COMMON ACCIDENT DEDUCTIBLE

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

1. If one family Member meets the appropriate individual Deductible, 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.

F. PAYMENT ALLOWANCES UNDER THIS COVERAGE

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

1. Members pay the appropriate Coinsurance percentage as indicated on the Schedule of Benefits until the Out-of-Pocket Maximum Amount shown on the Schedule of Benefits page is met, unless otherwise specified within this Plan.
2. Covered Services will be reimbursed at one hundred percent (100%) of the Allowable Charges over the Out-of-Pocket Maximum Amount per calendar year as shown on the Schedule of Benefits.

All Coinsurance amounts paid by a Member for Covered Services will be applied toward satisfaction of both the Participating and non-Participating Out-of-Pocket Maximum Amounts.

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

NOTE: Member's Coinsurance liability does not apply to PREVENTIVE CARE.

G. CALCULATION OF OUT OF AREA PAYMENTS

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

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

1. BlueCard® Program

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

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

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

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

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

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

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

   a. Member's Liability Calculation
   When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by non-Participating Providers, the amount the Member pays for Covered Services will generally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the non-Participating Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

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

H. NO-SURPRISES BILLING

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

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. ACUTE REHABILITATIVE SERVICES

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

BENEFITS-

1. Services rendered at an Acute Rehabilitation Unit.

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

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

LIMITATIONS AND EXCLUSIONS-

1. Inpatient rehabilitative benefits are only provided for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

2. Inpatient benefits will be provided to an unlimited number of visits per calendar year per Member.

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ALLERGY SERVICES

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

DEFINITION – "Allergy services" are services provided to alleviate the response elicited by an allergen after an allergic state has been established.

BENEFITS –

Benefits will be provided for allergy services. Covered Services include but are not limited to:

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

LIMITATIONS AND EXCLUSIONS -

1. Benefits are not available for clinical ecology, orthomolecular therapy, vitamins, dietary nutritional supplements, or related testing rendered on an Outpatient basis.

2. Benefits are not available for the following allergy testing modalities: nasal challenge testing, provocative/neutralization testing, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgE level testing for food allergies, general volatile organic screening test and mauve urine test.

3. Benefits are not available for the following methods of desensitization: provocation/neutralization therapy by sublingual (drops) intradermal and subcutaneous routes, urine autoinjections, repository emulsion therapy, candidiasis hypersensitivity syndrome treatment or IV vitamin C therapy.

See GENERAL LIMITATIONS AND EXCLUSIONS

C. AMBULANCE SERVICES

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

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

1. For Inpatient care to the nearest Hospital with appropriate facilities or, under similar restrictions, from one Hospital to another.
2. For outpatient care to the nearest Hospital with appropriate facilities when such care is related to a Medical Emergency or an accident.
3. From the nearest Hospital to the Member's home, nursing home, or skilled nursing facility in the same locale.
4. Transportation to the closest facility with the appropriate level of care will be required, unless otherwise approved by Blue Cross Blue Shield of Wyoming.

Covered Services provided for Medical Emergencies as defined in the DEFINITIONS section will always be paid as Participating benefits, even when provided by non-Participating providers. However, Members will be responsible for paying any amounts above the Allowable Charges if a non-Participating provider is used. Charges in excess of the Allowable Charges will not apply toward the Deductible or Out of Pocket Maximum Amount.

LIMITATIONS AND EXCLUSIONS -

1. Air Ambulance: In most cases, ground ambulance is the normally approved method of transportation. Air ambulance is subject to the Participating cost-share. If the Member could have been safely transported by Ground Ambulance, Air Ambulance is not a Covered Service.

2. Other Transportation Services: The Plan will not pay for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.

3. Patient Safety Requirement: If Members could have been transported by automobile or public transportation without danger to their health or safety, an ambulance trip will not be covered. No benefits will be provided for such ambulance services even if other means of transportation were not available.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

D. ANESTHESIA SERVICES

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

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: 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.

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

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

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

LIMITATIONS AND EXCLUSIONS -

1. Hypnosis: Not covered for anesthesia purposes.

2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to anesthesia service.

See GENERAL LIMITATIONS AND EXCLUSIONS

E. BLOOD EXPENSES

DEFINITION - "Blood" expenses include the following:

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

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

LIMITATIONS AND EXCLUSIONS -

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

See GENERAL LIMITATIONS AND EXCLUSIONS

F. CARDIAC REHABILITATION

DEFINITION – "Cardiac rehabilitation" is a course of medically supervised exercise therapy to improve efficiency of the heart, lungs, and circulatory system. Treatment must be in an approved center, Hospital, or rehabilitation Hospital and the provider of care must be a board-certified cardiologist. The program must use telemetry, monitoring and be equipped with appropriate emergency equipment.

BENEFITS –

Benefits will be provided for Outpatient Covered Services when a cardiac rehabilitation regimen for phases I and II is prescribed by a qualified Physician.

LIMITATIONS AND EXCLUSIONS –

1. Benefits for cardiac rehabilitation are limited to a maximum of 36 visits per Member per benefit period.
2. Phase III is not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. CHEMOTHERAPY AND RADIATION THERAPY

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

BENEFITS -

1. Inpatient chemotherapy.
2. Outpatient chemotherapy.
3. Inpatient radiation.
4. Outpatient radiation.
5. Prescription chemotherapy.

LIMITATIONS AND EXCLUSIONS –

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

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

LIMITATIONS AND EXCLUSIONS -

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

See GENERAL LIMITATIONS AND EXCLUSIONS

I. DENTAL SERVICES

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

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

BENEFITS -

Hospital:

Inpatient: If a Member is hospitalized for one of the following reasons, benefits will be provided as shown under ROOM EXPENSES AND ANCILLARY SERVICES, 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. Emergency repair due to injury to sound natural teeth within one year of the accident, including the replacement of sound natural teeth.

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

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

Physician:

Inpatient and Outpatient: Benefits will be provided for the 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.

Preventive Care: Dental screenings as indicated under PREVENTIVE CARE.

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

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

LIMITATIONS AND EXCLUSIONS -

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

   a. Services, supplies, and appliances must be required due to an accidental injury.
   b. Treatment must be for injuries to sound natural teeth.
   c. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
   d. 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 Member must be hospitalized for a non-covered dental procedure, he or she may receive benefits for inpatient Hospital charges. However, benefits for the services provided by the dentist or oral surgeon will still be limited to those described under the Dental Expenses, if applicable.

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

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

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

6. No Physician services are provided for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.

7. Routine dental services such as cleaning, restoration, panoramic X-Rays are not Covered Services.

8. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under the Dental Expense Rider, if applicable.

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

2. Additional Medically Necessary self-management training shall be provided upon a significant change in symptoms, Condition, or treatment. This additional training shall be limited to three (3) hours per year.

LIMITATIONS AND EXCLUSIONS -

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

See GENERAL LIMITATIONS AND EXCLUSIONS

K. HEMODIALYSIS AND PERITONEAL DIALYSIS

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

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

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

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

BENEFITS -

Authorization Review is required before benefits are payable.

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

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

LIMITATIONS AND EXCLUSIONS -

1. Coverage of this benefit is subject to all Authorization Review requirements including the use of Designated facility Providers.

2. Donor expenses are not covered if the donor is a Member but the recipient is not.

3. Donor expenses for which benefits are available from another source are not covered.

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

5. Meals, lodging: The cost of meals and lodging related to a human organ transplant are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS.

M. HOME HEALTH CARE

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

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

1. The Member would have to be admitted to a Hospital or skilled nursing facility if he or she did not receive home health care.
2. The Member's home health care must be ordered by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the Condition for which hospitalization was required.

BENEFITS -

Inpatient: Not covered.

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

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

Covered Services will be subject to the Coinsurance after the Deductible as shown in the Schedule of Benefits. Benefits will be provided to a maximum of 180 days per Member per calendar year.

Benefits will NOT be payable 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

N. HOSPICE BENEFITS

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

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

1. The Member must experience an illness for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief) that cannot be obtained at a lower level of care, rather than curative care, is considered most appropriate.
3. The attending Physician must refer the Member to the program and must be in agreement with the plan for treatment of the Member's Condition.

BENEFITS -

Inpatient benefits:

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

Outpatient benefits are provided for the following:

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

Covered Services will be subject to the Coinsurance after the Deductible as shown in the Schedule of Benefits. 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

O. HUMAN ORGAN TRANSPLANTS

DEFINITION – "Human organ or tissue transplant" services are those required in connection with the replacement of a diseased human organ or tissue by transplantation of a healthy human organ or tissue from a donor.

BENEFITS –

Blue Cross Blue Shield of Wyoming (the Claims Supervisor) does not administer the benefits or process claims for transplant related services rendered between the dates of the transplant and the 365th day from the transplant.

Benefits for human organ and tissue transplantation are provided through OptumHealth's Managed Transplant Program. Human organ or tissue transplant services for eligible Members are covered under OptumHealth's Managed Transplant Program according to its terms and conditions. Transplant claims will be paid by OptumHealth as described in their coverage document.

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

The OptumHealth transplant benefit is a carve out benefit. Deductible and Coinsurance do not apply to transplant services rendered between the dates of the transplant and the 365th day from the transplant, as these services are covered by the OptumHealth transplant benefit.

Transplant related services rendered on or after the 366th day will not be covered under OptumHealth but will instead be covered under this Plan and subject to this Plan's Deductible and Coinsurance provisions.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

P. INHERITED ENZYMATIC DISORDERS

BENEFITS-

The equipment, supplies and Outpatient self-management training and education, including medical nutrition therapy for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids, as prescribed by a healthcare provider, are Covered Services.

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

LIMITATIONS AND EXCLUSIONS -

1. Outpatient self-management training and education must be provided by a certified, registered or licensed healthcare provider with expertise in inherited enzymatic disorders.
2. Outpatient self-management training and education is limited to:

    a. A one (1) time evaluation and training program when Medically Necessary, within one (1) year of diagnosis;
    b. Additional Medically Necessary self-management training shall only be provided upon a significant change in symptoms, Condition or treatment.
    c. Coverage will only be provided for prescribed medical nutrition formula and supplies that are medically appropriate. Coverage will not be provided for medical-grade food except in circumstances where formula nutrition is insufficient and not for the convenience or preference of the Member.

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. LABORATORY, PATHOLOGY, X-RAY, & RADIOLOGY

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

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

"X-ray" and "radiology" 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 services provided by a Hospital or Facility Provider, or by a Physician, independent pathology laboratory, or independent radiology laboratory. Routine pap smears will be paid as indicated under PREVENTIVE CARE.

LIMITATIONS AND EXCLUSIONS -

1. Unrelated services: Services which are not related to a specific illness or injury are not covered.

2. Routine Examinations: Services related to routine examinations (such as yearly physicals or screening examinations for school, camp, or other activities) are not covered except as described under PREVENTIVE CARE.

3. Weight Loss Programs: The Plan will not pay for laboratory or X-ray services related to weight loss programs.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

R. MATERNITY AND NEWBORN CARE

DEFINITIONS - “Maternity” services are those required by either female Employees or 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 or when the pregnancy is the result of rape or incest to the extent permitted by State and Federal Law.
5. Ectopic pregnancies.

"Newborn" services include the following:

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

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

BENEFITS -

Hospital:

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

Outpatient: The following charges are covered:

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

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

1. Delivery services (pre- and post-natal medical care is included in the allowance for delivery services).
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.

NOTE: Dependent children are not eligible for maternity-related benefits; except to the extent required by the Affordable Care Act for preventive care.

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.

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

3. Dependent children are not eligible for maternity-related benefits.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

S. MEDICAL CARE FOR GENERAL CONDITIONS

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

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

"Outpatient Medical Care" expenses are those billed by a Physician, Professional Provider, Hospital, or Facility Provider for services rendered in the provider's office, the outpatient department of a Hospital or Facility Provider, or in the Member's home, for a Condition which does not require Surgery.

BENEFITS -

Hospital:

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

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

Physician:

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

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

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

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

Covered Services for spinal manipulations are limited to eight (8) visits per Member per calendar year.

LIMITATIONS AND EXCLUSIONS -

1. Private Room Expenses: If a Member has a private room in a Hospital, covered charges under this 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.

3. Eye Care: Except as described under PREVENTIVE CARE, services will not be covered for the Condition of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

See GENERAL LIMITATIONS AND EXCLUSIONS

T. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required before ABA therapy services are payable as a Covered Service to the Member under this Agreement. Member must contact Blue Cross Blue Shield of Wyoming at (800) 251-1814 to obtain Authorization Review *before* receiving ABA therapy services. The failure to obtain Authorization Review may result in a denial or reduction in coverage for this benefit.

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

"Mental Health benefits" means benefits with respect to services for Mental Health Conditions as defined under the terms of this Plan and in accordance with any applicable Federal and State Law, including Mental Health Parity and Addiction Equity Act of 2008.

"Substance Use Disorder benefits" means benefits with respect to services for Substance Use Disorders as defined under the terms of this Plan and in accordance with any applicable Federal and State Law.

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

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

BENEFITS –

Inpatient:

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

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

Intensive Outpatient:

Subject to any Deductible and Coinsurance provisions, benefits will be provided based on the Allowable Charges for intensive outpatient services provided by a Hospital or Facility Provider.

Other Outpatient or Office:

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

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

In addition, Covered Services provided for Medical Emergencies as defined in the DEFINITIONS section will always be paid as Participating benefits, even when provided by non-Participating providers. However, Members will be responsible for paying any amounts above the Allowable Charges if a non-Participating provider is used. Charges in excess of the Allowable Charges will not apply toward the Deductible or Out-of-Pocket Maximum Amount.

Benefits include healthcare services provided under the psychiatric Collaborative Care Model as defined by the American Medical Association.

LIMITATIONS AND EXCLUSIONS –

1. Diagnosis for Mental Health or Substance Use Disorder: Services must be for the diagnosis and/or treatment of manifest Mental Health or Substance Use Disorders. These disorders are described in the following publication:

    a. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

2. Professional Services: Professional services must be performed by a Physician, licensed clinical psychologist, or Professional Provider who is properly licensed or certified. A Professional Provider must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All providers, whether performing services or supervising the services of others, must be acting within the scope of their license.

3. Educational Credits: Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Member's education or training regardless of the diagnosis or symptoms that may be present.

4. Marital Counseling: Benefits will not be paid for marital counseling or related services.

5. Tobacco Dependency: Benefits will not be paid for services, supplies or drugs related to tobacco dependency except as described under PREVENTIVE CARE.

6. Co-dependency Treatment: Services related to the treatment of the family of a person receiving treatment for tobacco, chemical or alcohol dependence are not covered.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

U. NUTRITIONAL SUPPLEMENTS

DEFINITION - A nutritional supplement is intended to provide nutrients that may otherwise not be consumed in sufficient quantities.

BENEFITS –

Special dietary supplement for treatment for phenylketonuria (PKU) is covered when prescribed by a Physician.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

V. OUTPATIENT MEDICATIONS

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

BENEFITS-

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

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

LIMITATIONS AND EXCLUSIONS-

1. Certain medications require use of a preferred product. Preferred products are cost-effective, clinically appropriate treatments based on current medical guidelines and best practice standards. If a non-preferred product is used without authorization, the non-preferred product will not be a covered benefit. The Member may request access to non-preferred products not otherwise covered by Blue Cross Blue Shield of Wyoming through a request for exception. You may seek an exception by calling us at 1-800-442-2376 or by writing to Blue Cross Blue Shield of Wyoming, P.O. Box 2266, Cheyenne, WY 82003-2266. You can review a complete listing of these medications by visiting our website, www.bcbswy.com.

2. Prescription Drugs related to weight loss programs are not Covered Services.

3. Prescription Drugs considered "lifestyle" drugs are not Covered Services. Examples include but are not limited to: hair loss, facial hair, wrinkles, etc.

4. Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not a Covered Service.

5. For Chemotherapy medications, please see section CHEMOTHERAPY AND RADIATION THERAPY.

See GENERAL LIMITATIONS AND EXCLUSIONS

W. PODIATRY SERVICES

DEFINITION – "Podiatry services" are concerned with the diagnosis and treatment of disorders of the feet.

BENEFITS –

Benefits are provided for palliative or cosmetic foot care including flat foot Conditions, supportive devices for the foot (orthotics), the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

X. PRESCRIPTION DRUGS AND MEDICINES

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

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

A. BENEFITS AVAILABLE THROUGH THE PRESCRIPTION DRUG BENEFIT RETAIL PROGRAM

Prescription Drugs and medicines are covered by the Prescription Drug Benefit when purchased from a Participating Pharmacy. When a Member needs a prescription filled, the Member should go to a Participating Pharmacy and present his or her identification card. The Participating Pharmacy will only charge for the Member cost share as shown in the Schedule of Benefits. The Pharmacy will be reimbursed for the remaining balance.

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

1. Tier 1 Drugs: Consists of the lowest cost prescription medications; primarily Generic but includes some Preferred Brand medications.
   Tier 2 Drugs: Consists of the lowest cost prescription medications; primarily Generic but includes some Non-Preferred Generic medications.
   Tier 3 Drugs: Consists of medium-cost prescription medications; mostly Preferred Brands but may have Generics, as well Generic-appearing Brand medications.
   Tier 4 Drugs: Consists of medium-cost prescription medications; mostly Non-Preferred Brands but may have Generics, as well Generic-appearing.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Member cost-share for covered Prescription Drugs and medicines under this benefit will be applied toward the Plan's Out-of-Pocket Maximum Amount.
2. Where a prescription is ordered and a generic version is available, the prescriber does not indicate dispensing the brand-name version is medically necessary, and the Member chooses to have the brand-name version filled: Member will be required to pay the non-preferred brand tier cost-share, as well as the difference in cost between the brand drug and the generic drug (referred to here as "Member Pays the Difference" (MPTD) penalty). MPTD penalty paid amount does not contribute to the Member's Out-of-Pocket annual

maximum. Additionally, when the Out-of-Pocket Maximum Amount has been reached, Member will continue to pay the MPTD penalty.

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

B. BENEFITS AVAILABLE THROUGH THE MAIL SERVICE PHARMACY PROGRAM:

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

Benefits for Prescription Drugs and medicines purchased through the Mail Service Pharmacy Program are based on Allowable Charges:

1. Tier 1 Drugs: Consists of the lowest cost prescription medications; primarily Generic but includes some Preferred Brand medications.
   Tier 2 Drugs: Consists of the lowest cost prescription medications; primarily Generic but includes some Non-Preferred Generic medications.
   Tier 3 Drugs: Consists of medium-cost prescription medications; mostly Preferred Brands but may have Generics, as well Generic-appearing Brand medications.
   Tier 4 Drugs: Consists of medium-cost prescription medications; mostly Non-Preferred Brands but may have Generics, as well Generic-appearing.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Member cost-share for covered Prescription Drugs and medicines under this benefit will be applied toward the Plan's Out-of-Pocket Maximum Amount.
2. Where a prescription is ordered and a generic version is available, the prescriber does not indicate dispensing the brand-name version is medically necessary, and the Member chooses to have the brand-name version filled: Member will be required to pay the non-preferred brand tier cost-share, as well as the difference in cost between the brand drug and the generic drug (referred to here as "Member Pays the Difference" (MPTD) penalty). MPTD penalty paid amount does not contribute to the Member's Out-of-Pocket annual maximum. Additionally, when the Out-of-Pocket Maximum Amount has been reached, Member will continue to pay the MPTD penalty.
3. The maximum amount or quantity of Prescription Drugs that will be considered as eligible charges may not exceed a 90-day supply when taken in accordance with the directions of the prescriber.

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

C. PAYDHEALTH SELECT DRUGS AND PRODUCTS^{SM} PROGRAM:

The Plan requires Members to enroll in the Paydhealth Select Drugs and Products Program when they are prescribed prescription drugs listed on the Paydhealth drug list. This Program is paid for by the Plan and provides matching of alternate funding programs to Members. All Members using listed drugs are required to meet Authorization Review, enrollment in the Paydhealth Program and

adjudication of their drug costs by an alternate funding program prior to meeting Plan coverage criteria. Failure to authorize and complete the requirements of the Paydhealth Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in benefits payable. This will be treated as an adverse benefit determination under the Plan and the Member will have an opportunity to (i) appeal that decision or (ii) comply with the requirements of the Program to avoid the cost containment penalty.

Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Member will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan.

Questions related to the Paydhealth Select Drugs and Products Program may be made directly to the Paydhealth contact center by calling (877) 869-7772.

NOTE: Drugs listed on the Paydhealth drug list require Authorization Review.

LIMITATIONS AND EXCLUSIONS -

1. Non-Prescription Items: The Plan will not cover drugs and medicines that can be purchased without a written prescription, even if the Physician has prescribed such "over-the-counter" medications except as described under PREVENTIVE CARE.

2. Take-Home Drugs: Drugs and medicines which are provided as "take-home supply" by the Hospital are not covered.

3. Weight loss: Prescription Drugs and medicines related to weight loss programs are not covered.

4. 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. Hair Loss: Prescription Drugs and medications related to hair loss are not covered.

6. Tobacco Dependency: Prescription Drugs and medications related to tobacco dependency are not covered except as described under PREVENTIVE CARE.

7. Cosmetic Drugs: Prescription Drugs and medicines used for cosmetic purposes are not covered.

8. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not covered.

9. Certain Prescription Drugs are not covered. A list of excluded drugs is available at myprime.com. Navigate to the Forms page and either sign into your account or click“Continue without sign in” and select “BCBSWY Wyoming” as your health plan. For additional

assistance, please call BCBSWY Member Services at 1-800-442-2376 or message us from your online account at yourwyoblue.com.

10. Members using drugs included on the Paydhealth drug list must enroll in the Paydhealth Select Drugs and Products Program. Contact the Paydhealth contact center for additional information at 877-869-7772. Failure to meet Authorization Review criteria, including enrollment in the Paydhealth Select Drugs and Products Program when applicable, will result in a cost containment penalty equal to a 100% reduction in benefits payable.

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. PREVENTIVE CARE

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

1. United States Preventive Services Task Force (USPSTF) recommendations Grade A and B only;

2. Center for Disease Control and Prevention's (CDC) and Prevention's Advisory Committee on Immunization Practices' (ACIP) recommendations for immunizations;

3. Health Resources and Services Administrations' (HRSA) recommendations for children and women preventive care and screenings;

BENEFITS – When Covered Services are provided by Participating or non-Participating HealthFair providers, benefits will be subject to the cost share as shown in the Schedule of Benefits. A list of covered Preventive services and their limitations can be found on our website at https://www.bcbswy.com/wellness/.

Covered services include:

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

1. Newborn blood screening
2. Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum
3. Birth through 12 months – 7 visits
4. 13 months through 35 months – 4 visits
5. 36 months through 72 months – 1 visit per calendar year
6. Immunizations as recommended by the CDC
7. Congenital hypothyroidism screening under age 1
8. Hearing loss screening up to 1 month of age
9. Phenylketonuria (PKU) screening – once per lifetime ages 0 – 1 years old
10. Sickle cell disease screening – up to age 1
11. Iron deficiency anemia prevention for children at risk 6 to 12 months
12. Hematocrit or Hemoglobin through age 1
13. Lead Screening through age 6
14. Developmental and Autism Screening through age 2
15. Oral health screening
16. Fluoride varnish for the prevention of dental caries in children from birth up to the age of 6. Applied by primary care clinicians.
17. Newborn bilirubin screening

B. Well child care to the Member's 21st birthday:

1. Visual impairment screening – 1 per calendar year
2. Sensory hearing screening – 1 per calendar year (in addition to screening listed above) through age 21
3. Tuberculin test
4. Behavioral/Social/Emotional Screening

C. For Members age 6 years and older:

1. Routine physical examination (office visit) – Males 1 per calendar year. Well-woman preventive care visits as medically appropriate. These office visits may include depression screening, screening for urinary incontinence, skin cancer evaluation, and education or brief counseling to prevent the initiation of tobacco use among school-aged children and adolescents.
2. Adult aortic aneurysm screening for male Members age 65 and older – lifetime maximum of 1 screening
3. Alcohol misuse screening and behavioral counseling intervention– 1 visit per calendar year for Members 6 to 18; unlimited for Members 18 and older
4. Asymptomatic bacteriuria screening – pregnant women only
5. Hepatitis B virus infection screening
6. Rh (D) incompatibility screening – pregnant women only
7. Osteoporosis screening once every 2 calendar years
8. Diabetes screening – pregnant women 24-28 weeks gestation
9. Iron deficiency anemia screening – pregnant women only
10. Contraceptive methods and management – female sterilizations, IUD inserted or removed, injections, cervical cap, sponge, female condoms, spermicide and diaphragm used to prevent conception
11. Lipid disorders screening once every 5 calendar years
12. Osteoporosis screening once every 2 calendar years – females age 60 and older
13. Sexually transmitted disease (STD) screening and counseling:

    a. Chlamydial infection screening – women all ages and males 11-21
    b. Gonorrhea infection screening – women all ages and males 11-21
    c. Syphilis infection screening – pregnant women and men and women at risk

14. Counseling for sexually transmitted infections
15. Type 2 diabetes mellitus screening
16. Immunizations as recommended by the CDC
17. HPV testing once every 3 calendar years – females age 30 and older
18. Screening and counseling for interpersonal and domestic violence
19. HIV screening and counseling
20. Colorectal cancer screening for Members aged 45 through 75 with a screening diagnosis:

    a. Fecal occult blood test – 1 per calendar year

b. FIT (Fecal Immunochemical Test) – 1 per calendar year
c. FIT-DNA - one per three calendar years
d. Colonoscopy (including related services) – 1 every 10 years. Additionally, allow for a follow-up colonoscopy performed within one year after a non-invasive stool-based screening test or direct visualization test OR
e. Sigmoidoscopy (including related services) – 1 every 5 years
f. CT colonography - 1 every 5 calendar years

21. Cervical cancer screening and related office visit – 1 per calendar year
22. PSA test – 1 per calendar year for Employee and spouse only
23. Mammogram screenings – 1 per calendar year
24. Tobacco cessation counseling – 8 visits per calendar year
25. Lipid disorders screening (1) every 5 calendar years
26. Exercise or physical therapy for community-dwelling adults aged 65 years or older who are at increased risk for falls
27. Breast Pump – 1 pump per pregnancy (manual or electric pump from a Participating home medical equipment provider only).
28. BRCA testing and genetic counseling if appropriate for women whose family history is associated with an increased risk for breast and ovarian cancer and ovarian cancer and for those with a family history of tubal and peritoneal cancer
29. Hepatitis C screening
30. Screening for lung cancer – limited to Members aged 50-80 with a diagnosis of Tobacco Dependency, 1 per calendar year
31. Behavioral counseling interventions for the following reasons – limit 26 visits per year from age 6 years-18 years and 12 visits per year for 19 years & older:

    a. To promote a healthful diet and physical activity for cardiovascular disease and diabetes prevention in adults with related risk factors. Includes diagnosis of BMI's 30-70+ and group sessions for preventive medicine counseling.
    b. For healthy weight gain during pregnancy.
    c. For Midlife Women ages 40 to 60 with normal or overweight body mass index (BMI) (18.5-29.9) to maintain weight or limit weight gain to prevent obesity.

32. Screening for high blood pressure in adults – cover Ambulatory Blood Pressure Monitoring (ABPM) for diagnostic confirmation
33. 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.
34. Routine prenatal services
35. Screening for latent tuberculosis infection in adults
36. Coverage for lactation support and counseling –5 visits per pregnancy covered
37. Interventions to prevent Perinatal Depression- 12 visits per calendar year for women who are pregnant or within 12 months of delivery
38. HIV Preexposure Prophylaxis

D. Prescription Drugs – When filled as a prescription and submitted through the Prescription Drug Benefit program, covered at 100% of Allowable Charges without regard to any Copayment or Coinsurance that might otherwise apply except as specified:

1. Aspirin – limited to 81 mg only

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

2. Folic acid (non-prenatal) – limited to 0.4-0.8 mg only (women only)
3. Oral fluoride – over the counter or prescription strength; children age 6 months – 16 years when sufficient fluoride is lacking in available drinking water
4. Iron supplements – children ages 6-12 months
5. Tobacco cessation – up to 180 day supply

    a. Non-nicotine replacement therapy (pills)
    b. Over the counter nicotine replacement therapy (lozenges, patch and gum)
    c. Prescription nicotine replacement therapy (nasal spray and inhalers)

6. Contraceptives used to prevent conception – Tier 1 & 2 paid at 100%; Tiers 3 & 4 subject to Copayment and Coinsurance.

    a. Oral
    b. Patches
    c. Vaginal Rings
    d. Sponge
    e. Condoms
    f. Spermicide
    g. Emergency Contraception
    h. All other FDA-approved contraceptive methods, including over-the-counter methods for which the method is both FDA-approved and prescribed by the health care provider, are covered under the Prescription Drug Benefits section of the Plan.

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

    a. Generic drugs require no Copayment or Coinsurance and no preventive diagnosis is required.
    b. Brand drugs are subject to the Prescription Drug Benefit Member cost-share 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, the required Copayment and Coinsurance would be waived.

8. Bowel Prep Medications Required for the Preparation of a Preventive Colonoscopy – $0 copay for generics, brands pay at the normal benefit level

9. Statin use for the prevention of Cardiovascular Disease:

   a. Adults 40-75
   b. Includes Lovastin, Pravastin, and Rosuvastatin

10. Preexposure Prophylaxis for the Prevention of HIV

Where a prescription is ordered and a generic version is available, the prescriber does not indicate dispensing the brand-name version is medically necessary, and the Member chooses to have the brand-name version filled: Member will be required to pay the non-preferred brand tier cost-share, as well as the difference in cost between the brand drug and the generic drug (referred to here as "Member Pays the Difference" (MPTD) penalty). MPTD penalty paid amount does not contribute to the Member's Out-of-Pocket annual maximum. Additionally, when the Pharmacy Out-of-Pocket Maximum Amount has been reached, Member will continue to pay the MPTD penalty.

LIMITATIONS AND EXCLUSIONS -

1. PREVENTIVE CARE provided by non-Participating providers: Benefits will not be provided for PREVENTIVE CARE services provided by non-Participating providers.

2. 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.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. PRIVATE DUTY NURSING SERVICES

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

BENEFITS -

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

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

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS -

1. Alternative Care: Benefits will not be provided for nursing services which ordinarily would be provided by Hospital staff or its intensive care or coronary care units.

2. Claims Review: Blue Cross Blue Shield of Wyoming will review all claims for appropriateness and Medical Necessity.

3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the Member or the Member's family. (Examples: bathing, feeding, exercising, homemaking, moving the Member, giving medication, or acting as a companion or sitter.) In other words, services which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

AA. ROOM EXPENSES AND ANCILLARY SERVICES

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

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

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

BENEFITS -

Inpatient:

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

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

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

LIMITATIONS AND EXCLUSIONS -

1. Medical Care for General Conditions: All benefits for room expenses and ancillary services related to general Conditions are paid according to MEDICAL CARE FOR GENERAL CONDITIONS.

2. Mental Health or Substance Use Disorders: All benefits for room expenses and ancillary services related to these Conditions are paid according to the section of this Plan titled MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.

3. Personal or Convenience Items: Benefits will not be provided for services and supplies provided for personal convenience which are not related to the treatment of the Member's

Condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

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

5. Skilled Nursing Facilities: Services or supplies provided by skilled nursing facilities, extended care facilities, or similar institutions are not covered except as described under PRUDENT MEDICAL CARE in the GENERAL PROVISIONS section of this Plan.

See GENERAL LIMITATIONS AND EXCLUSIONS

BB. SKILLED NURSING FACILITY

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

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

BENEFITS -

Inpatient and Outpatient:

After the Deductible and Coinsurance has been met, benefits will be provided for daily charges for room and board and general nursing services in a licensed, skilled nursing. This coverage is to become available if such confinement complies with the following:

1. The attending Physician certifies that twenty-four (24) hour skilled nursing care is essential for recuperation.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. SUPPLIES, EQUIPMENT AND APPLIANCES

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

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

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

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

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

BENEFITS -

1. Durable medical equipment – Benefits will be provided for either the rental or the purchase of Medically Necessary durable medical equipment, whichever is less expensive. When a purchase is authorized, benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment.

2. Medical supplies, including but not limited to:

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

3. The following Prosthesis and Orthopedic Appliances, if they satisfy Blue Cross Blue Shield of Wyoming's Medical Policy and are otherwise Medically Necessary, are Covered Services, as well as fitting, adjusting, repairing, and replacement of an appliance due to wear, or a change in the Member's Condition which makes a new appliance necessary. Services and/or device costs covered by a manufacturer's warranty will not be Covered Services.

    a. Artificial arms or legs.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Cervical collars.

e. Surgical implants.
f. Artificial eyes.
g. Pacemakers
h. Breast prosthesis and special bras.
i. Cochlear implants and bone-anchored hearing aids (BAHAs).

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

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

5. Oxygen – The Plan will pay for oxygen and the equipment needed to administer it.

6. Breast pumps as indicated under PREVENTIVE CARE. Authorization Review is required for any Hospital grade breast pumps.

7. Payment for the following items is reimbursed at 100% of the Allowable Charges without reference to the Deductible:

   a. Peak flow meter for oxygen
   b. Spacer for oxygen

8. Diabetic Supplies:
   Equipment and supplies for the treatment of diabetes including, but not limited to the following, are Covered Services:

   a. Syringes
   b. Blood glucose monitors, lancets and test strips
   c. Continuous glucose monitors and sensors
   d. Insulin Pumps

   When purchased at a Participating Pharmacy:
   Tier 1: Consists of the lowest cost equipment and supplies
   Tier 2: Consists of medium-cost, preferred brand equipment and supplies
   Tier 3: Consists of higher-cost, brand name equipment and supplies

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

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

LIMITATIONS AND EXCLUSIONS -

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

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

2. Durable Medical Equipment: Items such as air conditioners, purifiers, humidifiers, dehumidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical Condition.

3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered except for cochlear implants and bone-anchored hearing aids (BAHAs).

4. Hospital Beds: Benefits will not be provided for Hospital beds (including waterbeds or other floatation mattresses).

5. Medical Supplies: Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid or available over the counter are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics, non-rigid braces.)

6. Special Braces: Benefits will not be provided for special braces or special equipment.

7. Diabetic supplies purchased from a non-Participating Pharmacy are not Covered Services under this Agreement. Payment for diabetic supplies from a non-Participating Pharmacy will be the sole responsibility of the Subscriber/Member.

See GENERAL LIMITATIONS AND EXCLUSIONS

DD. SURGERY

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

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

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

BENEFITS -

Hospital:

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

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

1. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be subject to the Coinsurance after the Deductible as shown in the Schedule of Benefits.
2. Covered Services performed in the outpatient department of a Hospital will be subject to the Coinsurance after the Deductible as show in the Schedule of Benefits.

Physician:

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

More than one Surgery performed by the same Physician during the course of only one operative period is called a "multiple Surgery." Since allowances for Surgery include benefits for pre- and

post-surgical care, total benefits for multiple surgeries are reduced as pre- and post-Surgery allowances do not duplicate those of the primary Surgery. The reduced benefit varies, depending upon the circumstances of the multiple surgeries.

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

1. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be subject to the Coinsurance after the Deductible as shown in the Schedule of Benefits.
2. Covered Services performed in the outpatient department of a Hospital will be subject to the Coinsurance after the Deductible as shown in the Schedule of Benefits.

Prophylactic Surgery:

The following Prophylactic Surgeries will be a Covered Service:

1. Mastectomy
2. Oophorectomy
3. Hysterectomy

LIMITATIONS AND EXCLUSIONS -

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

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

   NOTE: Subject to Authorization Review, any Member who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA):

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

2. Dental Surgery: For a complete description of benefits allowed for dental services, see DENTAL SERVICES.

3. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the primary Surgery. Additional benefits are not allowed for these procedures.

4. Obesity and Weight Loss: Benefits will be provided for Surgery required as the result of obesity only as specified in GENERAL LIMITATIONS AND EXCLUSIONS.

5. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.

6. Private Room Expenses: If the Member has a private room in a Hospital, Allowable Charges are limited to the semi-private room allowance, whether or not a semi-private room is available.

7. Gender Reassignment: Benefits will not be provided for sex change operations, or related expenses.

8. Sterilization Procedures: Sterilization procedures and related expenses will be covered. See PREVENTIVE CARE for certain Sterilization Procedures covered at 100% of the Allowable Charges for Covered Services without regard to Deductible, Copayment or Coinsurance that might otherwise apply. Reversals of sterilization procedures are not covered.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

EE. SURGICAL ASSISTANTS

DEFINITION - A "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 according to where services are rendered as follows:

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

LIMITATIONS AND EXCLUSIONS -

1. Eligible Procedures: Surgical assistant benefits are available only for surgical procedures which are of such complexity that they require a surgical assistant as specified in the Medicare Correct Coding Initiative.

2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to surgical assistant services.

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

DEFINITIONS - "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.

"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 -

Hospital:

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

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

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

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

Physician:

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

1. Physical therapy provided by a registered physical therapist or Physician.
2. Respiratory therapy.
3. Occupational therapy.
4. Speech therapy.
5.

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

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

LIMITATIONS AND EXCLUSIONS -

1. Outpatient occupational therapy is covered for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

2. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year.

3. Physical and speech therapy – maintenance therapy is not covered.

4. Speech therapy services are ***not*** covered to treat speech impairment resulting from Surgery, congenital anomalies, previous therapeutic processes, disease, and injury.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS AND EXCLUSIONS

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

A. ACUPUNCTURE

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

B. ALTERNATIVE MEDICINE

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

C. ARTIFICIAL CONCEPTION

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

D. AUTHORIZATION REVIEW

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

E. AUTOPSIES

Services related to autopsies are not covered.

F. BIOFEEDBACK

Services related to biofeedback are not covered.

G. CELLULAR AND GENETIC THERAPY

Any prescription drug classified as "Gene Therapy" provided by any hospital, long-term facility, drug manufacturer, pharmaceutical vendor or any other provider that dispenses or administers medications to Members will not be covered by the Plan.

Those drugs include but are not limited to the following listing. For verification, you may submit an Authorization Review request.

1. Abecma (idecabtagene vicleucel)
2. Allocord (HOC, Cord Blood)
3. Amondys 45 (casimersen)
4. BankHPC, Cord Blood - LifeSouth
5. Breyanzi
6. Carvykti (ciltacabtagene autoleucel)
7. Clevecord (HPC Cord Blood)

8. Ducord (HPC Cord Blood)
9. Exondys 51 (eteplirsen)
10. Gintuit (Allogeneic Cultured Keratinocytes and Fibroblasts in Bovine Collagen)
11. Hemacord ((HPC, Cord Blood)
12. HPC, Cord Blood
13. HPC, Cord Blood - MD Anderson Cord Blood
14. HPC, Cord Blood - Bloodworks
15. Imlygic (talimogene laherparepvec)
16. Kalydeco (ivacftor)
17. Kymriah (tisagenlecleucel)
18. Laviv (Azficel-T)
19. Luxturna
20. MACI (Autologous Cultured Chondrocytes on a Porcine Collagen Membrane)
21. Orkambi (lumacaftor, ivacaftor)
22. Provenge (sipuleucel-T)
23. Rethymic
24. Ryplazim (plasminogen, human-tymh)
25. Spinraza (nusinersen)
26. Stratagraft
27. Symdeko (tezacaftor)
28. Tecartus (brexucabtagene autoleucel)
29. Tegsedi (lnotersen)
30. Trikafta (elexacaftor, tezacaftor, ivavaftor)
31. Viltepso (Viltolarsen)
32. Vyondys 53 (golodirsen)
33. Yescarta (axicabtagene ciloleucel)
34. Zolgensma (onasemnogene abeparvovec-xioi)
35. Zynteglo (betibeglogene autoemcel)

H. CHELATION THERAPY

Chelation therapy is not covered.

I. CLOSE RELATIVE

Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

J. COMPLICATIONS OF NON-BENEFIT SERVICES

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

K. 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.

L. COSMETIC SURGERY

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

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

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

NOTE: Any Member who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA):

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

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

M. CUSTODIAL CARE

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

N. DIAGNOSTIC ADMISSIONS

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

O. DOMICILIARY CARE

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

P. EAR WAX

Services for the removal of ear wax are not covered.

Q. EDUCATIONAL PROGRAMS

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

R. ELECTIVE ABORTIONS

Elective abortions are not covered.

S. ENVIRONMENTAL MEDICINE

Treatment and services for environmental medicine and clinical ecology are not covered benefits 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.

T. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Procedures which are Experimental or Investigational in nature as defined in DEFINITIONS are not covered. This exclusion does not apply to services or treatments used in an Approved Clinical Trial, as defined by the ACA.

U. EYE CARE

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

V. GAMBLING ADDICTION

Treatment of an addiction to gambling is not a covered benefit.

W. GENDER REASSIGNMENT

Services related to gender reassignment operations and reversals of such procedures are not covered.

X. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Except as described under PREVENTIVE CARE, genetic molecular testing is not covered except for the following:

1. Amniocentesis testing is covered up to one (1) test per Member per pregnancy and
2. Testing is covered 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. This exclusion does not apply to the BRCA risk assessment and genetic counseling/testing requirement of the women's Preventive Care mandate of the ACA.

Authorization Review by Blue Cross Blue Shield of Wyoming is required before benefits will be paid.

Y. 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.

Z. HAIR LOSS

Wigs or artificial hairpieces, or hair transplants or implants, regardless of whether there is a medical reason for hair loss, are not covered except as described under SUPPLIES, EQUIPMENT AND APPLIANCES.

AA. 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.

BB. HYPNOSIS/HYPNOTHERAPY

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

CC. ILLEGAL ACT OR OCCUPATION OR ACT OF TERRORISM

Services for the treatment of an injury or illness sustained during, or resulting from, the commission of, or attempt to commit a felony, or to which a contributing cause was the Member's being engaged in an illegal occupation or any illegal act, are not covered. This includes, but is not limited to, acts of terrorism. This exclusion will not apply if the injury occurred as a result of being the victim or an act of domestic violence or if it occurred as the direct result of the participant's mental or physical medical Condition.

DD. ILLEGAL SERVICES

Services that are in violation of applicable State or Federal Law are not Covered Services.

EE. INCARCERATION

Benefits will not be provided to a Member who has been incarcerated.

FF. INFERTILITY

Benefits will not be provided for the treatment of infertility.

GG. LEGAL PAYMENT OBLIGATIONS

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

HH. MANAGED CARE PROVISIONS

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

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

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

JJ. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

KK. MISSED APPOINTMENTS

Expenses for missed appointments will not be considered eligible.

LL. NEGLIGENCE OR PROVIDER ERROR

Additional costs and/or care related to provider negligence. Wrong Surgeries include, but are not limited to, Surgery performed on the wrong body part, Surgery performed on the wrong person, objects left in patients after Surgery, etc.

MM. NUTRITIONAL SUPPLEMENTS

Except as specifically described in this Plan or where required by law, nutritional supplements are not covered.

NN. OBESITY AND WEIGHT LOSS

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

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

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

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

OO. ORTHOGNATHIC SURGERY

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

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

IMPORTANT NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required for Orthognathic Surgery. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization Review *before* receiving these healthcare services. Authorization Review may include the required

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

PP. PAYMENT IN ERROR

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

QQ. PERSONAL COMFORT OR CONVENIENCE

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

RR. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Services rendered by a physician 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.)

SS. PROCEDURES RELATED TO STUDIES

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

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

TT. PROHIBITED BY LAW EXCLUSION

That are to the extent that payment under this Plan is prohibited by law.

UU. 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.

VV. RADIOACTIVE CONTAMINATION
Benefits will not be provided for the treatment of radioactive contamination.

WW. REFRACTIVE ERRORS
Benefits will not be provided for the treatment of refractive errors.

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

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

ZZ. RIOT
Charges for services received as result of actively participating in a riot or public disturbance are not covered.

AAA. ROUTINE HEARING EXAMINATIONS
Except as indicated under PREVENTIVE CARE and for cochlear implants and bone-anchored hearing aids (BAHAs), services will not be covered for the testing of hearing acuity. Services will not be covered for the prescription or fitting of a hearing aid or for the services related to the prescription or fitting unless it is for cochlear implants and bone-anchored hearing aids (BAHAs).

BBB. 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.)

CCC. SELF-INFLICTED INJURIES
Injuries arising from attempted suicide and self-inflicted injuries or illness are not covered unless the injury is the result of a medical Condition (either physical or mental) or domestic violence.

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

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

obtained outside the United States are not covered.

FFF. SERVICES NOT IDENTIFIED

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

GGG. SERVICES PRIOR TO THE EFFECTIVE DATE

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

HHH. SEXUAL DYSFUNCTION/IMPOTENCE

Services related to the treatment of sexual dysfunction and impotence are not covered.

III. STERILIZATION

Sterilization is not covered except for female sterilizations as described under PREVENTIVE CARE.

JJJ. 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.

KKK. SUBROGATION

Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

LLL. SUBSCRIPTION SERVICES

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

MMM. TAXES

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

NNN. TELEMEDICINE

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

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

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

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

OOO. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

PPP. THERAPIES

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

QQQ. TOBACCO DEPENDENCY

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

RRR. TRAVEL EXPENSES

Travel expenses are not covered.

SSS. UNRELATED SERVICES

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

TTT. WAR

Expenses incurred for any illness or injury due to, or aggravated by, war or an act of war, whether declared or undeclared, civil war, insurrection, rebellion, acts of terrorism or revolution are not covered..

UUU. WEEKEND ADMISSIONS

Except in the case of a Medical Emergency, benefits will not be provided for a Member if he or she could have safely been admitted into the Hospital on a weekday.

VVV. WEIGHT LOSS PROGRAMS

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

WWW. WORKERS' COMPENSATION

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

GENERAL PROVISIONS

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

A. ASSIGNMENT OF BENEFITS

All benefits stated in this Plan are personal to the Member. Neither those benefits nor the payments to the Member may be assigned to any person, corporation, or entity. Any attempted assignment shall be void. Although Blue Cross Blue Shield of Wyoming may make direct payment to the Member's healthcare providers at its election, this payment will not constitute an assignment of benefits under this Agreement or any waiver of this provision. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. The direct payment from the Plan to a health care provider is not intended to confer upon the health care provider status as a beneficiary, under ERISA or otherwise, and shall not be construed to be an assignment of benefits to the health care provider. The right of any Covered Person to receive any benefits or payments under this Plan shall not be alienable by the Covered Person by assignment or any other method and shall not be subject to claims by the Covered Person's creditors by any process whatsoever. Any attempt to cause such right to be subjected will not be recognized, except to the extent required by law. Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

B. CHANGE TO THE PLAN

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

C. CLAIM FORMS

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

D. CLERICAL ERROR

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

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

E. COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this Plan. "Excess Insurance" and "Other Plan" as described below, do not include long-term care benefits; coverage only for accident (including accidental death and dismemberment); coverage for only a specified disease or illness (for example, cancer policies); hospital indemnity or other fixed indemnity insurance; or disability income insurance.

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third-party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation

When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses

"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan.

When some Other Plan provides benefits in the form of services rather than cash payments,

the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

1. Group, blanket or franchise insurance coverage;
2. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or Employee benefit organization plans;
3. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
4. Coverage under any Health Maintenance Organization (HMO); or
5. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will never pay more than it would have paid as primary. The plan first determines the amount it would have paid as primary and compares to what the Primary Other Insurance (OI) Carrier has paid.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

1. Non-Dependent or Dependent
    a. Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a Dependent, for example as an Employee, Member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a Dependent is the secondary plan.
    b. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
        (1) Secondary to the plan covering the person as a Dependent; and
        (2) Primary to the plan covering the person as other than a Dependent (e.g. a retired Employee,
    c. Then the order of benefits is reversed so that the plan covering the person as an Employee, Member, Subscriber, policyholder or retiree is the secondary

plan and the other plan covering the person as a Dependent is the primary plan.

2. Dependent Child Covered Under More than One Plan
Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:
   a. For a Dependent child whose parents are married or are living together, whether or not they have even been married:
      (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
   b. For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have even been married:
      (1) If a court decree states that one of the parent's is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      (2) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
      (3) If a court decree states that the parent have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provision of subparagraph (a) of this paragraph shall determine the order of benefits; or
      (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         (a) The plan covering the custodial parent;
         (b) The plan covering the custodial parent's spouse;
         (c) The plan covering the ono-custodial parent; and then
         (d) The plan covering the non-custodial parent's spouse.
   c. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.
      (1) For a Dependent child who has coverage under either or both parents' plan and also has his or her own coverage as a Dependent under a spouse's plan, the rule is paragraph (5) applies.
      (2) In the event the Dependent child's coverage under the spouse's plan

began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-Off Employee
   a. The plan covers a person as an active Employee that is, an Employee who is neither laid off nor retired or as a Dependent of an active Employee is the primary plan, The plan covering that same person as a retired or laid-off Employee or as a Dependent of a retired or laid-off Employee is the secondary plan.
   b. If the other plan does not have this rule, and as result, the plans do not agree on the order of benefits, this rule is ignored.
4. COBRA or State Continuation Coverage
   a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an Employee, Member, Subscriber or retiree or covering the person as a Dependent of an Employee, Member, Subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
   b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
   c. This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments,

this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan

within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired Condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage

You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or federal Medicaid program will be

secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you or your Dependent(s) are enrolled in the Plan due to your Retiree coverage, and you and/or your Dependent(s) did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with Benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non- discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active Employees age 65 or over and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

1. The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

   If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

2. The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end- stage renal disease). In this case the Plan is primary.

NOTE: This Plan will not pay primary for you or any covered Dependent if your Employer has fewer than 100 Employees (as determined under federal law). In this situation, Medicare will pay primary. Please contact the Plan Administrator for more information as to whether or not this provision applies to you.

3. End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3- month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non- discrimination rules issued by the Department of Defense.

F. DISCLAIMER OF LIABILITY

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

G. DISCLOSURE OF A MEMBER'S MEDICAL INFORMATION

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

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

4. In the event of a claim or litigation between the Member or prospective Member and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent, subject to Federal and State Law.

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

H. DISTINCT LEGAL ENTITIES

The Plan and the Employer are distinct legal entities.

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 Members have. Members should:

1. Always carry their identification card and present it to the Hospital, Facility Provider, Physician or Professional Provider whenever the Member receives treatment. However, this presentation shall not be construed as a solicitation of services by Blue Cross Blue Shield of Wyoming from the Healthcare Provider.
2. Be sure to carry the *new* identification card they will receive in the event that they change coverage. The old identification card should then be destroyed.
3. Contact Blue Cross Blue Shield of Wyoming immediately in the event the Identification Card is lost or stolen.

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. MEMBER'S LEGAL OBLIGATIONS

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

M. 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.

N. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

O. PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

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

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

1. The Group must ensure it takes the steps necessary to reasonably and appropriately safeguard all PHI it creates, receives, maintains or transmits on behalf of the Plan.
2. The Group must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
3. The Group will neither use nor further disclose a Member's PHI except as permitted by this Benefit Booklet or as required by law.
4. The Group will ensure that its agents, including subcontractors, to whom it provides a Member's PHI, agree to the same restrictions and conditions that apply to the Group with respect to a Member's PHI.
5. The Group will not use or disclose a Member's PHI for any actions or decisions related to a Member's employment or in connection with any other Employee related benefits made available to a Member.
6. The Group will promptly report to the Plan any use or disclosure of a Member's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.

7. The Group will make available to the Plan any PHI necessary to comply with the Member's right to access his/her PHI.
8. The Group will make available to the Plan any PHI necessary to amend and/or incorporate any amendments to PHI as required by law.
9. The Group will document disclosures it makes of a Member's PHI and make this disclosure information available to the Plan in order to allow the Plan to provide an accounting of disclosures as required by law.
10. The Group will make its internal practices, books, and records relating to its use and disclosure of a Member's PHI available to the U. S. Department of Health and Human Services as necessary to determine compliance with federal law.
11. The Group will, where feasible, return or destroy a Member's PHI and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Group must limit further uses or disclosures of a Member's PHI to those purposes that make the return or destruction of the information infeasible.
12. The Group will ensure adequate separation between itself and the Plan in accordance with 45 C.F.R. §§164.504(f)(2)(iii) and 164.314(b)(2)(ii). Only the following Employees or classes of Employees will be given access to a Member's PHI: The designated group contact and Employees in charge of benefit administration. These Employees' or classes of Employees' access to and use of a Member's PHI is limited to the administrative functions that the Group performs for the Plan. Any issues relating to the Group's non-compliance of these requirements shall be handled pursuant to the requirements set out under HIPAA and other applicable federal and state law.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage, Disclosures of Genetic Information:

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

P. PRUDENT MEDICAL CARE

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

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

Q. SELECTION OF DOCTOR

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

R. SENDING NOTICES

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

S. STATEMENTS AND REPRESENTATIONS

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

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

1. The statements and/or representations are fraudulent; or

2. The statements are material to the acceptance of the risk or coverage of the benefits provided under the Plan; or
3. The Plan sponsor, in good faith, if it knew the true facts as required by any application or other document as provided in this section, would not have:

    a. Entered into the Plan or issued the coverage; or
    b. Provided coverage with respect to the Condition which is the basis for a claim under this Plan.

T. SUBROGATION

Payment Condition:

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.
3. In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered

designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation:

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action.
2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
3. The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

    a. The responsible party, its insurer or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' Compensation or other liability insurance company; or
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

    The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement:

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The

obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Covered Person Is A Trustee Over Plan Assets:

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance:
If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds:
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death:
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations:
1. It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan's rights;

b. To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;
h. To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;
i. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or Condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset:
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status:
1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the

minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation:
The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability:
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

U. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Plan not more than forty-five (45) days or with respect to services in a non-Participating emergency department of a Hospital or with respect to Emergency Services in a non-Participating Independent Freestanding Emergency Department not later than thirty (30) days after receipt of written proof of the claim and supporting evidence. Such supporting evidence may include, but not be limited to, medical records or other documentation required for claim analysis and payment in accordance with this Plan. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Plan, the claim payment time will not commence until all such necessary records or documentation are received by Blue Cross Blue Shield of Wyoming from any source.

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

The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Group and Blue Cross Blue Shield of Wyoming, that Blue Cross Blue Shield of Wyoming is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the Association permitting Blue Cross Blue Shield of Wyoming to use the Blue Cross Blue Shield Service Marks in the State of Wyoming, and that Blue Cross Blue Shield of Wyoming is not contracting as the agent of the Association. The Group further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross Blue Shield of Wyoming and that no person, entity, or organization other than Blue Cross Blue Shield of Wyoming shall be held accountable or liable to the Group for any of Blue Cross Blue Shield of Wyoming's obligations to the Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross Blue Shield of Wyoming other than those obligations created under other provisions of this Agreement.

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

X. COVID-19 AMENDMENT

In accordance with guidance or mandates from federal, state, or local authorities, administrative bodies, or regulatory agencies; there may be a temporary change to the way services are rendered and paid under certain extraordinary circumstances (such as pandemics, states of emergency, etc.).

COVID-19 Testing

The Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior Authorization Review or other medical management requirements, for the following items and services furnished during any portion of the period covered by the COVID-19 public health emergency declaration:

1. An in vitro diagnostic test for the detection of SARs-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test, that:
    a. Has been approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act;
    b. The developer has requested, or intends to request, emergency use authorization under the Federal Food, Drug, and Cosmetic Act (unless and until the request is denied or the developer does not submit a request within a reasonable timeframe);
    c. Has been developed in, and authorized by, a State, and for which proper notification has been made to Department of Health and Human Services ("HHS"); or
    d. The HHS has deemed to be appropriate.
2. Items and services furnished to an individual during health care provider office visits (including both in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic test described in subsection (a), but only to the extent such items and services relate to the furnishing or administration of such test or to the evaluation of such individual for purposes of determining the need of such individual for such test.

Rapid Coverage of Prevention Services and Vaccines for Coronavirus

1. The plan shall cover qualifying coronavirus preventive services without any cost sharing (including deductibles, copayments, and coinsurance).
2. For purposes of this Section, the term "qualifying coronavirus preventive service" means an item, service, or immunization that is intended to prevent or mitigate the COVID-19 disease and that is:
    a. an evidence-based item or service that has in effect a rating of 'A" or "B" in the current recommendations of the United States Preventive Services Task force; or
    b. an immunization that has in effect a recommendation from the Advisory
3. Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
    a. This Section shall become effective as of the date that is 15 business days after the date on which a recommendation relating to the qualifying coronavirus preventive service as described in paragraph (b)(ii) above is made.
    b. Subject to subsequent guidance to the contrary, the provision of the Section shall apply only to the qualifying coronavirus preventive services furnished by a Participating provider, under rules similar to the coverage of preventive services governed by the Affordable Care Act.

Temporary Exemption for Telehealth Services.

Effective through the end of the COVID-19 emergency public health declaration, the Group health Plan shall not impose cost share for telehealth and other remote care services.

Prescription Drugs

Allow for early Prescription Drug refills, extended supplies, and coverage of new medications.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. PLAN ADMINISTRATOR

1. This Plan is the benefit plan of Cyclone Drilling, also called the Plan sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. The Plan sponsor may also be the Plan Administrator or an individual may be appointed by the Plan sponsor to be the Plan Administrator and serve at the convenience of the Plan sponsor. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Plan sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

2. The Plan Administrator, or its designee, shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator, or its designee, shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator, or its designee, will be final and binding on all interested parties.

3. Service of legal process may be made upon the Plan Administrator.

4. The direct payment from the Plan to a Health Care Provider is not intended to confer upon the Health Care Provider status as a beneficiary, under ERISA or otherwise, and shall not be construed to be an assignment of benefits to the Health Care Provider. The right of any Covered Person to receive any benefits or payments under this Plan shall not be alienable by the Covered Person by assignment or any other method and shall not be subject to claims by the Covered Person's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

B. DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.

2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

3. To decide disputes which may arise relative to a Plan Member's rights.

4. To prescribe procedures for filing a claim for benefits and to review claim denials.

5. To keep and maintain the Plan booklets and all other records pertaining to the Plan.

6. To appoint a Claims Supervisor to pay claims.

7. To perform all necessary reporting as required by ERISA.

8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves without compensation, however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

D. FIDUCIARY

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

E. FIDUCIARY DUTIES

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the Plan documents to the extent that they agree with ERISA.

F. THE NAMED FIDUCIARY

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

MEMBERS' RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

A. PLAN DOCUMENTS AND FINANCIAL REPORTS

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

1. Examine, without charge, at the plan Administrator's, or Employer's, offices, as applicable, and at other specified locations, such as union halls or worksites, all benefit (plan) booklets including insurance contracts, and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and benefit (plan) descriptions.

2. Obtain copies of all benefit booklets and other information upon written request to the plan Administrator, or Employer, as appropriate. A reasonable charge may be made for these copies.

3. Receive a summary of a benefit financial report. The plan Administrator is required by law to furnish each Member with a copy of this summary annual report upon request.

B. FIDUCIARIES AND THEIR OBLIGATIONS

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

C. LEGAL RIGHTS TO BENEFITS

1. No person, including an employer, or any other person, may fire Members or otherwise discriminate against Members in any way to prevent Members from obtaining an employment benefit or exercising their rights under ERISA.

2. If any claim for a benefit that Members are legally entitled to is denied or ignored, in whole or in part, Members must receive a written explanation of the reason for the denial. This explanation may come in various formats. Members have the right to have Blue Cross Blue Shield of Wyoming review and reconsider their claim in accordance with the steps below.

3. Under the provisions of ERISA, there are various steps Members can take to enforce the above rights. For instance, if Members request materials and do not receive them within 30 days, Members may seek assistance from the U.S. Department of Labor, or

they may file a lawsuit in Federal Court. In such a case the court may require the entity from whom the Members requested materials to provide the materials and pay the Members up to $110.00 a day until they receive the materials, unless the materials the Members requested were not sent because of reasons beyond the control of the entity from whom materials were requested.

4. If Members have a claim for benefits that is denied or ignored, in whole or in part, the Members may file a lawsuit in a state or Federal Court. If it should happen that fiduciaries misuse the plan's money, or if the Members are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Members are successful the court may order the person being sued to pay these costs and fees. If the Members lose, the court may order them to pay these costs and fees; for example, if the court finds the Members' claim is frivolous.

D. CLAIMS FOR BENEFITS REQUIRING A REVIEW

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

If the Member and/or the Member's authorized representative improperly submits a claim for benefits, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative as soon as possible, but no later than 5 days after receipt of the claim for benefits and provide the Member and/or the Member's authorized representative with the proper procedures to be followed when filing a Claim for benefits. Blue Cross Blue Shield of Wyoming may also request additional or specified information after receiving a claim for benefits, but any such request will be made prior to the expiration of the initial 15 day time period after receiving the claim for benefits. Upon receiving notice of an improperly filed claim for benefits or a request for additional or specified information, the Member and/or the Member's authorized representative has 45 days in which to properly file the Claim for benefits and submit the requested information. After receiving the properly filed claim for benefits or additional or specified information, Blue Cross Blue Shield of Wyoming shall notify the Member and/or the Member's authorized representative of its determination within a reasonable period of time, but no later than 15 days after receipt of the properly filed claim for benefits and additional information.

E. CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For services or benefits requiring Authorization Review and involving an ongoing course of treatment taking place over a period of time or number of treatments, Blue Cross Blue

Shield of Wyoming will provide the Member and/or the Member's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Member and/or the Member's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

Upon receipt of a claim for benefits for emergency services from a Member and/or a Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination as soon as possible but no later than 72 hours after receiving the claim for benefits.

If the Member and/or the Member's authorized representative improperly submits a claim for benefits or the claim for benefits is incomplete and Blue Cross Blue Shield of Wyoming requests additional or specified information, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative as soon as possible, but no later than 24 hours after receipt of the claim for benefits. Upon receiving notice of an improperly filed claim of benefits or the request from Blue Cross Blue Shield of Wyoming for additional or specified information, the Member and/or the Member's authorized representative has 48 hours to properly file the claim for benefits or to provide the requested information. After receiving the properly filed claim for benefits or requested information, Blue Cross Blue Shield of Wyoming shall notify the Member and/or the Member's authorized representative of its determination as soon as possible, but no later than 48 hours after receipt of the additional or specified information requested by Blue Cross Blue Shield of Wyoming, or within 48 hours after expiration of the Member's time period to respond.

G. CLAIMS FOR BENEFITS NOT REQUIRING AUTHORIZATION REVIEW, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

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

H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

Upon receipt of a claim for benefits under the Plan from a Member and/or the Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member

and/or the Member's authorized representative of its determination within a reasonable period of time, but no later than 30 days from receiving the claim for benefits and only if the determination is adverse to the Member. Blue Cross Blue Shield of Wyoming may extend this initial time period in reviewing a claim for benefits an additional 15 days if Blue Cross Blue Shield of Wyoming is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's authorized representative notice of the need for additional time prior to the expiration of the initial 30 day time period.

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

I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW

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

J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

The Member and/or the Member's authorized representative have up to one-hundred eighty (180) days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of an Authorization Review of services or a Claim for Benefits for emergency services. Upon receipt of an appeal from a Member and/or the Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination, whether adverse or not, as soon as possible, but no later than seventy-two (72) hours after receiving the Member and/or the Member's authorized representative request for a review. A Member and/or the Member's authorized representative may request an appeal from a determination involving a Claim for Benefits for emergency services orally or in writing, and Blue Cross Blue Shield of Wyoming will accept needed materials by telephone or facsimile.

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

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

L. EXTERNAL CLAIMS REVIEW PROCEDURE

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

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

1. Medical Necessity Denials:
   Expedited Review: The Member may be entitled to an expedited review when his or her medical Condition or circumstances required, and in any event within 72 hours, where:

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

   To request an external review or an expedited review, the Member must submit the following completed documents that accompanied his or her claims and Authorization Review denial: Request form, release for records, a healthcare professional's statement of Medical Necessity and any other documents necessary. The State of Wyoming requires a fee to be submitted with all external review requests as noted in the Notice of Appeal Rights.

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

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

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

   To request an external review or an expedited review for his or her claims or Authorization Review denial the Member's request must be made in writing and sent to Blue Cross Blue Shield of Wyoming, 4000 House Ave., PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

M. DISCRETION OF PLAN ADMINISTRATOR

The Plan Administrator has full, conclusory, exclusive, and binding discretion to act with respect to the management, operation, and administration of this Plan in accordance with the provisions of the Plan.

N. ANSWERS TO QUESTIONS

1. If Members have any questions about any of the benefits associated with this health insurance agreement or their rights under this agreement, they should contact their employer or Blue Cross Blue Shield of Wyoming at (307) 634-1393. They can also call Blue Cross Blue Shield of Wyoming toll free at:

   In-State: 1-800-442-2376

2. If Members have any questions about their rights under ERISA, they should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.