CYCLONE DRILLING

Plan Document and Summary Plan Description

Effective October 1, 2016

Claims Supervisor:

BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross and Blue Shield Association

CYCLONE DRILLING
AMENDMENT
Effective October 1, 2017

In your Benefit Document on page 20, ELIGIBILITY REGULATIONS, the following language has been *added:*

B. DEPENDENT ELIGIBILITY

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.

In your Benefit Document on page 50, BENEFITS, the following highlighted language has been *revised:*

N. HUMAN ORGAN OR TISSUE 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 Participants 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

****

In your Benefit Document on page 66, BENEFITS, the following language has been *added:*

28. Screening for high blood pressure in adults – cover Ambulatory Blood Pressure Monitoring (ABPM) for diagnostic confirmation before starting treatment at 100%.
29. 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.
30. Routine prenatal services are covered at 100%.
31. Screening for latent tuberculosis infection in adults covered at 100%

****

In your Benefit Document under the section BENEFITS, page 70, the following language has been *revised:*

D. Prescription Drugs* - Must be filled as a prescription and submitted through the RxCare Wyoming™ Prescription Drug card program:

    1. Aspirin – limited to 81 mg only

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

CYCLONE DRILLING
AMENDMENT
Effective January 1, 2017

In your Benefit Document on page 69, BENEFITS, the following language has been *revised*:

X. REHABILITATION

BENEFITS -

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

For all other services, please refer to the Therapy Services section.

CYCLONE DRILLING
AMENDMENT
Effective January 1, 2017

In your Benefit Document on page 44, BENEFITS, the following language has been *added*:

G. DENTAL SERVICES

8. Emergency repair due to injury to sound natural teeth within one year of the accident, including the replacement of sound natural teeth.

****

In your Benefit Document on page 45, BENEFITS, the following language has been *removed*:

G. DENTAL SERVICES

LIMITATIONS AND EXCLUSIONS-

d. The first services must be performed within 90 days after the accident.
f. All services must be performed while the Participant's coverage is still in effect.

****

In your Benefit Document on page 51, BENEFITS, the following highlighted language has been *added*:

M. HOSPICE BENEFITS

Benefits are provided for the following:

7. Facilities

****

In your Benefit Document on page 71, BENEFITS, the following language has been *revised*:

X. REHABILITATION

BENEFITS -

Inpatient: Benefits will be provided to an unlimited number of visits per calendar year per Participant

Outpatient: Benefits will be provided to an unlimited number of visits per calendar year per Participant

****

In your Benefit Document on page 71, BENEFITS, the following language has been *removed*:

X. REHABILITATION

LIMITATIONS AND EXCLUSIONS -

Benefits are provided under this section only for CVA (cerebral vascular accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery, amputations, multiple fractures, severe burns, neonatal high risk infants, multiple sclerosis, amyotrophic lateral sclerosis, end stage cancer, and acquired immune deficiency syndrome.

The name RxCare Wyoming™ has been replaced with the Preferred Specialty Pharmacy Program

The name BlueCard® Program has been replaced with BCBS Global Core

CYCLONE DRILLING
AMENDMENT
Effective October 1, 2016

In your Benefit Document on the cover page, the following language has been *added:*

Restated October 1, 2015
Original Effective Date October 1, 2001

In your Benefit Document on page 3, GENERAL INFORMATION, the following language has been *revised:*

PLAN ADMINISTRATOR: Plan Administrator/ Plan Sponsor

In your Benefit Document on page 8, DEFINITIONS, the following language has been *revised*:

Spouse means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your state. The Plan Administrator may require documentation proving a legal marital relationship.

****

In your Benefit Document on page 21, ELIGIBILITY REGULATIONS, the following stricken language has been *revised*:

B. DEPENDENT ELIGIBILITY

3. For newly married individuals, an enrollment form must be submitted prior to the 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.

In your Benefit Document on page 26, HOW TO ADD, CHANGE, OR END COVERAGE, the following language has been *added:*

F. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

e. How to apply for the additional 29 months for disability: The disability must last until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to the employer on a date that is both within sixty (60) days after the late of 1) the date of the Social Security determination; 2) the date the coverage under the Plan would end due to the qualifying event; or 3) the date the Participant is given notice of the obligation to provide such notice and before the end of the initial 18-month period of coverage. If the Participant is later determined not disabled by Social Security determination; or 2) the date the Participant is given notice of the obligation to provide such notice.

****

In your Benefit Document on page 27, HOW TO ADD, CHANGE, OR END COVERAGE, the following language has been *revised:*

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.

****

In your Benefit Document on page 30, HOW TO ADD, CHANGE, OR END COVERAGE, the following language has been *added:*

I. 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.

THIS COVERAGE IS CONSIDERED A "GRANDFATHERED HEALTH PLAN"

The Plan Administrator believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Patient Protection Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 5800 Mohan Rd, Gillette, WY82717 (Ph. 306-682-4161). For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CYCLONE DRILLING

TABLE OF CONTENTS

APPROVAL 1

INTRODUCTION 2

GENERAL INFORMATION 3

SCHEDULE OF BENEFITS 4

DEFINITIONS 7

A. ADULT AND DEPENDENT COVERAGE 7
B. AGGREGATE DEDUCTIBLE 7
C. ALLOWABLE CHARGES 7
D. ANNIVERSARY DATE 7
E. APPLICANT OR EMPLOYEE 7
F. BILLING SERVICE DATE 7
G. BLUECARD® PROGRAM 7
H. CLAIMS SUPERVISOR 7
I. COINSURANCE 7
J. CONDITION 8
K. COPAYMENT 8
L. COVERED SERVICE 8
M. DEDUCTIBLE 8
N. DEPENDENT 8
O. DIAGNOSTIC SERVICE 9
P. ENROLLMENT DATE 9
Q. EXPERIMENTAL/INVESTIGATIONAL 9
R. FACILITY OTHER PROVIDER 9
S. FAMILY COVERAGE 10
T. FORMULARY 10
U. GROUP 10
V. HOME HEALTH AGENCY 11
W. HOSPITAL 11
X. INPATIENT 11
Y. LATE ENROLLEE 11
Z. LEGALLY EMPLOYED 12
AA. MEDICAL CARE 12
BB. MEDICAL EMERGENCY 12
CC. MEDICAL NECESSITY 12
DD. MENTAL ILLNESS 13
EE. NETWORK 13

FF. OPEN ENROLLMENT PERIOD 13
GG. OUT OF POCKET MAXIMUM AMOUNT 14
HH. OUTPATIENT 14
II. PARTICIPANTS 14
JJ. PARTICIPATING 14
KK. PHARMACY 14
LL. PHYSICIAN 14
MM. PLAN ADMINISTRATOR 15
NN. PRESCRIPTION DRUGS 15
OO. PROBATIONARY/WAITING PERIOD 15
PP. PROFESSIONAL OTHER PROVIDER 15
QQ. PROTECTED HEALTH INFORMATION (PHI) 15
RR. REHABILITATIVE ADMISSIONS 16
SS. SINGLE COVERAGE 16
TT. SURGERY 16
UU. THERAPY SERVICE 16
VV. TWO ADULT COVERAGE 16

FUNDING LEVELS AND CONTRIBUTIONS 17
A. HOW FUNDING LEVELS ARE ESTABLISHED AND CHANGED 17
B. CONTRIBUTION REQUIREMENTS 17

ELIGIBILITY REGULATIONS 18
A. ELIGIBILITY 18
B. DEPENDENT ELIGIBILITY 20

HOW TO ADD, CHANGE, OR END COVERAGE 21
A. HOW TO ADD EMPLOYEES 21
B. HOW TO ADD DEPENDENTS 21
C. CHANGES 23
D. WHEN COVERAGE UNDER THIS PLAN ENDS 23
E. WHEN COVERAGE FOR DEPENDENTS ENDS 24
F. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) 24
G. FAMILY AND MEDICAL LEAVE ACT 26
H. ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS 27

HOW BENEFITS WILL BE PAID 29
A. HOSPITALS AND FACILITY OTHER PROVIDERS 29
B. PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS 30
C. COVERAGE OF MEDICAL EMERGENCIES 30
D. DEDUCTIBLE REQUIREMENTS 30
E. PAYMENT ALLOWANCES UNDER THIS COVERAGE 31

F. CALCULATION OF OUT OF AREA PAYMENTS 32

BENEFITS 34
A. ACCIDENTS 35
B. ALLERGY SERVICES 36
C. AMBULANCE SERVICES 37
D. ANESTHESIA SERVICES 38
E. BLOOD EXPENSES 39
F. CARDIAC REHABILITATION 40
G. CONSULTATIONS 41
H. DENTAL SERVICES 42
I. DIABETES SERVICES 44
J. HEMODIALYSIS AND PERITONEAL DIALYSIS 45
K. HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY 46
L. HOME HEALTH CARE 48
M. HOSPICE BENEFITS 49
N. HUMAN ORGAN TRANSPLANTS 50
O. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, & MAGNETIC RESONANCE SERVICES 52
P. MATERNITY AND NEWBORN CARE 54
Q. MEDICAL CARE FOR GENERAL CONDITIONS 56
R. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE 58
S. NUTRITIONAL SUPPLEMENTS 60
T. PODIATRY SERVICES 61
U. PRESCRIPTION DRUGS AND MEDICINES 62
V. PREVENTIVE CARE 65
W. PRIVATE DUTY NURSING SERVICES 68
X. REHABILITATION 69
Y. ROOM EXPENSES AND ANCILLARY SERVICES 70
Z. SUPPLIES, EQUIPMENT AND APPLIANCES 72
AA. SURGERY 74
BB. SURGICAL ASSISTANTS 77
CC. THERAPIES 78

GENERAL LIMITATIONS AND EXCLUSIONS 80
A. ACUPUNCTURE 80
B. ALTERNATIVE MEDICINE 80
C. ARTIFICIAL CONCEPTION 80
D. AUTOPSIES 80
E. BIOFEEDBACK 80
F. CHELATION THERAPY 80
G. COMPLICATIONS OF NON-BENEFIT SERVICES 80
H. CONVALESCENT CARE 80
I. COSMETIC SURGERY 80
J. CUSTODIAL CARE 81

K.	DIAGNOSTIC ADMISSIONS	81
L.	DOMICILIARY CARE	81
M.	EAR WAX	81
N.	EDUCATIONAL PROGRAMS	81
O.	ELECTIVE ABORTIONS	81
P.	ENVIRONMENTAL MEDICINE	81
Q.	EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES	82
R.	EYE CARE	82
S.	GAMBLING ADDICTION	82
T.	GENETIC AND CHROMOSOMAL TESTING/COUNSELING	82
U.	GOVERNMENT INSTITUTIONS AND FACILITIES	82
V.	HAIR LOSS	83
W.	HOSPITALIZATIONS	83
X.	HYPNOSIS/HYPONOTHERAPY	83
Y.	ILLEGAL ACT OR OCCUPATION	83
Z.	INCARCERATION	83
AA.	INFERTILITY	83
BB.	LEARNING DISABILITIES	83
CC.	LEGAL PAYMENT OBLIGATIONS	83
DD.	MANAGED CARE PROVISIONS	83
EE.	MEDICAL SERVICES RECEIVED AS A RESULT OF CONTRACTUAL OBLIGATIONS OR A THIRD PARTY'S GUARANTEE TO PAY	83
FF.	MEDICALLY NECESSARY SERVICES OR SUPPLIES	84
GG.	MISSED APPOINTMENTS	84
HH.	NUTRITIONAL SUPPLEMENTS	84
II.	OBESITY AND WEIGHT LOSS	84
JJ.	ORTHOGNATHIC SURGERY	84
KK.	PAYMENT IN ERROR	85
LL.	PERSONAL COMFORT OR CONVENIENCE	85
MM.	PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS	85
NN.	PRE-ADMISSION REVIEW (PRIOR AUTHORIZATION)	85
OO.	PRE-CERTIFICATION (PROSPECTIVE REQUEST)	85
PP.	PROCEDURES RELATED TO STUDIES	86
QQ.	PROPHYLAXIS/PROPHYLACTIC MEDICINE	86
RR.	RADIOACTIVE CONTAMINATION	86
SS.	REFRACTIVE ERRORS	86
TT.	REPORT PREPARATION	86
UU.	ROUTINE HEARING EXAMINATIONS	86
VV.	ROUTINE PHYSICALS	86
WW.	SELF-INFLICTED INJURIES	87
XX.	SERVICES AFTER COVERAGE ENDS	87
YY.	SERVICES OUTSIDE THE UNITED STATES	87
ZZ.	SERVICES NOT IDENTIFIED	87
AAA.	SERVICES PRIOR TO THE EFFECTIVE DATE	87
BBB.	SEX CHANGE OPERATIONS	87

CCC. SEXUAL DYSFUNCTION/IMPOTENCE 87
DDD. STERILIZATION 87
EEE. SUBLUXATION 87
FFF. TAXES 87
GGG. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) 87
HHH. THERAPIES 88
III. TOBACCO DEPENDENCY 88
JJJ. TRAVEL EXPENSES 88
KKK. UNRELATED SERVICES 88
LLL. WAR 88
MMM. WEEKEND ADMISSIONS 88
NNN. WEIGHT LOSS PROGRAMS 88
OOO. WORKERS' COMPENSATION 88

GENERAL PROVISIONS 89
A. ASSIGNMENT OF BENEFITS 89
B. CHANGE TO THE PLAN 89
C. CLAIM FORMS 89
D. CLERICAL ERROR 89
E. COORDINATION OF BENEFITS 89
F. DISCLAIMER OF LIABILITY 91
G. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION 91
H. EXECUTION OF PAPERS 91
I. GENERAL INFORMATION ABOUT FILING CLAIMS 91
J. LIMITATION OF ACTIONS 92
K. PARTICIPANT'S LEGAL OBLIGATIONS 92
L. PHYSICAL EXAMINATION AND AUTOPSY 92
M. PLAN IS NOT AN EMPLOYMENT CONTRACT 92
N. PRIVACY OF PROTECTED HEALTH INFORMATION 92
O. PRUDENT MEDICAL CARE 94
P. SELECTION OF DOCTOR 94
Q. SENDING NOTICES 94
R. STATEMENTS AND REPRESENTATIONS 94
S. SUBROGATION 95
T. TIME OF CLAIM PAYMENT 96
U. WRITTEN NOTICE OF CLAIM 97

RESPONSIBILITIES FOR PLAN ADMINISTRATION 98
A. PLAN ADMINISTRATOR 98
B. DUTIES OF THE PLAN ADMINISTRATOR 98
C. PLAN ADMINISTRATOR COMPENSATION 99
D. FIDUCIARY 99
E. FIDUCIARY DUTIES 99
F. THE NAMED FIDUCIARY 99

PARTICIPANTS' RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 100
A. PLAN DOCUMENTS AND FINANCIAL REPORTS 100
B. FIDUCIARIES AND THEIR OBLIGATIONS 100
C. LEGAL RIGHTS TO BENEFITS 100
D. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE- CERTIFICATION 101
E. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE- CERTIFICATION AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS 102
F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES 102
G. CLAIMS FOR BENEFITS NOT REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS 102
H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS 103
I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION 103
J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES 104
K. INTERNAL APPEALS OF CLAIMS FOR ALL OTHER SERVICES OR BENEFITS 104
L. EXTERNAL CLAIMS REVIEW PROCEDURE 104
M. DISCRETION OF PLAN ADMINISTRATOR 105
N. ANSWERS TO QUESTIONS 106

APPROVAL

BENEFIT DOCUMENT

ACKNOWLEDGMENT OF RECEIPT AND APPROVAL

The Benefit Document for Cyclone Drilling

is approved.

Effective date is October 1, 2016.

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 Document 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.

GENERAL INFORMATION

The Plan originated on October 1, 2001 and was restated October 1, 2015.

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

PLAN SPONSOR: Cyclone Drilling

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: Cyclone Drilling

AGENT FOR SERVICE OF LEGAL PROCESS: Cyclone Drilling

NAMED FIDUCIARY: Cyclone Drilling

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

SCHEDULE OF BENEFITS

EMPLOYER NAME: Cyclone Drilling GROUP NUMBER : 312578
EFFECTIVE DATE: October 1, 2015

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.

DEDUCTIBLES: Network & Non-network Deductibles cross-accumulate.

Network:

Deductible per Participant per calendar year: $ 650
Maximum Aggregate Deductible per calendar year: $ 1300

Non-network

Deductible per Participant per calendar year: $ 750
Maximum Aggregate Deductible per calendar year: $ 1500

NOTE: RxCare Wyoming™ Copayments and Coinsurance cannot be applied to the Deductible.

COINSURANCE: Network & Non-network Coinsurance cross accumulates.

After the Deductible has been satisfied:

Network: Participants pay 40% Coinsurance for most Covered Services.

Non-network: Participants pay 60% Coinsurance for most Covered Services.

OUT OF POCKET MAXIMUM AMOUNT:

Network:

$1650 per Single coverage or,

$2500 per Family, Two Adult, or Adult & Dependent coverage, then:

Non-network:

$1750 per Single coverage or,

$3500 per Family, Two Adult, or Adult & Dependent coverage, then:

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-network providers and charges for services not covered by this Plan will NOT count toward satisfaction of Participants' Deductible or Out of Pocket Maximum Amount. Participants may be responsible for amounts over the Allowable Charges.

RxCare Wyoming™ Program:

Tier 1 Drugs:	Covered generic drugs require that Participants pay a $ 5 Copayment and 50% as Coinsurance.
Tier 2 Drugs:	Covered formulary brand drugs require that Participants pay a $ 10 Copayment and 50% as Coinsurance.

Mail Service Prescription Drug Program:

Tier 1 Drugs:	Covered generic drugs require that Participants pay a $ 10 Copayment and 50% as Coinsurance.
Tier 2 Drugs:	Covered formulary brand drugs require that Participants pay a $ 20 Copayment and 50% as Coinsurance.

Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit will be applied toward the 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:

Ambulance Services
Anesthesia Services
Blood Expenses
Cardiac Rehabilitation
Consultations
Diabetic Services
Home Health Care
Hospice Benefits
Hemodialysis and Peritoneal Dialysis
Human Organ Transplant
Laboratory, Pathology, X-ray, and Radiology Services
Magnetic Resonance Services
Maternity & Newborn Care
Mental Health or Substance Use Disorder Care
Physician's Office Visits
Podiatry Services
Prescription Drugs & Medicine
Preventive Care
Rehabilitation
Room Expenses & Ancillary Services
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)
Surgical Assistants
Therapy (Chemotherapy, Radiation Therapy, Physical Therapy)

Preventive Care is covered only when services are provided by a Network provider and without regard to any Deductible or Coinsurance that might otherwise apply. Please see this section on PREVENTIVE CARE for details.

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

THIS COVERAGE ALSO INCLUDES THE FOLLOWING:

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

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.

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

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

L. *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.

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

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

O. *BILLING SERVICE DATE*
The date used in assigning effective dates and issuing billings.

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

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

R. *COINSURANCE*
A percentage of the cost of Covered Services that is a Participant's responsibility after the Deductible has been met. Blue Cross Blue Shield of Wyoming calculates a Participant's Coinsurance Amount off of the Allowable Charges. In the case of services obtained out of Blue Cross Blue Shield of Wyoming's service area, a local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require a Coinsurance calculation that is not

based on the discounted price the provider has agreed to accept from the Host Plan, but is, instead, based on the provider's full billed charges. This may result in a higher or, in some cases, lower Coinsurance payment for certain claims incurred when outside of Blue Cross Blue Shield of Wyoming's service area. Because of the many different arrangements between the host Plans and their providers, it is not possible to give specific information for each out-of-area provider. (NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.)

S. CONDITION

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

T. COPAYMENT

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

U. COVERED SERVICE

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

V. DEDUCTIBLE

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

W. DEPENDENT

An Employee's Dependents are the following:

1. Legal spouse who is currently a permanent resident in the home of the Employee.
2. The children, including newborn children, step children, adopted children, Dependents which the court has decreed support to the Employee and legal wards of the Employee or the Employee's spouse. The limiting age for covered children is 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.

X. DIAGNOSTIC SERVICE

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

Y. 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.

Z. 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.

AA. FACILITY OTHER PROVIDER

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

1. Substance Use Disorder Treatment Center or Facility is a detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism, or a Facility Other Provider which is primarily engaged in providing detoxification and rehabilitation treatment for substance use disorders.
2. Ambulatory Surgical Facility is a Facility Other Provider, with an organized staff of Physicians, which:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis,
b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility,
c. does not provide inpatient accommodations, and
d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician, or Professional Other Provider.

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

BB. FAMILY COVERAGE

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

CC. 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.

DD. 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.

EE. 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.

FF. HOSPITAL

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

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

GG. INPATIENT

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

HH. 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.

II. 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.

JJ. MEDICAL CARE

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

KK. MEDICAL EMERGENCY

A Medical Emergency condition is:

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

LL. MEDICAL NECESSITY

1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
   a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
   b. Provides for the diagnosis, direct care and treatment of the Participant's condition, illness, disease or injury;
   c. Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care;
   d. Is not primarily for the convenience of the Participant, Physician or other health care provider; and
2. A medical service, procedure or supply shall not be excluded from being a Medical Necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

a. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act.

MM. MENTAL ILLNESS

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

NN. NETWORK

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

NOTE: A Hospital, Facility Other Provider, Physician, or Professional Other Provider who has not entered into an agreement with Blue Cross Blue Shield of Wyoming or another Blue Cross Blue Shield plan is called Non-network. When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by such Non-network Providers, the amount(s) a Participant pays for Covered Services will generally be based on either the Host Blue's Non-network Provider local payment or the pricing arrangements required by applicable state law. In some instances, a Non-network Physician or Professional Other Provider may bill Participants directly and payments will be made directly to the Participant. Similarly, if Participants choose a Non-network Hospital or Facility Other Provider, they may be billed directly and payments may be made directly to the Participant. Participants will be responsible to Non-network Providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Plan.

OO. OPEN ENROLLMENT PERIOD

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

PP. *OUT OF POCKET MAXIMUM AMOUNT*

The total Copayment, Deductible and Coinsurance amounts for Covered Services that are a Participant's responsibility during a single calendar year. When the Participant'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 Network and Non-network 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.

QQ. *OUTPATIENT*

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

RR. *PARTICIPANTS*

The Employee and the Employee's covered Dependents.

SS. *PARTICIPATING*

A dentist or 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 dentist or Pharmacy.

NOTE: A dentist or 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 dentist or Pharmacy, the amount(s) a Participant pays for Covered Services will generally be based on either the Host Blue's Non-participating Provider local payment or the pricing arrangements required by applicable state law. A non-participating dentist or Pharmacy will bill Participants directly and the Participants will be responsible for all charges.

TT. *PHARMACY*

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

UU. *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.

VV. 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").

WW. 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.

XX. PROBATIONARY/WAITING PERIOD

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

YY. PROFESSIONAL OTHER PROVIDER

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

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

ZZ. PROTECTED HEALTH INFORMATION (PHI)

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

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

5. Identifies a Participant or could reasonably be used to identify a Participant.

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

AAA. REHABILITATIVE ADMISSIONS

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

BBB. SINGLE COVERAGE

Coverage provided for the Employee only.

CCC. 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.

DDD. THERAPY SERVICE

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

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

EEE. TWO ADULT COVERAGE

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

FUNDING LEVELS AND CONTRIBUTIONS

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

A. *HOW FUNDING LEVELS ARE ESTABLISHED AND CHANGED*

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

   a. 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).

   b. Determining Full-Time Employee Status for New Variable Hour or Part-Time Employees
      In determining whether a new variable hour 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.

c. Material Change in Position or Employment Status for New Variable Hour 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).

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: Active Employees age 65 and over must choose one of the following:
a. Retain coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary, or
b. Choose primary coverage benefits from the federal Medicare program. If the federal Medicare program is chosen, the Employee will NOT be allowed to remain on the Plan.

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. Covered spouses who turn age 65 must choose one of the following:
   a. Retain coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary, or
   b. Choose primary coverage benefits from the federal Medicare program. If the federal Medicare program is chosen, the spouse will NOT be allowed to remain on the Plan.

HOW TO ADD, CHANGE, OR END COVERAGE

A. HOW TO ADD EMPLOYEES

1. The Employee should complete an application for coverage which must be forwarded to Blue Cross Blue Shield of Wyoming within thirty (30) days of the end of any applicable Probationary Period. If there is no Probationary Period, the application must be received within thirty (30) days of the date of hire.

2. Based on the completeness and acceptability of the application, 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 application is not submitted as described above, the Employee will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the Group's annual Open Enrollment Period (September 1-30). Provided the application is received by Blue Cross Blue Shield of Wyoming during the Open Enrollment Period, a Late Enrollee will have coverage effective under this Plan on October 1.

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

B. HOW TO ADD DEPENDENTS

1. Eligible Dependents can be added at the time the Employee applies for coverage by including their names and dates of birth on the application and checking the appropriate box. If the Dependent is included on the Employee's application, 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 application, a new application is required. If the application 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 application. Eligible Dependents who are considered to be Late Enrollees because their application was not received by Blue Cross Blue Shield of Wyoming 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 application is received by Blue Cross Blue Shield of Wyoming 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 application for coverage and forward it to Blue Cross Blue Shield of Wyoming immediately. The application must be received by Blue Cross Blue Shield of Wyoming within the prescribed period following the acquisition of the new Dependent as described below.

4. The effective date of coverage for newly acquired Dependents will be as follows:

   a. The new spouse will be effective on the date of marriage providing an application is received prior to the date of marriage. If the application 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 application 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 application for coverage of the newborn child is received by Blue 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 application for coverage for the child will be required before claims will be processed. The Employee may continue the coverage for the adopted child or legal ward beyond the 31-day automatic coverage provided that the completed application for the adopted child or legal ward is received by Blue Cross Blue Shield of Wyoming within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the effective date of coverage will be the date of entry of a final adoption decree by the court). NOTE: (1) The adoption or legal guardianship papers must accompany the application; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

NOTE: If a new application is not received by Blue Cross Blue Shield of Wyoming 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 application is forwarded to Blue Cross Blue Shield of Wyoming during the Open Enrollment Period, a Late Enrollee will have coverage under this Plan on October 1.

C. CHANGES

The Employee or 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. These changes will be made only upon approval by Blue Cross Blue Shield of Wyoming. All changes must be in accordance with the ELIGIBILITY REGULATIONS section of this Plan.

D. 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. When there is improper use of this Plan or the identification card, or when there is fraud or material misrepresentation associated with the application, or with the filing of a claim by the Participant. The Employee is liable for any benefits payments made through such improper actions.

6. Active Employees age 65 and over must choose one of the following:
   a. Retain coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary, or
   b. Choose primary coverage benefits from the federal Medicare program. If the federal Medicare program is chosen, the Employee will NOT be allowed to remain on the Plan.

E. 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 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.

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 Employee notifies Blue Cross Blue Shield of Wyoming in writing to end coverage for a Dependent. Coverage ends on the next Billing Service Date following receipt of the written request

6. For newborn and adopted children, at the end of the 31-day automatic coverage period, unless a completed application for coverage of the child is forwarded to Blue Cross Blue Shield of Wyoming no later than thirty (30) days after the end of that automatic coverage period.

7. Covered spouses who turn age 65 must choose one of the following:
   a. Retain coverage under this Plan as their primary coverage while the federal Medicare program serves as secondary, or
   b. Choose primary coverage benefits from the federal Medicare program. If the federal Medicare program is chosen, the spouse will NOT be allowed to remain on the Plan.

F. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) Participants may qualify for continued coverage under this Plan for a specified period of

time after coverage would normally terminate. Such continued benefits may last for up to 18, 24, 29 or 36 months, depending on the "Qualifying Event".

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

    a. When the Employee's employment is terminated (except for termination due to gross misconduct), or suffers a reduction in work hours (resulting in loss of coverage), the Employee is still eligible for continuation of coverage under the Plan.

    b. The Employee has the right to remain in the Plan at his or her own expense.

    c. The employer must notify Blue Cross Blue Shield of Wyoming within 30 days after an Employee terminates or has a reduction in work hours resulting in the loss of eligibility for health coverage. Blue Cross Blue Shield of Wyoming will notify the Employees of their continuation of coverage rights within 14 days of receiving notification from the employer or Employee. The Employee then must sign and return the COBRA election form to Blue Cross Blue Shield of Wyoming within sixty (60) days of either the date of the letter containing the form or the effective date of the COBRA continuation coverage, whichever is later. NOTE: Employees who do not apply for coverage within 60 days as described are <u>not</u> later eligible to apply during the annual Open Enrollment period.

    d. The period of continuation of coverage for the Employee under the original group plan is 18 months (24 months for a Employee who leaves the job and enters the Armed Forces on a full time basis, or up to a maximum of 29 months if a Employee is disabled at the time of termination), or to the time of either coverage under another group health plan or entitlement to Medicare, whichever occurs first.

    e. Continuation of coverage can be canceled only upon 1) abolition of all health plans by the employer, 2) the Employee's failure to make timely payment of monthly contributions, 3) the Employee's entitlement to Medicare, and 4) the Employee's coverage under another group health plan via remarriage.

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

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

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

b. Dependents have the right to remain in the Plan at their own expense.

c. The Employee or covered Dependent must notify Blue Cross Blue Shield of Wyoming within 60 days of the date of the loss of eligibility of the covered Dependent. Blue Cross Blue Shield of Wyoming will then notify Dependents of their rights to continuation of coverage within 14 days of Blue Cross Blue Shield of Wyoming's notification by the Employee or Dependent. These Dependents will then have 60 days to elect continuation of coverage under the Plan. (NOTE: If the Employee or covered Dependent fails to report the Dependent's loss of eligibility within 60 days as described, the Dependent loses the right to continuation of coverage.)

d. The period of continuation of coverage is 18, 24, 29 or 36 months as stated above, or to the time of either coverage under another group health plan or entitlement to Medicare, whichever occurs first.

G. *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 Participants while the Employee is on FMLA leave. Coverage for the Participants will be on the same basis as that provided for any other similarly situated 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.

H. ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS

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

1. If at the time of initial eligibility, Employees or Dependents decline coverage under this Plan because of other group health insurance coverage, they may be eligible for a special enrollment, provided they request enrollment within 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 application for coverage which must be forwarded to Blue Cross Blue Shield of Wyoming 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 Blue Cross Blue Shield of Wyoming of a substantially complete application.

2. If Employees gain a new Dependent as a result of marriage, birth, adoption, or placement for adoption, they may be eligible for a special enrollment for themselves and their Dependents, provided they complete an application for coverage which is forwarded to Blue Cross Blue Shield of Wyoming 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 application for coverage which must be forwarded to Blue Cross Blue Shield of Wyoming within thirty (30) days after the date of termination of the Employee's full-time duty status. The effective date of coverage under this Plan for all such Applicants will be the date of application, assuming receipt by Blue Cross Blue Shield of Wyoming of a substantially complete application.

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

HOW BENEFITS WILL BE PAID

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

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

A. HOSPITALS AND FACILITY OTHER PROVIDERS

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

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

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

PRE-ADMISSION REVIEW

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

PRE-CERTIFICATION

The Plan may require pre-certification of certain Covered Services as a requirement for payment. Pre-certification may include the required use of designated providers who have demonstrated high quality, cost efficient care. Services that require pre-certification are either identified through the pre-admission review process described above, or are listed under PRE-CERTIFICATION in the section on GENERAL LIMITATIONS AND EXCLUSIONS.

B. PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS

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

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

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

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

C. COVERAGE OF MEDICAL EMERGENCIES

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

D. 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 Participant will be eligible for benefits. The remaining family members will be eligible for benefits when they have collectively satisfied the remaining balance of the maximum Aggregate Deductible.

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

All Deductible amounts paid by a Participant for Covered Services will be applied toward satisfaction of both the Network and Non-network Deductible and Out of Pocket Maximum Amounts.

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

NOTE: The Deductible does not apply to PREVENTIVE CARE.

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 Participants' 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 Participant's calendar year. The other family members will not have to meet any additional Deductible requirements for charges related to the accident.

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

E. PAYMENT ALLOWANCES UNDER THIS COVERAGE

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

1. Participants 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 Participant for Covered Services will be applied toward satisfaction of both the Network and Non-network Out of Pocket Maximum Amounts.

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

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

F. CALCULATION OF OUT OF AREA PAYMENTS

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

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

1. BlueCard® Program

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

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

a. The billed charges for the Participant's Covered Services; or

b. The negotiated price that the Host Blue makes available to Blue Cross Blue Shield of Wyoming.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Participating Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Participating Provider or provider group that may include types of settlements, incentive payments, and/or

other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

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

   a. Participant's Liability Calculation

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

   b. Exceptions

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

BENEFITS

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

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

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

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

A. ACCIDENTS

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

BENEFITS -

Inpatient: See ROOM EXPENSES AND ANCILLARY SERVICES.

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

See SUPPLEMENTAL ACCIDENT BENEFIT for additional information relating to accidents.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ALLERGY SERVICES

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

BENEFITS –

Benefits include, but are not limited to, direct skin testing and patch testing, as well as allergy serum and injections.

LIMITATIONS AND EXCLUSIONS -

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 Participant cannot be safely transported by any other means. Benefits will be determined based on the final diagnosis:

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

Covered Services provided for Medical Emergencies as defined in the DEFINITIONS section will always be paid as Network benefits, even when provided by Non-network providers. However, Participants will be responsible for paying any amounts above the Allowable Charges if a Non-network 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 a benefit only when terrain, distance, or the Participant's condition warrants air ambulance services.

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

D. ANESTHESIA SERVICES

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

BENEFITS -

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

1. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services).
2. Covered Services performed in the outpatient department of a Hospital will be subject to 40% Coinsurance after the Deductible for Network services (subject to 60% Coinsurance after the Deductible for Non-network services).

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 -

1. 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 program designed to assist Participants recovering from recent heart problems by teaching them about their disease, symptoms, and management, and helping them to improve their coronary risk factors.

BENEFITS –

Pre-certification is required before benefits are payable.

Benefits will be provided for Inpatient and Outpatient cardiac rehabilitation services.

LIMITATIONS AND EXCLUSIONS –

Phase III cardiac rehabilitation is not covered.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. 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, Participants should provide any test results provided by their Physician when they obtain the second surgical opinion.

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

LIMITATIONS AND EXCLUSIONS -

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

See GENERAL LIMITATIONS AND EXCLUSIONS

H. 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 Participant 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).

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

Outpatient: Benefits will be provided for initial services provided by a Hospital or other facility for any one of the 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.

LIMITATIONS AND EXCLUSIONS -

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

a. Services, supplies, and appliances must be required due to an accidental injury.

b. Treatment must be for injuries to sound natural teeth.

c. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.

d. The first services must be performed within 90 days after the accident.

e. Related services must be performed within one year after the accident.

f. All services must be performed while the Participant's coverage is still in effect.

2. Hazardous Medical Conditions: If, due to a hazardous medical condition (e.g. a heart condition), a Participant must be hospitalized for a non-covered dental procedure, he or she may receive benefits for inpatient Hospital charges. However, benefits for the services provided by the dentist or oral surgeon will still be limited to those described under the Dental Expenses, if applicable.

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

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

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

6. 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. 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

I. 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 GENERAL LIMITATIONS AND EXCLUSIONS

J. 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 Participant as an Inpatient, in the outpatient department of a Hospital or Facility Other Provider, or in the Participant's home. The Plan will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Physician and required for therapeutic use.

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

BENEFITS -

Pre-certification is required before benefits are payable.

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

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

LIMITATIONS AND EXCLUSIONS -

1. Coverage of this benefit is subject to all pre-admission review and pre-certification requirements including the use of designated facility providers.

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

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS.

L. HOME HEALTH CARE

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

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

1. The Participant would have to be admitted to a Hospital or skilled nursing facility if he or she did not receive home health care.
2. The Participant's home health care must be ordered by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the condition for which hospitalization was required.
5. The program must begin within fourteen (14) days of discharge from the Hospital or skilled nursing facility.

BENEFITS -

Pre-certification is required before benefits are payable.

Inpatient: Not covered.

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

1. Nursing Care: Part-time or periodic home nursing care. A registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed public nurse, or a licensed vocational nurse under the supervision of a registered nurse may provide the service.

2. Home Health Aide Care: Part-time or periodic care by home health aides.

3. Rehabilitative Care: Physical, occupational, or speech therapy, if provided by the home health care agency.

4. Medical Supplies: Medicines and medical supplies ordered by a Physician and provided by the home health care agency.

Covered Services will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services). Benefits will be provided to a maximum of 180 days per Participant 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.

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HOSPICE BENEFITS

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

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

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

BENEFITS -

Pre-certification is required before benefits are payable.

Benefits are provided for the following:

1. Periodic nursing care by registered or practical nurses.
2. Home health aides.
3. Homemaker services.
4. Physical, occupational and respiratory therapy.
5. Medical social workers.
6. Bereavement counseling sessions for covered family members following the death of the terminally ill patient to a maximum of fifteen (15) visits per calendar year. (Covered bereavement sessions will be subject to 50% Coinsurance after the Deductible for both Network and Non-network services.)

Except as described above for bereavement sessions, Covered Services will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services). These hospice benefits are in place of all other benefits provided under any other part of the Plan for the same services.

See GENERAL LIMITATIONS AND EXCLUSIONS

N. HUMAN ORGAN TRANSPLANTS

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

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

BENEFITS -

Pre-certification is required before benefits are payable.

Hospital:

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

Physician:

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

LIMITATIONS AND EXCLUSIONS –

1. Transportation, meals, lodging: The cost of transportation, meals, and lodging related to a human organ transplant are not covered.

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

3. 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.

4. Donor expenses are not covered if the donor is a Participant but the recipient is not.

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

Pre-admission testing that is repeated in the Hospital will *not* be paid unless medically necessary.

LIMITATIONS AND EXCLUSIONS -

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

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

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

4. When more than one (1) magnetic resonance service is performed on the same day, benefits for the technical component will be limited to 50% of the Allowable Charge for each magnetic resonance service after the first.

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

6. Venipuncture/Handling Fee: Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.

See GENERAL LIMITATIONS AND EXCLUSIONS

P. MATERNITY AND NEWBORN CARE

DEFINITIONS - "Maternity" services are those required by 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.
5. Ectopic pregnancies.

"Newborn" services include the following:

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

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

BENEFITS -

Hospital:

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

Outpatient: The following charges are covered:

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

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

1. Delivery services (pre- and post-natal medical care is included in the allowance for delivery services).
2. Laboratory and X-ray services (see LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

Newborn Care:

1. Routine nursery charges billed by a Hospital.

2. Routine inpatient care of the newborn child and standby care of a pediatrician at a caesarean section.

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

LIMITATIONS AND EXCLUSIONS -

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

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. MEDICAL CARE FOR GENERAL CONDITIONS

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

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

BENEFITS -

Hospital:

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

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

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

Physician:

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS -

1. Private Room Expenses: If a Participant 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, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

See GENERAL LIMITATIONS AND EXCLUSIONS

R. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

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

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

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

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

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

BENEFITS –

Inpatient:

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

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

Intensive Outpatient:

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

Other Outpatient or Office:

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

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

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

In addition, Covered Services provided for Medical Emergencies as defined in the DEFINITIONS section will always be paid as Network benefits, even when provided by Non-network providers. However, Participants will be responsible for paying any amounts above the Allowable Charges if a Non-network 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. Diagnosis for Mental Health or Substance Use Disorder: Services must be for the diagnosis and/or treatment of manifest mental health or substance use disorders. These disorders are described in two publications:

   a. The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693)
   b. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

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

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

S. 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

T. 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, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

U. PRESCRIPTION DRUGS AND MEDICINES

"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".

Pharmaceutical manufacturer volume discounts in connection with the purchase of certain covered Prescription Drugs may occur. Such discounts are the sole property of Blue Cross Blue Shield of Wyoming and will not be considered in calculating any Participant's Coinsurance, Copayment, or benefit maximums. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the Plan.

A. BENEFITS AVAILABLE THROUGH THE RxCare Wyoming™ RETAIL PHARMACY PROGRAM

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

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

1. Tier 1 Drugs: Covered generic drugs require a $ 5.00 Copayment and 50% Coinsurance.
   Tier 2 Drugs: Covered Formulary brand drugs require a $10.00 Copayment and 50% of Allowable Charges as Coinsurance.

   Insulin and diabetic supplies are considered to be covered under RxCare Wyoming™ benefits. Prescription birth control products that are self-administered and do not require the services of a Physician beyond the writing of the prescription (for example: oral medication, patches, and the Nuvaring), are also covered. Tier 1 and Tier 2 prescription birth control products prescribed for the purpose of contraception will be covered as indicated under PREVENTIVE CARE.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit will be applied toward the Plan's Out of Pocket Maximum Amount.
2. If the Participant chooses a brand drug when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug.

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

If a Participant must purchase drugs from a non-participating Pharmacy, Blue Cross Blue Shield of Wyoming can provide the Participant with special claim forms to obtain benefits under this section of the Plan. The claim forms must be sent to the address indicated on the form. When using a non-participating Pharmacy, the Participant will be responsible for the difference between RxCare Wyoming's™ Allowable Charge and the actual charge made by the Pharmacy.

B. BENEFITS AVAILABLE THROUGH THE RxCare Wyoming™ MAIL SERVICE PHARMACY PROGRAM:

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

Insulin and diabetic supplies are considered to be covered under RxCare Wyoming™ benefits. Prescription birth control products that are self-administered and do not require the services of a Physician beyond the writing of the prescription (for example: oral medication, patches, and the Nuvaring), are also covered. Tier 1 and Tier 2 prescription birth control products prescribed for the purpose of contraception will be covered as indicated under PREVENTIVE CARE.

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

1. Tier 1 Drugs: Covered generic drugs require a $ 10.00 Copayment and 50% Coinsurance.
   Tier 2 Drugs: Covered Formulary brand drugs require a $20.00 Copayment and 50% Coinsurance.

   Formulary drugs are determined by Blue Cross Blue Shield of Wyoming. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit will be applied toward the Plan's Out of Pocket Maximum Amount.
2. If the Participant chooses a brand drug when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug.
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.

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 under RxCare Wyoming™.

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.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. 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 Network providers, benefits will be reimbursed at 100% of the Allowable Charges for Covered Services without regard to any Deductible or Coinsurance that might otherwise apply. (Benefits will also be provided when services are provided by a licensed health fair.)

Covered services include:

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

   1. Birth through 12 months – 7 visits
   2. 13 months through 35 months – 4 visits
   3. 36 months through 72 months – 1 visit per calendar year
   4. Oral health screening
   5. Fluoride varnish for the prevention of dental caries in children from birth up to the age of 6. Applied by primary care clinicians.
   6. Newborn blood screening – Bright Futures Update

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

   1. Visual impairment screening – 1 per calendar year
   2. Sensory hearing screening – 1 per calendar year
   3. Tuberculin test

C. For Participants age 6 years and older:

   1. Routine physical examination (office visit) – females: 2 per calendar year
      males: 1 per calendar year
   2. Adult aortic aneurysm screening for male Participants age 65 and older – lifetime maximum of 1 screening
   3. Alcohol misuse screening and behavioral counseling intervention (NOTE: Participants ages 6 to 18 only are limited to 1 / calendar year)
   4. Asymptomatic bacteriuria screening – pregnant women only

5. Hepatitis B virus infection screening
6. Rh (D) incompatibility screening – pregnant women only
7. Diabetes screening – pregnant women only
8. Iron deficiency anemia screening – pregnant women only

9. Contraceptive methods and management – female sterilizations, IUD inserted or removed & inserted on the same day, injections, cervical cap, sponge, female condoms, spermicide and diaphragm used to prevent conception
10. Lipid disorders screening once every 5 calendar years
11. Osteoporosis screening once every 2 calendar years – females age 60 and older
12. Sexually transmitted disease (STD) screening and counseling:

a. Chlamydial infection screening – men ages 16 – 18 and all women
b. Gonorrhea infection screening – men ages 16-18 and all women
c. Syphilis infection screening – women and men

13. Type 2 diabetes mellitus screening
14. Immunizations
15. HPV once every 3 calendar years – females age 30 and older
16. Screening and counseling for interpersonal and domestic violence
17. HIV screening and counseling
18. Colorectal cancer screening for Participants age 50 through 75:

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

19. Cervical cancer screening and related office visit – 1 per calendar year
20. PSA test – 1 per calendar year for Employee and spouse only
21. Mammogram screenings – 1 per calendar year for Employee and spouse only for routine services
22. Breast Pump – 1 pump per pregnancy (manual or electric pump from a Network home medical equipment provider only). Prior approval is required for Hospital grade pumps.
23. BRCA testing and genetic counseling if appropriate for women whose family history is associated with an increased risk for breast and ovarian cancer
24. Vitamin D supplementation for community-dwelling adults aged 65 years or older who are at increased risk for falls.
25. Hepatitis C screening – 1 per lifetime for Participants age 18 and older
26. Screening for lung cancer – limited to Participants age 55-80, 1 per calendar year
27. Behavioral counseling for cardiovascular health

D. Prescription Drugs – When filled as a prescription and submitted through the RxCare Wyoming™ Prescription Drug 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 males
   b. Ages 55 – 79 for females
   c. 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 – 6 years
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. 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 RxCare Wyoming™ Copayment and Coinsurance provisions unless the brand drug is both prescribed for preventive use and there is a demonstrated need for use of the brand rather than a generic drug. In that case, the required Copayment and Coinsurance would be waived.

If the Participant chooses a brand drug when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. See PRESCRIPTION DRUGS AND MEDICINES for more information.

LIMITATIONS AND EXCLUSIONS

1. PREVENTIVE CARE provided by Non-network providers: Benefits will not be provided for PREVENTIVE CARE services provided by Non-network 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.

See GENERAL LIMITATIONS AND EXCLUSIONS

W. PRIVATE DUTY NURSING SERVICES

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

BENEFITS -

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

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

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS -

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

X. REHABILITATION

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

BENEFITS -

Except for speech therapy, benefits are only provided for CVA (cerebral vascular accidents), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

Benefits for restorative or rehabilitative speech therapy are provided when necessary because of loss or impairment due to an illness, injury or Surgery, or therapy to correct a congenital anomaly.

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. ROOM EXPENSES AND ANCILLARY SERVICES

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

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

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

BENEFITS -

Inpatient:

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

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

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

LIMITATIONS AND EXCLUSIONS -

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

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

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

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

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

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

Z. SUPPLIES, EQUIPMENT AND APPLIANCES

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

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

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

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

BENEFITS -

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

2. Medical supplies, including but not limited to:

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

3. The following prosthesis and orthopedic appliances are covered, as well as fitting, adjusting, repairing, and replacement due to wear, or a change in the Participant's condition which makes a new appliance necessary.

    a. Artificial arms or legs.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Cervical collars.
    e. Surgical implants.
    f. Artificial eyes.
    g. Pacemakers
    h. Breast prosthesis and special bras.

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

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

6. Breast pumps as indicated under PREVENTIVE CARE. Pre-certification is required for any Hospital grade breast pumps.

7. Wigs – The purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer to a lifetime maximum of one (1) per Participant.

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

    a. Eocene glucose meter
    b. Eocene blood pressure cuff
    c. Eocene weight scale
    d. Eocene tracker
    e. Peak flow meter for oxygen
    f. Spacer for oxygen
    g. Eocene glucose monitor

LIMITATIONS AND EXCLUSIONS -

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

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

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

3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered.

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

AA. SURGERY

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

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

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, 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 will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services).
2. Covered Services performed in the outpatient department of a Hospital will be subject to 40% Coinsurance after the Deductible for Network services (subject to 60% Coinsurance after the Deductible for Non-network services).

Physician:

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

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

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

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

1. Covered Services performed in the Physician's office or at an Ambulatory Surgical Facility will be will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services).
2. Covered Services performed in the outpatient department of a Hospital will be subject to 40% Coinsurance after the Deductible for Network services (subject to 60% Coinsurance after the Deductible for Non-network services).

LIMITATIONS AND EXCLUSIONS -

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

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

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

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

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

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

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

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

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

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

7. Sex-Change Operations: 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

BB. 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 will be subject to 20% Coinsurance after the Deductible for Network services (subject to 40% Coinsurance after the Deductible for Non-network services).
2. Covered Services performed in the outpatient department of a Hospital will be subject to 40% Coinsurance after the Deductible for Network services (subject to 60% Coinsurance after the Deductible for Non-network services).

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

LIMITATIONS AND EXCLUSIONS -

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

CC. THERAPIES
(CHEMOTHERAPY, RADIATION, OCCUPATIONAL, PHYSICAL, SPEECH)

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

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

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

"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 Participant is admitted, the following types of therapy are covered:

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

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

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

Physician:

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS -

1. Occupational and Speech Therapy: Benefits will not be provided for occupational or speech therapy services (except as described under REHABILITATION).

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

See GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS AND EXCLUSIONS

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

A. ACUPUNCTURE

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

B. ALTERNATIVE MEDICINE

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

C. ARTIFICIAL CONCEPTION

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

D. AUTOPSIES

Services related to autopsies are not covered.

E. BIOFEEDBACK

Services related to biofeedback are not covered.

F. CHELATION THERAPY

Chelation therapy is not covered.

G. COMPLICATIONS OF NON-BENEFIT SERVICES

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

H. CONVALESCENT CARE

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

I. COSMETIC SURGERY

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

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

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

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

J. CUSTODIAL CARE

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

K. DIAGNOSTIC ADMISSIONS

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

L. DOMICILIARY CARE

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

M. EAR WAX

Services for the removal of ear wax are not covered.

N. EDUCATIONAL PROGRAMS

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

O. ELECTIVE ABORTIONS

Elective abortions are not covered.

P. 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.

Q. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

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

R. 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, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

S. GAMBLING ADDICTION

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

T. 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 Participant 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.

U. GOVERNMENT INSTITUTIONS AND FACILITIES

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

V. *HAIR LOSS*

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.

W. *HOSPITALIZATIONS*

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

X. *HYPNOSIS/HYPONOTHERAPY*

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

Y. *ILLEGAL ACT OR OCCUPATION*

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 Participant's being engaged in an illegal occupation or any illegal act, are not covered.

Z. *INCARCERATION*

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

AA. *INFERTILITY*

Benefits will not be provided for the treatment of infertility.

BB. *LEARNING DISABILITIES*

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

CC. *LEGAL PAYMENT OBLIGATIONS*

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

DD. *MANAGED CARE PROVISIONS*

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

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

Benefits will not be paid for any claims related to medical services or supplies that a Participant receives in relation to a third party's offer of any form of compensation or promise to pay any part or all of the costs of the medical services or supplies, as an inducement for the Participant to seek, request, undergo or otherwise receive those medical services or supplies. This exclusion includes, but is not limited to, surrogate

parenting, donation of body parts or organs, testing of medical procedures or supplies, gestational carrier services, pharmaceutical product testing and trials, and similar arrangements and agreements wherein the Participant receives compensation, directly or indirectly, in cash or any other form of consideration (including a promise to pay any part or all of the costs of such medical services or supplies), in exchange for the Participant's agreement to seek or receive such medical services or supplies.

FF. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

GG. MISSED APPOINTMENTS

Benefits will not be provided for missed appointments.

HH. NUTRITIONAL SUPPLEMENTS

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

II. OBESITY AND WEIGHT LOSS

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

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

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

JJ. ORTHOGNATHIC SURGERY

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

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

Pre-certification by Blue Cross Blue Shield of Wyoming is required before benefits are payable.

KK. PAYMENT IN ERROR

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

LL. PERSONAL COMFORT OR CONVENIENCE

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

MM. 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.)

NN. PRE-ADMISSION REVIEW (PRIOR AUTHORIZATION)

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

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

OO. PRE-CERTIFICATION (PROSPECTIVE REQUEST)

The following services MUST be authorized in advance as described in the BENEFITS section before benefits will be paid:

1. Breast reconstruction surgery
2. Cosmetic surgery
3. Dental-related services
4. High cost prescription drugs and medicines
5. High dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support
6. Home Health Care
7. Hospice Care
8. Human organ transplants
9. Obesity and weight loss services
10. Orthognathic surgery

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

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

QQ. 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.

RR. RADIOACTIVE CONTAMINATION

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

SS. REFRACTIVE ERRORS

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

TT. REPORT PREPARATION

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

UU. ROUTINE HEARING EXAMINATIONS

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

VV. 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.)

WW. 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.

XX. SERVICES AFTER COVERAGE ENDS

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

YY. SERVICES OUTSIDE THE UNITED STATES

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

ZZ. SERVICES NOT IDENTIFIED

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

AAA. SERVICES PRIOR TO THE EFFECTIVE DATE

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

BBB. SEX CHANGE OPERATIONS

Services related to sex change operations and reversals of such procedures are not covered.

CCC. SEXUAL DYSFUNCTION/IMPOTENCE

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

DDD. STERILIZATION

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

EEE. 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.

FFF. TAXES

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

GGG. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

HHH. THERAPIES

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

III. TOBACCO DEPENDENCY

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

JJJ. TRAVEL EXPENSES

Travel expenses are not covered.

KKK. UNRELATED SERVICES

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

LLL. WAR

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

MMM. WEEKEND ADMISSIONS

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

NNN. WEIGHT LOSS PROGRAMS

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

OOO. WORKERS' COMPENSATION

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

GENERAL PROVISIONS

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

A. ASSIGNMENT OF BENEFITS

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

B. CHANGE TO THE PLAN

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

C. CLAIM FORMS

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

D. CLERICAL ERROR

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

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

E. COORDINATION OF BENEFITS

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Participants often have other coverage providing duplicate benefits. In the event of other coverage, the Plan will not duplicate benefits if otherwise provided for (or should have been provided had the Participant elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage. If the Plan is determined to be secondary payor,

the sum of the benefits payable by the primary payor plus the sum of the benefits payable under this Plan shall not exceed the amount payable under this Plan had this Plan been determined to be the primary payor.

Determination of primary and secondary payor will be based on the following:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision.

2. Group coverage will be primary over an individual policy with a non-duplication provision.

3. Coverage of a plan, which covers the patient as an Employee will be primary over a plan covering the patient as a Dependent.

4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payor. If a plan does not have this provision, the primary payor will be determined by the provision of the plan not having this paragraph.

5. The above applies for children, except in situations where the parents are separated or divorced.

    a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the plan covering the child as a Dependent of the parent without custody.

    b. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the step-parent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.

    c. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.

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

    Except in situations of a laid-off or retired employee, or a Dependent of such employee, the plan covering the person as an active employee will be primary, over

the coverage as a laid-off or retired employee, unless either coverage does not contain a provision for laid-off or retired employees, then this subparagraph shall not apply.

F. DISCLAIMER OF LIABILITY

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

G. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION

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

1. Upon a written, dated, and signed authorization by the Participant or prospective Participant or by a person authorized to provide consent for a minor or an incapacitated person;
2. If the data or information does not identify either the Participant or prospective Participant or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
3. Pursuant to statute or court order for the production or discovery of evidence; or
4. In the event of a claim or litigation between the Participant or prospective Participant and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent.

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

H. EXECUTION OF PAPERS

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

I. GENERAL INFORMATION ABOUT FILING CLAIMS

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

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

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

J. LIMITATION OF ACTIONS

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

K. PARTICIPANT'S LEGAL OBLIGATIONS

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

L. 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.

M. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

N. PRIVACY OF PROTECTED HEALTH INFORMATION

The Group is the plan sponsor of this group health plan (Plan) within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Group also administers the Plan for the benefit of the Plan and its Participants. In order for the Group to properly administer the Plan, the Plan, or Blue Cross Blue Shield of Wyoming at the Plan's request, may disclose "summary health information" to the Group if the Group requests the summary health information for purposes of: (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending or terminating the Plan. "Summary health information" is information that summarizes the claims history, claims expenses, or claims experience of Participants for whom the Group has provided benefits under the Plan, but which has

been de-identified, pursuant to 45 C.F.R. §164.514(b)(2)(i). The Plan, or Blue Cross Blue Shield of Wyoming at the Plan's request, may also disclose to the Group information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

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

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

Employees' or classes of Employees' access to and use of a Participant's PHI is limited to the administrative functions that the Group performs for the Plan. Any issues relating to the Group's non-compliance of these requirements shall be handled pursuant to the requirements set out under HIPAA and other applicable federal and state law.

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

O. PRUDENT MEDICAL CARE

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

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

P. SELECTION OF DOCTOR

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

Q. SENDING NOTICES

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

R. 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.

S. SUBROGATION

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

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

5. If the Participant does not seek damages for his or her Condition, the Participant must permit the Plan Sponsor to initiate recovery on Participant's half (including the right to bring suit in Participant's name). This is called subrogation.

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

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

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

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

1. When a third party injures the Participant, for example, in an automobile accident or through medical malpractice.
2. When the Participant is injured on a premises owned by a third party.
3. When the Participant is injured and Benefits are available to Participant or Participant's dependents, under any law or under any type of insurance, including, but not limited to:
   a. No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by the Participant to treat those benefits as secondary to this Agreement.
   b. Uninsured and underinsured motorist coverage.
   c. Workers' compensation benefits.
   d. Medical reimbursement coverage.

T. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Plan not more than forty-five (45) days after receipt of written proof of the claim and supporting evidence. Such supporting evidence may include, but not be limited to, medical records required for claim analysis and payment in accordance with this Plan. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under this Plan, the 45-day claim payment time will not commence until all such necessary records are received by Blue Cross Blue Shield of Wyoming from any source.

U. WRITTEN NOTICE OF CLAIM

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

2. The Plan sponsor will not be liable under this Plan unless proper notice (proof) is furnished to Blue Cross Blue Shield that Covered Services have been rendered to a Participant. Written notice must be given within twelve (12) months after completion of services that are covered under this Plan. The notice must include the data necessary for Blue Cross Blue Shield of Wyoming to determine benefits. An expense will be considered incurred on the date the service or supply was rendered.

3. Failure to give notice to Blue Cross Blue Shield of Wyoming within the time specified above will not invalidate nor reduce any claim for benefits if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

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 Participant'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.

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 Participant's rights.

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

5. To keep and maintain the Plan documents 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.

PARTICIPANTS' 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 Participant as to all their rights under ERISA. Participants should consult their employer to determine whether their Plan is covered under ERISA.

A. PLAN DOCUMENTS AND FINANCIAL REPORTS

Participants 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 Participants 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) documents 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 documents 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 Participant with a copy of this summary annual report upon request.

B. FIDUCIARIES AND THEIR OBLIGATIONS

In addition to creating rights for employment benefit Participants, 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 Participants' employment benefits prudently and in the best interests of the Participants.

C. LEGAL RIGHTS TO BENEFITS

1. No person, including an employer, or any other person, may fire Participants or otherwise discriminate against Participants in any way to prevent Participants from obtaining an employment benefit or exercising their rights under ERISA.

2. If any claim for a benefit that Participants are legally entitled to is denied or ignored, in whole or in part, Participants must receive a written explanation of the reason for the denial. This explanation may come in various formats. Participants 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 Participants can take to enforce the above rights. For instance, if Participants request materials and do not receive them within 30 days, Participants 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 Participants requested materials to provide the materials and pay the Participants up to $110.00 a day until they receive the materials, unless the materials the Participants requested were not sent because of reasons beyond the control of the entity from whom materials were requested.

4. If Participants have a claim for benefits that is denied or ignored, in whole or in part, the Participants may file a lawsuit in a state or Federal Court. If it should happen that fiduciaries misuse the plan's money, or if the Participants 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 Participants are successful the court may order the person being sued to pay these costs and fees. If the Participants lose, the court may order them to pay these costs and fees; for example, if the court finds the Participants' claim is frivolous.

D. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

Upon receipt of a claim for benefits under this Plan from a Participant and/or Participant's authorized representative that is conditioned on a Participant's obtaining approval in advance of obtaining the benefit or service, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 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 Participant and/or the Participant's authorized representative notice of the need for additional time prior to the expiration of the initial 15 day time period.

If the Participant and/or the Participant's authorized representative improperly submits a claim for benefits, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative as soon as possible, but no later than 5 days after receipt of the claim for benefits and provide the Participant and/or the Participant'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 Participant and/or the Participant'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 Participant and/or the Participant'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 PRE-ADMISSION REVIEW OR PRE-CERTIFICATION AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For services or benefits requiring pre-admission review or pre-certification 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 Participant and/or the Participant's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Participant and/or the Participant's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant'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 Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible but no later than 72 hours after receiving the claim for benefits.

If the Participant and/or the Participant'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 Participant and/or the Participant'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 Participant and/or the Participant'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 Participant and/or the Participant'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 Participant's time period to respond.

G. CLAIMS FOR BENEFITS NOT REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For a claim for benefits that does not require pre-admission review or pre-certification, 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 Participant and/or the Participant's authorized representative with notice that

the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Participant and/or the Participant's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant'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 Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 30 days from receiving the claim for benefits and only if the determination is adverse to the Participant. 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 Participant and/or the Participant'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 Participant and/or the Participant'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 Participant and/or the Participant'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 PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

The Participant and/or the Participant's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a claim for benefits requiring preauthorization or prior approval of benefits or services. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 30 days after receiving the Participant's and/or the Participant's authorized representative's request for review.

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

J. *INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES*

The Participant and/or the Participant's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a claim for benefits for emergency services. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination, whether adverse or not, as soon as possible, but no later than 72 hours after receiving the Participant and/or the Participant's authorized representative request for a review. A Participant and/or the Participant'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.

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

K. *INTERNAL APPEALS OF CLAIMS FOR ALL OTHER SERVICES OR BENEFITS*

The Participant and/or the Participant's authorized representative have up to 180 days to appeal Blue Cross Blue Shield of Wyoming's adverse benefit determination of a claim for benefits. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 60 days after receiving the Participant and/or the Participant's authorized representative request for review.

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

L. *EXTERNAL CLAIMS REVIEW PROCEDURE*

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

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

1. Medical Necessity Denials:

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

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

   To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial: Request form, release for records, a health care professional's statement of medical necessity and any other documents necessary. The State of Wyoming requires a fee to be submitted with all external review requests as noted in the Notice of Appeal Rights.

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

2. All Other Denials:

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

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

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

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 Participants 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 Participants 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.

UnitedHealthcare Insurance Company

Specified Disease Policy

Organ and Tissue Transplant

185 Asylum Street
Hartford, Connecticut 06103-3408

Enrolling Group: Cyclone Drilling/JSH Time, LLC

Policy Number: 1001195

Policy Effective Date: October 1, 2017

Premium Due Date: October and the first day of each month thereafter

Policy Anniversaries will be each October 1

This policy is issued in Wyoming.

UnitedHealthcare Insurance Company ("we", "us" or "our") agrees to provide, for Eligible Persons becoming insured under this Policy, benefits according to the terms, provisions, conditions, exclusions and limitations of this Policy, including the *Certificate of Coverage*. The following pages, including the *Certificate of Coverage*, any Riders, endorsements or Amendments, are part of the Policy.

The Policy is issued in consideration of the Enrolling Group's application, a copy of which is attached.

This Policy replaces and supersedes any previous agreements relating to Coverage for Transplant Services between the Enrolling Group and us.

We shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy becomes effective at 12:01 A.M. Eastern Standard time on the Policy Effective Date shown above. The Policy will continue in force by the payment of Premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Enrolling Group and us. If the Enrolling Group has any questions or problems with the Policy, we are ready to help the Enrolling Group. The Enrolling Group may call upon its agent or our Home Office for assistance at any time.

Our President and Secretary have executed the Policy at Hartford, Connecticut. If the Enrolling Group or the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, the Enrolling Group or the Covered Person may call 1-800-367-4436.

Jeffrey Alter, President

Thomas J. McGuire, Secretary

POLICY GENERAL PROVISIONS

Article 1: Definitions

The terms used in this Policy have the same meaning given those terms *Section 13: Definitions* in the *Certificate of Coverage ("Certificate")*, unless otherwise specifically defined in this Policy.

Article 2: Coverage

Subscribers and their Enrolled Dependents are entitled to Coverage for Transplant Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate* and *Schedule of Benefits* included in this Policy. The *Certificate* and *Schedule of Benefits* describes the Transplant Services, including any optional Riders and Amendments, required Coinsurance, and the terms, conditions, limitations and exclusions related to Coverage.

Article 3: Premium Rates and Policy Charge

Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified on Exhibit 1 to this Policy entitled "Premiums." We reserve the right to change the schedule of rates for Premiums after a 31-day prior written notice on the first anniversary of the effective date of this Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of this Policy are amended. We also reserve the right to change the schedule of rates for Premiums, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates.

Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each coverage classification that we show in our records at the time of calculation. The Policy Charge will be calculated as follows using the Premium rates in effect at that time:

A full month's Premium shall be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.

Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers, or changes in coverage classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 60 days prior to the date we receive notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Coverage.

The Enrolling Group must notify us in writing within 31 days of the effective date of enrollments, terminations or other changes. The Enrolling Group must notify us in writing each month, of any change in the coverage classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges shall be automatically added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation shall result in an increase in Premium, in an amount we determine.

Payment of the Policy Charge

The Policy Charge is payable in advance by the Enrolling Group to us on a monthly basis. The first Policy Charge is due and payable on the effective date of this Policy. Subsequent Policy

Charges are due and payable no later than the first day of each period thereafter that this Policy is in effect.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments shall be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is made.

The Enrolling Group shall reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

Grace Period

A grace period of 31 days shall be granted for the payment of any Policy Charge, during which time this Policy shall continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate the Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days the Policy was in force during the grace period.

This Policy shall automatically terminate on the date the grace period expires if the Policy Charge remains unpaid.

Article 4: Policy Termination

Conditions for Termination of This Entire Policy

This Policy and all Coverage for Transplant Services under this Policy shall automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time the Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us, that this Policy shall be terminated.

C. On the date specified by us, after at least 31 days prior written notice to the Enrolling Group, that this Policy shall be terminated due to the Enrolling Group’s violation of participation and/or contribution rules.

D. On the date specified by us, after at least 31 days prior written notice to the Enrolling Group, that this Policy shall be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of Coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

    1. the effective date of this Policy.

    2. the date of the act, practice or omission, if later.

E. On the date specified by us in written notice to the Enrolling Group that this Policy will be terminated because the Enrolling Group does not provide us with information that we need to administer the Policy or fails to perform any of its obligations that relate to the Policy.

F. On the date specified by us, after at least 90 days prior written notice to the Enrolling Group, that this Policy shall be terminated because we, in our sole discretion, will no longer issue this particular type of group limited benefit organ transplant plan within the applicable market.

G. On the date specified by us, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy shall be terminated because we will no longer issue any employer health benefit plan within the applicable market.

H. At our election on the Premium due date following the date the number of Eligible Persons insured under this Policy is less than fifty-one (51).

Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group shall be and shall remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the grace period preceding the termination.

Article 5: General Legal Provisions

Entire Policy

The group Policy, including the *Certificate of Coverage*, the application of the Enrolling Group, Amendments and Riders shall constitute the entire Policy between parties. All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy; unless: 1) it is contained in a written statement signed by the Covered Person; and 2) a copy of the statement is furnished to the Covered Person or his/her beneficiary.

Dispute Resolution

The parties acknowledge that because this Policy affects interstate commerce, the Federal Arbitration Act applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it shall submit the complaint or dispute to binding arbitration pursuant to the rules of the American Arbitration Association. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy. Arbitration will take place in Hartford, Connecticut.

The matter must be submitted to binding arbitration within 1 year of the date a final decision was furnished to the Enrolling Group, as described in *Section 7: Questions, Complaints and Appeals* of the *Certificate*. The arbitrators shall have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and shall be bound by controlling law.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, shall be used to void this Policy after it has been in force for a period of two years.

Amendments and Alterations

Amendments to this Policy are effective 31 calendar days after we send prior written notice to the Enrolling Group. Riders are effective on the date specified by us. No change will be made to this Policy unless made by an Amendment or a Rider that is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

Relationship Between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are **solely** contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups. The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or other coverage classification as defined in this Policy. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's Coverage) and for the timely payment of the Policy Charge.

Records

The Enrolling Group shall furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect all documents furnished to the Enrolling Group by an individual in connection with Coverage under this Policy, the Enrolling Group's payroll, and any other records pertinent to the Coverage under this Policy.

By accepting Coverage under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to them, to furnish us or our designees any and all information and records or copies of records relating to the services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

Administrative Services

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of its designee. If the Enrolling Group requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group shall pay for such services or reports at the then-current charges for such services or reports.

ERISA

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C., 1001 et seq., the Company will not be named as and will not be the Plan Administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Transplant Services, we may reasonably require that a Physician, acceptable to us, examine the Covered Person at our expense.

Clerical Error

Clerical error shall not deprive any individual of Coverage under this Policy or create a right to Coverage. Failure to report enrollments shall not result in retroactive Coverage for Eligible Persons. Failure to report the termination of Coverage shall not continue such Coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums shall be made. However, we shall not grant any such adjustment in Premiums or Coverage to the Enrolling Group for more than 60 days of Coverage prior to the date we received notification of such clerical error.

Workers' Compensation Not Affected

Coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of this Policy which, on its effective date, is in conflict with the requirements of any applicable state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate(s)* or *Schedule(s) of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate(s)* or *Schedule(s) of Benefits*, or to exercise any option which is herein provided, will in no way be construed to be a waiver of such provision of the Policy, *Certificate(s)* or *Schedule(s) of Benefits*.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate(s)* or *Schedule(s) of Benefits* are for reference purposes only and will not in any way affect the meaning or interpretation of the Policy, *Certificate(s)* or *Schedule(s) of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate(s)* or *Schedule(s) of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate(s)* or *Schedule(s) of Benefits* to the greatest extent legally permissible.

Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Continuation Coverage

We agree to provide Coverage under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 10: Continuation of Coverage under Federal law (COBRA)* of the *Certificate*.

We do not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator, including but not limited to notification of continuation of coverage under federal law (COBRA), and state law continuation rights, and billing and collection of Premium, remain the sole responsibility of the Enrolling Group.

Subscriber's Individual Certificate

We will issue *Certificates of Coverage* and any attachments to the Enrolling Group who will in turn make them available to each covered Subscriber. Such *Certificates* and any attachments may be provided by the Enrolling Group in electronic format. The *Certificate(s)* and any attachments will show all the benefits and provisions of the Policy.

EXHIBIT 1

Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified below:

Single: $5.44

Family: $13.05