

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

BLUESELECT PPO

THIS BENEFIT BOOKLET CONTAINS THE EXPANDED WELLNESS BENEFITS PROVIDED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. THE EXPANDED WELLNESS BENEFITS UNDER THIS BENEFIT BOOKLET REQUIRE THE USE OF AN IN-NETWORK PROVIDER. FOR A FURTHER DESCRIPTION OF THESE BENEFITS, PLEASE REFER TO SECTION 9 OF THIS BOOKLET. THIS BENEFIT BOOKLET DOES NOT MEET THE MINIMUM COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY THE WYOMING INSURANCE CODE.

Plan Year: January 1 - December 31, 2026

IMPORTANT CONTACT INFORMATION

If You Need Information About....	Contact....
Blue Cross Blue Shield of Wyoming General Information and Questions	**Street Address:** 4000 House Avenue Cheyenne, Wyoming 82001 **Mailing Address:** PO Box 2266 Cheyenne, Wyoming 82003-2266 **Phone Numbers:** (307) 634-1393 (800) 442-2376 Dental: (844) 653-4057 Vision: (800) 584-2865 **Secure Email:** Log into the "Online Member Services" on www.yourwyoblue.com **Website:** www.yourwyoblue.com **Business Hours:** Monday through Friday 8:00 a.m. - 5:00 p.m. MST
BlueSelect PPO Directory	**For PPO Providers Within the U.S.:** 1-888-359-6592 www.yourwyoblue.com **For PPO Providers Outside of the U.S.:** (877) 547-2903 if calling from within the U.S. (804) 673-1177 (collect call) if calling from outside U.S.
Authorization Review	(800) 442-2376
Prescription Drug Program	(307) 634-1393 (800) 442-2376
Wyoming Insurance Department	106 East 6th Ave Cheyenne, WY 82002 (800) 438-5768

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

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Díí kwe'é atah nilínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bina'idiłkidgo éí doodago háida biká anilyeedígíí t'áadoo le'é yina'idiłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodiilnil 800-442-2376.

WYOMING

NOTICE OF NON-DISCRIMINATION PRACTICE

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

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

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

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

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

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

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

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

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

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

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Section 1: Important Information About This Plan

A. ENTIRE AGREEMENT

This Benefit Booklet, including the application submitted to enroll in the health insurance coverage offered in this Benefit Booklet, Member's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card, Member's monthly Premium billing statements and any amendments or endorsements that are or may become attached to this Benefit Booklet, constitute the entire Agreement between Subscriber and Blue Cross Blue Shield of Wyoming, and supersedes and replaces all previous Agreements between Subscriber and Blue Cross Blue Shield of Wyoming. This Agreement may also be referred to as the "Plan."

This Agreement describes the Benefits available to Subscriber and Subscriber's Dependents, if any, as Members in this Blue Cross Blue Shield of Wyoming BlueSelect PPO Plan. The Benefits offered in this Plan are limited to the express written terms of this Agreement. If a Member has questions about his or her coverage after reading this Benefit Booklet, the Member should contact Blue Cross Blue Shield of Wyoming at the address or telephone numbers listed at the beginning of this Benefit Booklet and talk with a Blue Cross Blue Shield of Wyoming member services representative. Members may also find answers to their questions on Blue Cross Blue Shield of Wyoming's website at www.yourwyoblue.com.

B. AMENDMENTS TO THE AGREEMENT

All amendments to a Member's Agreement with Blue Cross Blue Shield of Wyoming shall be made through a written endorsement signed by Blue Cross Blue Shield of Wyoming's President and Chief Executive Officer. Amendments to this Agreement will be delivered to the Subscriber's last known address no less than sixty (60) days prior to the Effective Date of the amendment. If an amendment is made on the annual renewal date no less than fifteen (15) days notice prior to the Effective Date of the amendment will be provided to the Subscriber. After an amendment is made, the written endorsement will become part of the Member's Agreement with Blue Cross Blue Shield of Wyoming.

No employee, agent or representative of Blue Cross Blue Shield of Wyoming may change, amend or waive a provision of this Agreement by giving incomplete or incorrect information, or by contradicting the terms of this Agreement. Any such situation will not prevent Blue Cross Blue Shield of Wyoming from administering this Agreement in strict accordance with its terms.

C. STATEMENTS AND REPRESENTATIONS

All statements contained in an application or other written document made by or on behalf of a Member to obtain this Agreement shall be considered representations and not warranties. No such statements shall be used in any contest unless a copy of the document containing the statement is or has been furnished to the Member or, in the event of the death or incapacity of the Member, to the Member's beneficiary or personal representative.

Misrepresentations, omissions, concealment of facts and incorrect or incomplete statements as provided in this subsection shall not prevent this Agreement from remaining in effect or prevent reimbursement for Covered Services under this Agreement unless Blue Cross Blue Shield of Wyoming determines that the statements and/or representations constitute fraud or an intentional misrepresentation of a material fact associated with the acceptance of the risk

or coverage of the Benefits provided under this Agreement.

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

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

E. THE EFFECTIVE DATE OF THIS AGREEMENT

The Effective Date of this Agreement will be assigned after receipt and approval of the Subscriber's application and Subscriber's payment of the first month's Premium.

F. TERM OF THIS AGREEMENT

The term of this Agreement shall be one (1) month from its Effective Date. This Agreement will be renewed by Blue Cross Blue Shield of Wyoming from month to month, so long as Premiums are regularly and timely prepaid as scheduled and this Agreement has not otherwise been terminated as provided herein.

G. IDENTITY THEFT PROTECTION SERVICES

Blue Cross Blue Shield of Wyoming offers identity theft protection services to the Subscriber and Subscriber's Dependents, if any, as Members under this Agreement.

IN WITNESS WHEREOF, this Agreement is executed by Blue Cross Blue Shield of Wyoming through its duly authorized officer, undersigned, to take effect 12:01 a.m. Mountain Time on the Effective Date of this Agreement.

BLUE CROSS BLUE SHIELD OF WYOMING

Diane Gore

Diane Gore
President & CEO

Section 2: Identification Cards

A. IDENTIFICATION CARD

The Member should carry his/her Identification Card with him/her at all times to ensure he/she has the BlueSelect PPO Benefit information and Blue Cross Blue Shield of Wyoming contact information available should Benefits be needed.

The Member should:

1. Present the Identification Card to all Healthcare Providers whenever the Member receives Healthcare Services. However, this presentation shall not be construed as a solicitation of services by Blue Cross Blue Shield of Wyoming from the Healthcare Provider.

2. Be sure to carry the most recent Identification Card the Member has received from Blue Cross Blue Shield of Wyoming to ensure the Identification Card represents the most current Cost Sharing Amount information. Outdated Identification Cards should be destroyed.

3. Contact Blue Cross Blue Shield of Wyoming immediately in the event the Identification Card is lost or stolen.

Section 3: Member's Bill of Rights and Responsibilities

A. MEMBER'S RIGHTS

Blue Cross Blue Shield of Wyoming is committed to treating Members in a manner that respects their rights. In this regard, Blue Cross Blue Shield of Wyoming recognizes that each Member (or the Member's parent, legal guardian or other legal representative if the Member is a minor or incompetent) has the right to the following:

1. Member has the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, without discrimination on the basis of race, color, religious creed, ancestry, national origin, age, sex or disability.

2. Member has the right to considerate, respectful treatment at all times and under all circumstances with recognition of Member's preferences and personal dignity.

3. Member has the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.

4. Member has the right, but is not required under this Agreement, to select a primary care physician (PCP) of Member's choice. If a Member is dissatisfied for any reason with the PCP initially chosen, the Member has the right to choose another PCP.

5. Member has the right to expect communications and other records pertaining to Member's care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Federal and State Law.

6. Member has the right to know the identity and professional status of the individuals providing Healthcare Services to the Member and to know which Healthcare Provider is primarily responsible for Member's individual care. Member also has the right to receive information about Blue Cross Blue Shield of Wyoming's clinical guidelines and protocols.

7. Member has the right to a candid discussion with Member's Healthcare Providers responsible for coordinating Member's Medically Necessary treatment options for his/her Condition in a way that is understandable to Member and is not dependent upon the cost or benefit coverage for those treatment options.

8. Member shall have the right to participate with Healthcare Providers in decision making regarding Member's treatment plan.

9. Member has the right to give informed consent before the start of any procedure or treatment.

10. Member has the right to receive printed materials that describe important information about Blue Cross Blue Shield of Wyoming in a format that is easy to understand and easy to read.

11. Member has the right to appropriate auxiliary aids and services, provided through Blue

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

12. Member has the right to language assistance services, provided through Blue Cross Blue Shield of Wyoming, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

13. In order to obtain the interpretation services listed in paragraphs eleven (11) and twelve (12) of this section, please call (800) 442-2376 or use our Telecommunications Device for the Deaf (TDD) at (800) 696-4710.

14. Member has the right to a clear appeals process for complaints and comments and to have Member's issues resolved in a timely manner.

15. Member has the right to appeal any decision regarding Medical Necessity made by Blue Cross Blue Shield of Wyoming and its BlueSelect PPO Providers.

16. Member has the right to file a grievance regarding potential discrimination. To file a grievance, please call Blue Cross Blue Shield of Wyoming at (307) 634-1393 or (800) 422-2376 and request the Civil Rights Coordinator in the Legal Department or mail a letter describing the grievance to 4000 House Avenue, Cheyenne, WY 82001 to the attention of the Legal Department.

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

18. Member has the right to make recommendations regarding Blue Cross Blue Shield of Wyoming's Member's rights and responsibilities policies.

19. Member shall have the right to receive information about Blue Cross Blue Shield of Wyoming, its services, the Healthcare Providers in its networks and Member's rights and responsibilities.

20. Member has the right to confidentiality. For information on Disclosure of a Members Medical Information see Section 14: Additional Provisions.

21. Member has the right to access the service Blue Cross Blue Shield of Wyoming provides by contacting Member Services or using the online provider finder.

B. MEMBER'S RESPONSIBILITIES

Each Member (or the Member's parent, legal guardian or other legal representative if the

Member is a minor or incompetent) is responsible for cooperating with Blue Cross Blue Shield of Wyoming and the Healthcare Providers providing Covered Services to the Member, and shall have the following responsibilities:

1. Member has the responsibility to learn how to use health benefits and access Member assistance to ask questions about benefits.

2. Member has the responsibility to provide to Member's Healthcare Provider, to the best of Member's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to Member's health. Member has the responsibility to report unexpected changes in Member's Condition to the responsible Healthcare Provider. Member is responsible for communicating whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

3. Member is responsible for carrying Member's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card with him/her and for having his/her Identification Card numbers available when telephoning or contacting Blue Cross Blue Shield of Wyoming.

4. Member is responsible for supplying information and following all access and availability procedures including Authorization Review requirements as described throughout this Benefit Booklet.

5. Member is responsible for seeking services for a Medical Emergency at an In-Network emergency facility whenever possible. In the event an Ambulance is used, Members should direct the Ambulance to the nearest In-Network emergency facility, unless that transport would put the Member at serious risk of harm.

6. Member is responsible for notifying Blue Cross Blue Shield of Wyoming of any emergency Hospital admission during the next business day or as soon thereafter as reasonably possible after becoming physically or mentally able to give notice.

7. Member is responsible for keeping appointments and, when Member is unable to do so for any reason, for notifying the responsible Healthcare Provider.

8. Member is responsible for following his/her treatment plan as recommended by the Healthcare Provider primarily responsible for Member's care. Member is also responsible for participating, to the degree possible, in understanding his/her own healthcare problems including behavioral problems and developing mutually agreed upon treatment goals.

9. Member is responsible for Member's own actions if Member refuses treatment or does not follow a Healthcare Provider's instructions.

10. Member is responsible for notifying the Health Insurance Marketplace (Marketplace) within thirty (30) days if Member changes his/her name, address or phone number.

Section 4: Eligibility, Enrollment and Termination

A. ELIGIBILITY

1. Subscriber

Subscriber will be eligible for coverage under this Agreement according to the following guidelines:

a. Subscriber is a citizen, national or noncitizen who is lawfully present in the United States.

b. Subscriber is not incarcerated, other than pending the disposition of charges.

c. Subscriber meets the applicable residency requirements.

d. Subscriber has paid all required Premiums.

e. As otherwise determined by applicable Federal and State Law.

f. As otherwise required by the Marketplace.

2. Dependent(s)

An eligible Subscriber's Dependent(s), as defined below, will also be eligible for coverage under this Agreement if the Subscriber has elected the appropriate Class of Coverage and all applicable eligibility and enrollment requirements of the Marketplace have been met with regard to the Subscriber's Dependent(s):

a. Subscriber's Spouse. For purposes of this Agreement, Subscriber's Spouse is defined and limited to a legally recognized spouse who is a current and permanent resident in the Subscriber's home.

b. Domestic Partner

c. Subscriber's child, stepchild, adopted child, or legal ward under the age of twenty-six (26).

d. Subscriber's child, stepchild, adopted child, or legal ward who has attained age twenty-six (26) may be eligible if the child is unmarried and is BOTH incapable of self-sustaining employment and chiefly dependent upon the Subscriber or Subscriber's Dependent Spouse for their support and maintenance by reason of physical or intellectual disability. Proof of disability and dependency must be furnished to Blue Cross Blue Shield of Wyoming upon request.

NOTE: Subscriber's Spouse, children, stepchildren, adopted children and legal wards will be referred to throughout this Benefit Booklet as "Dependents" when referred to collectively. However, the terms "Dependent Spouse" or "Dependent Children" may be used when a differentiation between the Subscriber's Spouse and the Subscriber's children, stepchildren, adopted children or legal wards is required.

B. ENROLLMENT

An eligible Subscriber and the Subscriber's eligible Dependents will be able to enroll for coverage under this Agreement according to the following guidelines, or as may be otherwise determined by applicable Federal and State Law and Marketplace requirements:

1. Annual Open Enrollment Periods

Unless a qualifying event occurs, entitling Subscriber to a special enrollment period under this Plan, Subscriber may only enroll in this Plan during the Plan's annual open enrollment period. Subscriber's enrollment for this Plan must be made through the Marketplace established for individuals seeking individual or family health insurance coverage in the State of Wyoming. Subscriber and Subscriber's Dependents must comply with all Marketplace enrollment requirements to obtain health insurance coverage under this BlueSelect PPO Plan.

2. Special Enrollment Periods

Special enrollment periods include but are not limited to:

a. Newly Gained Dependent(s)

If, during the Plan Year, Subscriber gains a new Dependent(s) as a result of marriage, birth, adoption, placement for adoption, or court order, Subscriber may be eligible for a special enrollment for himself/herself and his/her Dependents. Subscriber and Subscriber's Dependent(s) must comply with all Marketplace special enrollment requirements on the Marketplace no later than sixty (60) days after the event causing Subscriber to gain the new Dependent(s). The eligibility and Effective Date of coverage for the Dependent(s) will be established by the Marketplace. A newborn child will automatically be covered under this Plan for the first thirty-one (31) days after the child's birth, with no additional premium due. However, verification of any newborn child is required before Claims for Benefits will be processed and paid. An adopted child/legal ward will automatically be covered under this Plan for the first thirty-one (31) days after the date the petition for adoption was 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 date of coverage will begin the date of the entry of a final adoption decree by the court), with no additional premium due. However, verification of any adopted child/legal ward is required before Claims for Benefits will be processed and paid. The Subscriber may continue coverage for the adopted child/legal ward beyond the thirty-one (31) day automatic coverage provided that the properly completed enrollment for coverage for the adopted child/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 date of coverage will begin the date of entry of a final adoption decree by the court). If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

b. Loss of Other Coverage

If the Subscriber and/or Subscriber's Dependents were not enrolled under this Agreement during the annual open enrollment period because of other health insurance coverage, they may be eligible for a special enrollment. To qualify for this special enrollment, the Subscriber and/or Dependent must have lost their other coverage due to either:

(1) The termination of employer's contributions.

(2) Loss of eligibility due to divorce, death, legal separation, termination of employment, reduction in work hours, or loss of eligibility for Kid Care CHIP or Medicaid.

(3) The exhaustion of group continuation coverage if the Subscriber and/or Dependent had been on group continuation coverage at the time of initial eligibility.

NOTE: Loss of other coverage does not include termination or loss due to failure to pay Premiums on a timely basis, including COBRA Premiums, or situations allowing for a rescission of coverage.

Subscriber and/or Dependent(s) must comply with all Marketplace special enrollment requirements no later than sixty (60) days after the loss of other coverage. Eligibility and the Effective Date of coverage for the Subscriber and Dependent(s) will be established by the Marketplace.

c. Required by Federal or State Law

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

C. TERMINATION

1. Termination Due to Loss of Eligibility

Subscriber's and/or Dependent's coverage may be terminated upon Subscriber's and/or Dependent's loss of eligibility as determined by the Marketplace. The termination date will be established by the Marketplace. Termination may be retroactive in the event the Subscriber fails to pay Premiums during any applicable grace period. Any Claims for Benefits paid by Blue Cross Blue Shield of Wyoming with a date of service after the

termination date will be the legal responsibility of the Subscriber and/or Dependent and must be reimbursed to Blue Cross Blue Shield of Wyoming.

2. Termination by Subscriber

Subscriber may terminate Subscriber's coverage and/or any Dependent coverage under this Plan at any time during the Plan Year. Subscriber and Subscriber's Dependent(s) must comply with all Marketplace requirements to terminate coverage under this Plan. The termination date will be established by the Marketplace. Any Claims for Benefits paid by Blue Cross Blue Shield of Wyoming with a date of service after the termination date will be the legal responsibility of the Subscriber and/or Dependent and must be reimbursed to Blue Cross Blue Shield of Wyoming.

3. Termination by Blue Cross Blue Shield of Wyoming

Blue Cross Blue Shield of Wyoming may terminate a Subscriber, and where applicable, a Subscriber's Dependent's coverage, upon the following:

a. Subscriber's failure to timely pay Premiums as set forth in this Agreement or as required by the Marketplace. The termination date will be the last day of the month in which Premiums were timely paid in full. Termination may be retroactive in the event the Subscriber fails to pay Premiums during any applicable grace period. Any Claims for Benefits paid by Blue Cross Blue Shield of Wyoming with a date of service after the termination date will be the legal responsibility of the Subscriber and/or Dependent and must be reimbursed to Blue Cross Blue Shield of Wyoming.

b. When there is fraud or intentional misrepresentation of a material fact associated with the enrollment for coverage, or with the filing of a Claim for Benefits by the Subscriber and/or Dependent. The Subscriber is liable for any payments made by Blue Cross Blue Shield of Wyoming to, or on behalf of, the Subscriber and/or Dependent as a result of such improper actions.

c. Discontinuation of the product under this Agreement or discontinuation of all products in the market.

Section 5: Premium Payments and Premium Tax Credits

A. PREMIUM PAYMENTS

1. How Premiums Are Established And Changed

The Premium for coverage under this Agreement is specified on Subscriber's monthly billing statements. The Premium has been established and may be changed by Blue Cross Blue Shield of Wyoming according to any of the following:

a. Factors such as age, tobacco usage and geographical location as allowed by Federal and State Law.

b. Subscriber's Class of Coverage.

In addition to the list above, the Premium may be changed annually by Blue Cross Blue Shield of Wyoming upon Blue Cross Blue Shield of Wyoming giving the Subscriber fifteen (15) days written notice of a change in Premium. Payment of the Premium will be conclusive proof of Subscriber's agreement to the change.

2. How And When To Pay Premiums

The initial Premium is due and payable on the Effective Date of this Agreement. Subscriber's coverage (and Dependents' coverage where applicable) will not become effective until Blue Cross Blue Shield of Wyoming receives that first Premium payment. Blue Cross Blue Shield of Wyoming may collect past Premium due within the last twelve (12) months from Subscriber and any payment made by Subscriber will be applied first to such past Premium due before being applied to the initial Premium.

Subsequent billing statements will be delivered to Subscriber at Subscriber's last known mailing address indicated in Blue Cross Blue Shield of Wyoming's membership records. Payment of the Premium shall be due and payable as indicated in the billing statement. Blue Cross Blue Shield of Wyoming will only accept payments from third parties in accordance with its third party payment policy. Please visit www.BCBSWY.com/ThirdPartyPay for more information.

3. Non-APTC Grace Period

If payment is not made by the due date indicated in the billing statement, the Subscriber will be granted a late payment grace period ending on the last day of the month in which the Premium payment was due. During this grace period, the Agreement shall remain in force. If claims are paid by Blue Cross Blue Shield of Wyoming to or on behalf of the Member for Covered Services received during the grace period, any Premium payment then due and unpaid may be deducted from the amount of the Claims paid. This grace period does not apply to the Subscriber's payment of the initial Premium upon enrollment in this Plan, or to Subscribers receiving Advance Premium Tax Credits.

B. ADVANCE PREMIUM TAX CREDITS

Some Subscribers will be eligible for financial assistance to help them off-set the cost of their Premium for this Plan. Eligible Subscribers may elect to receive this assistance in the form of an Advance Premium Tax Credit (APTC). APTCs are tax credits advanced to the Subscriber, meaning that instead of the Subscriber having to wait until after the end of the tax year to receive the tax credit, the Subscriber will receive the APTC in advance in the form of monthly payments to coincide with the time the Subscriber's monthly Premiums are due.

The Marketplace will determine a Subscriber's eligibility for an APTC at the time of enrollment on the Marketplace. The Marketplace will collect all the necessary information from the Subscriber and determine the amount of any APTC available to the Subscriber in accordance with Section 36B of the Internal Revenue Code.

The amount of the APTC will vary from Subscriber to Subscriber depending on the individual Subscriber's financial situation and other factors. In some instances, the Subscriber's full Premium will be covered by the APTC. In others, the Subscriber may be required to pay for a portion of the Premium.

Where the Subscriber qualifies for an APTC, the APTC will be paid directly to Blue Cross Blue Shield of Wyoming each month to cover part or all of the Subscriber's monthly Premium. The Subscriber will be responsible for timely payment of any portion of the Premium on Subscriber's monthly billing statement that is not covered by the APTC.

APTCs do not automatically renew from year-to-year and Subscribers must re-apply for APTCs on a yearly basis.

C. GRACE PERIODS WHERE SUBSCRIBER RECEIVES AN ADVANCE PREMIUM TAX CREDIT

Where Subscriber has qualified to receive an APTC and has made at least the initial enrollment Premium payment under their current plan, the Subscriber shall be entitled, if needed, to a late payment grace period in which to pay the delinquent Premium. The grace period shall be no longer than three (3) months and will begin on the first day of the month following the last month in which Subscriber's portion of the Premium was timely paid in full. During the first month of the grace period, the Benefit Booklet shall remain in force and Claims for Benefits will be paid. However, Claims for Benefits will be pended and not paid during the remainder of the grace period. If the full Premium amounts owed by the Subscriber are received prior to the end of the grace period, any pended Claims for Benefits will be processed for payment and the grace period will end. If the full Premium amounts owed by the Subscriber are not received by the end of the three (3) months following the beginning of the grace period, this Agreement will be terminated as of the last day of the first month of the grace period. Following termination, Blue Cross Blue Shield of Wyoming has no discretion to reinstate this Plan unless approved by the Marketplace. Any Benefits paid by Blue Cross Blue Shield of Wyoming to or on behalf of the Member for Covered Services received during the second or third months of the grace period will be the legal responsibility of the Subscriber/Member and must be reimbursed to Blue Cross Blue Shield of Wyoming. This grace period does not apply to the Subscriber's payment of the initial Premium, which must be paid in full on or before the Effective Date or to Subscribers who are not eligible for the APTC.

Section 6: Cost Sharing and Cost Sharing Assistance

Payments by Blue Cross Blue Shield of Wyoming for Covered Services under this Benefit Booklet are based on the Maximum Allowable Amount, less Cost Sharing Amounts that are the Member's responsibility.

A. COST SHARING AMOUNTS

Cost Sharing Amounts are those dollar amounts of the Maximum Allowable Amount that a Member is responsible for paying when Covered Services are received from a Healthcare Provider. Cost Sharing Amounts include Copayment Amounts, Deductible Amounts and Coinsurance Amounts. Healthcare Providers may either bill a Member directly for these amounts or request payment of these amounts from the Member at the time the Covered Services are provided.

1. Copayment Amount

A specified dollar amount payable by the Member to the Healthcare Provider for certain Covered Services. Healthcare Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not accumulate toward the Member's satisfaction of the Deductible Amount or Coinsurance Amount, but will accumulate toward the Member's satisfaction of the Out-of-Pocket Maximum.

2. Deductible Amount

A specified dollar amount that a Member must pay to the Healthcare Provider for Covered Services within a calendar year before Benefits for Covered Services are provided under this Agreement. Only dollar amounts of the Maximum Allowable Amount will contribute toward satisfaction of the Deductible Amount.

How the Deductible Amount can be met during the calendar year depends upon the Applicable Class of Coverage:

a. **Single Coverage**: If only the Subscriber is covered under this Plan, the Subscriber alone must meet the entire Single Deductible Amount.

b. **Family Coverage**: The Deductible Amount for each calendar year will be satisfied when any of the following scenarios occurs:

(1) When one (1) Member meets the Single Deductible Amount, that Member will be eligible for Benefits. The remaining Members will be eligible for Benefits when they have collectively satisfied the remaining balance of the Family Coverage Deductible Amount.

(2) When no one (1) Member meets the Single Deductible Amount, but all the Members collectively meet the Family Coverage Deductible Amount, then all Members will be eligible for Benefits.

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

NOTE: The Deductible Amount does not apply to PREVENTIVE CARE.

3. Coinsurance Amount

A percentage of the cost of Covered Services that is a Member's responsibility after the Deductible has been met.

Blue Cross Blue Shield of Wyoming calculates a Member's Coinsurance Amount, when Member obtains the Covered Services from Healthcare Providers in Blue Cross Blue Shield of Wyoming's service area, off of the Maximum Allowable Amount.

However, if the Member obtains Covered Services outside of the Blue Cross Blue Shield of Wyoming service area, the local Blue Cross Blue Shield Plan's (Host Plan's) contract with the Healthcare Provider may require that the Coinsurance Amount be based on the full amount of the Healthcare Provider's billed charges rather than the Maximum Allowable Amount. This may result in a significantly higher Coinsurance Amount to the Member for these Covered Services. It is not possible for Blue Cross Blue Shield of Wyoming to detail the specific information for each out-of-area Healthcare Provider in this Benefit Booklet because of the many different arrangements the various Host Plans have with their local Healthcare Providers. However, if a Member contacts Blue Cross Blue Shield of Wyoming prior to incurring out-of-area Healthcare Services, a Blue Cross Blue Shield of Wyoming member services representative may be able to provide the Member with more specific information on the applicable Coinsurance Amount.

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

4. Out-of-Pocket Maximum Amount

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

How the Out-of-Pocket Maximum Amount can be met during the calendar year depends upon the Applicable Class of Coverage:

a. **Single Coverage**: If only the Subscriber is covered under this Plan, the Subscriber alone must meet the entire Single Out-of-Pocket Maximum Amount.

b. **Family Coverage**: The Out-of-Pocket Maximum Amount for each calendar year

will be satisfied when any of the following scenarios occurs:

(1) When one (1) Member meets the Single Out-of-Pocket Maximum Amount, that Member's Covered Services will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for the remainder of that calendar year. The remaining Members Covered Services will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services for the remainder of that calendar year when they have collectively satisfied that remaining balance of the Family Coverage Out-of-Pocket Maximum Amount.

(2) When no one (1) Member meets the Single Out-of-Pocket Maximum Amount, but all the Members collectively meet the Family Coverage Out-of-Pocket Maximum Amount, then Covered Services for all Members will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for the remainder of that calendar year.

There are separate Out-of-Pocket Maximum Amounts for In-Network and Out-of-Network Cost Sharing Amounts. Satisfaction toward one type of Out-of-Pocket Maximum Amounts (i.e., In-Network Out-of-Pocket Maximum Amounts) will not work to satisfy the other type of Out-of-Pocket Maximum Amount (i.e., Out-of-Network Out-of-Pocket Maximum Amounts).

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

5. Schedule of Benefits/Summary of Benefits

The Cost Sharing Amounts applicable to this Plan are set out in the Schedule of Benefits and Summary of Benefits herein.

B. COST SHARING ASSISTANCE

Some Subscribers who qualified for the APTC and enroll in this BlueSelect PPO Silver Plan will also be eligible for financial assistance to help reduce their Cost Sharing Amounts incurred when Covered Services are provided by a BlueSelect Provider.

The Marketplace will determine the Subscriber's eligibility for Cost Sharing assistance at the time of enrollment on the Marketplace. The Marketplace will collect all the necessary information from the Subscriber and determine the amount of any Cost Sharing assistance the Subscriber is entitled to in accordance with applicable Federal Law.

The amount of the Cost Sharing assistance will vary from Subscriber to Subscriber depending on the individual Subscriber's financial situation and other factors.

Where the Subscriber qualifies for Cost Sharing assistance, the Cost Sharing assistance will be paid directly to Blue Cross Blue Shield of Wyoming each month to reduce the Cost Sharing Amount the Subscriber would otherwise be responsible for. The Subscriber will be responsible for timely payment of any portion of Subscriber's Cost Sharing Amounts not covered by the Cost Sharing assistance.

NOTE: Cost Sharing assistance does not apply, and will not be used to reduce a Member's Cost Sharing amounts incurred when Covered Services are provided by an Out-of-Network Healthcare Provider.

Section 7: The BlueSelect PPO Network

A. WHEN YOU RECEIVE HEALTHCARE IN WYOMING

1. BlueSelect PPO Network

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

In an effort to contain healthcare costs and keep Premiums down, Blue Cross Blue Shield of Wyoming has negotiated with these BlueSelect Providers to provide Healthcare Services to BlueSelect Members for reduced charges. Regardless of the total amount of charges the BlueSelect Provider's billing statement to the Member may indicate, a BlueSelect Provider has agreed to accept the Maximum Allowable Amount as full reimbursement for the Covered Services that the BlueSelect Provider provided to the Member. Blue Cross Blue Shield of Wyoming will pay the Maximum Allowable Amount directly to the BlueSelect Provider on behalf of the Member. A BlueSelect Provider may still bill the Member for Member's Cost Sharing Amounts and for any Non-Covered Services. However, the BlueSelect Provider may not bill the Member for the difference between the amount of the total charges that may have been reflected on the BlueSelect Provider's billing statement to the Member and the Maximum Allowable Amount the BlueSelect Provider has agreed to accept as reimbursement from Blue Cross Blue Shield of Wyoming for the Covered Services.

However, where a Member obtains Healthcare Services from a Healthcare Provider that has elected not to become part of the BlueSelect PPO Network, that Healthcare Provider may bill the Member for the total charges reflected in the Healthcare Provider's billing statement to the Member. Blue Cross Blue Shield of Wyoming will reimburse the Maximum Allowable Amount for the Covered Services directly to the Member. It will be the Member's responsibility to pay this Maximum Allowable Amount to the Healthcare Provider. However, in addition to any applicable Cost Sharing Amounts and charges for Non-Covered Services that are Member's responsibility, Member will also be responsible for paying the Healthcare Provider for the difference between the full amount of charges reflected in the Healthcare Provider's billing statement and the Maximum Allowable Amount Blue Cross Blue Shield of Wyoming reimbursed the Member for the Covered Services. The difference may be a considerable amount of money.

Member is free to select his or her Healthcare Providers. Blue Cross Blue Shield of Wyoming makes no guarantee as to the availability of any Healthcare Provider. Blue Cross Blue Shield of Wyoming's responsibility to Member is solely to make payment for the Benefits described in this Benefit Booklet. However, in order to receive the best value under this Benefit Booklet, the Member should use BlueSelect Providers whenever possible.

2. How to Find BlueSelect Providers

The BlueSelect PPO Network Directory can be accessed as follows:

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

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

NOTE: A Healthcare Provider's network status may change at any time without notice. Member is responsible for confirming a Healthcare Provider's BlueSelect PPO Network status prior to receiving any treatment or services from the provider.

B. WHEN YOU RECEIVE HEALTHCARE OUTSIDE OF WYOMING

Blue Cross Blue Shield of Wyoming has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Programs." These Inter-Plan Programs work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Member accesses Covered Services outside the geographic area Blue Cross Blue Shield of Wyoming serves, the Claim for Benefits for those Covered Services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described below.

When you receive care outside the geographic area Blue Cross Blue Shield of Wyoming serves, Members generally obtain care from healthcare providers that have a contractual agreement ("Network providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Network providers") with the Host Blue. Blue Cross Blue Shield of Wyoming explains below how Blue Cross Blue Shield of Wyoming pays both kinds of providers below.

1. BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, Blue Cross Blue Shield of Wyoming will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with Network Providers.

When you receive Covered Services outside Blue Cross Blue Shield of Wyoming's service area and the Claim for Benefits is processed through the BlueCard® Program, the amount the you pay for Covered Services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the your provider. Sometimes, it is an estimated price that considers special arrangements with your healthcare 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing also consider adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Blue Cross Blue Shield of Wyoming has used for your claim because they will not be applied after a claim has already been paid.

2. Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross Blue Shield of Wyoming through average pricing or fee schedule adjustments.

If Blue Cross Blue Shield of Wyoming has entered a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to you on your behalf, Blue Cross Blue Shield of Wyoming will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in the BlueCard Program section.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or State Laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Blue Cross Blue Shield of Wyoming will include any such surcharge, tax or other fee as part of the claim charge passed on to the Member.

4. Non-Network Providers Outside of Blue Cross Blue Shield of Wyoming's Service Area

a. Member's Liability Calculation

When Covered Services are provided outside of Blue Cross Blue Shield of Wyoming's service area by Non-Network Providers, the amount the Member pays for such services will be based on either the Host Blue's Non-Network healthcare provider local payment or the pricing arrangements required by applicable State Law. In these situations, the Member may be responsible for the difference between the amount that the Non-Network Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable Federal and State Law.

b. Exceptions

In certain situations, Blue Cross Blue Shield of Wyoming may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount Blue Cross Blue Shield of Wyoming will pay for services provided by Non-Network Providers. In these situations, you may be liable for the difference between the amount that the Non-Network Provider bills and the payment Blue Cross Blue Shield of Wyoming will make for the Covered Services as set forth in this paragraph.

5. Blue Cross Blue Shield Global® Core

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your Cost Sharing Amounts. In such cases, the hospital will submit your claim to the service center to begin claim processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **The Member must contact Blue Cross Blue Shield of Wyoming to obtain Authorization Review for non-emergency Inpatient services.**

b. Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require a you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available

from Blue Cross Blue Shield of Wyoming, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810- BLUE (2583), or call collect at 1-800-673-1177, 24 hours a day, seven days a week.

C. NO-SURPRISES BILLING

In accordance with the requirements of Federal Law: 1) applicable Covered Services that are received from certain Non-Network Healthcare Providers during an emergency, or 2) applicable Covered Services that are received from certain Non-Network Healthcare Providers delivering emergency or non-emergency services at certain Network facilities, that would otherwise be Covered Services if received from a Network Healthcare Provider, will be covered at the same Cost Sharing Amounts as would be applied if the services were provided by a Network Healthcare Provider (and such Cost Sharing Amounts shall be determined based upon an amount up to, but not to exceed, the Qualified Payment Amount - as defined by Federal Law), and the Cost Sharing Amounts applied to such services shall be counted towards the In-Network Deductible Amount and Out-of-Pocket Maximum Amount. For the purpose of this section, emergency services include Covered Services that are furnished by Non-Network Healthcare Providers or facilities after a Member is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the emergency.

D. DISCLAIMER OF LIABILITY

Blue Cross Blue Shield of Wyoming has no control over any diagnosis, treatment, care, or other Healthcare Service provided to a Member by any Healthcare Provider, and is not liable to the Member for any loss or injury the Member may incur as the result of any negligent or intentional act or omission on the part of the Healthcare Provider.

E. CONTINUITY OF CARE

1. As required by Federal Law, if a Member receiving Covered Services from a Network Provider experiences a change in Network status due to the following: 1) the Network Provider's contract is terminated; 2) a change in Network participation under the Plan; or 3) the Group terminates coverage through Blue Cross Blue Shield of Wyoming, the Member may request to continue treatment with their current provider for a period of time by submitting a Continuity of Care Request Form. Patients must be undergoing treatment for a serious and complex Condition, pregnancy, terminal illness, receiving Inpatient care, or be scheduled to undergo non-elective surgery to be eligible. If the request is approved, benefits will be provided at the Network level for treatment of the specific Condition for a defined period of time (up to ninety (90) days). Requests must be received within thirty (30) days of the effective date of coverage termination or change in the provider's Network status for consideration.

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

Section 8: Summary of Benefits

This summary provides an overview of some of the Benefits available under the BlueSelect PPO Silver73 HealthPlus Plan to the extent the services are covered by the Plan. For further information on the Benefits, as well as the applicable Limitations and Exclusions, please refer to Sections 9: Benefits (Covered Services) and Section 10: Limitations and Exclusions of this Benefit Booklet.

Member 's Calendar Year Cost Sharing Amounts		
Cost Sharing Amounts	**In-Network**	**Out-of-Network** No coverage for providers outside Wyoming
Deductible: Single Coverage	$5,000	$20,000
Family Coverage	$10,000	$40,000
Coinsurance Amount - All Classes of Coverage:	25%	50%
Copayment Amounts - All Classes of Coverage: **Primary Care Office Visits:**	$20 per visit Waive Deductible	No Copayment Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Mental Health/Substance Use Disorder Office Visits	$20 per visit Waive Deductible	No Copayment Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
MDLive	$10 per visit Waive Deductible	No Copayment Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Prescription Drugs: HealthPlus Tier 1:	$0 - Retail $0 - Mail	Not Covered
Tier 1:	$5 - Retail $15 - Mail	Not Covered
HealthPlus Tier 2:	$25 - Retail $75 - Mail	Not Covered
Tier 2:	$50 - Retail $150 - Mail	Not Covered

HealthPlus Tier 3:	No Copayment Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Not Covered
Tier 3:	No Copayment Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Not Covered
Tier 4:	No Copayment Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Not Covered
Out-of-Pocket Maximum Amount:		
Single Coverage:	$7,600	Unlimited
Family Coverage:	$15,200	Unlimited

BlueSelect PPO Summary of Benefits

Benefit Description	In-Network Cost Sharing	Out-Of-Network Cost Sharing No coverage for providers outside Wyoming
Hospital Services		
Room and Board (semi-private) *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Intensive/Progressive Care *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Emergency Room (includes but not limited to emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) *For Non-Network Facilities – this will also include ongoing care after the Member is stabilized.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Medical Emergencies subject to In-Network Deductible and Coinsurance Amount of 25% up to In-Network Out-of-Pocket Maximum. Medical non-emergencies are subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum.

Inpatient Ancillaries (x-ray, lab, drugs, oxygen, operating room, etc.)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Outpatient Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Physician Services		
Emergency Room (includes but not limited to emergency department of a Hospital, Independent Freestanding Emergency Department, and examination and treatment to stabilize the patient regardless of department) *For Non-Network Facilities – this will also include ongoing care after the Member is stabilized.	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Medical Emergencies subject to In-Network Deductible and Coinsurance Amount of 25% up to In-Network Out-of-Pocket Maximum. Medical non-emergencies are subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum.
Hospital Visit	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
MDLive Visit – Urgent Care or Mental Health and Substance Use Disorder	Subject to $10 Copayment Waive Deductible	Not Applicable
Office Visit - Primary Care	Subject to $20 Copayment Waive Deductible	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Office Visit - Specialist	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Outpatient Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Preventive Care - Adult	Paid at 100%	Not Covered
Preventive Care - Child	Paid at 100%	Not Covered

Surgery (Inpatient/Outpatient) *Authorization Review Required for Inpatient Hospitalization *Some Surgical Procedures may require Authorization Review, refer to Section 9: Benefits under SURGERY for details	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Urgent Care Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Other Facility Services		
Acute Rehabilitation Services (Inpatient) *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of forty-five (45) days per calendar year.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Limited to a maximum of forty-five (45) days per calendar year.
Ambulatory Surgical Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Birthing Center	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Habilitative Services (Inpatient) *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of forty-five (45) days per calendar year per Member.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Limited to a maximum of forty-five (45) days per calendar year per Member.
Habilitative Services (Outpatient)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of twenty (20) visits per calendar year per Member.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Limited to a maximum of twenty (20) visits per calendar year per Member.
Home Healthcare	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Hospice (Inpatient) *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Hospice (Outpatient)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum

Osteopathic Hospital (Inpatient) *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Outpatient Facility	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Skilled Nursing Facility *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Other Services & Conditions		
Accidents	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Acupuncture	Not Covered	Not Covered
Advanced Therapies *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Allergy Services *Certain Allergy Services require Authorization Review	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Alternative Medicine	Not Covered	Not Covered
Ambulance (Air and Ground Ambulance)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to In-Network Deductible and Coinsurance Amount of 25% up to In-Network Out-of-Pocket Maximum
Anesthesia Services *Certain Anesthesia Services require Authorization Review	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Artificial Conception/Fertilization	Not Covered	Not Covered
Autism	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Autopsies	Not Covered	Not Covered
Biofeedback	Not Covered	Not Covered
Blood Expenses	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum

Cardiac Rehabilitation *Phase I and II only	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 36 visits per calendar year.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Limited to a maximum of 36 visits per calendar year.
Chemotherapy and Radiation Therapy *Certain Chemotherapy and Radiation Services require Authorization Review	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Cleft Lip and Cleft Palate *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Consultations	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Contraceptives, Supplies and related services	Generic and Preferred Brand Prescription Drugs are paid at 100%. All other Prescription Drugs subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum.	Not Covered
Convalescent Care	Not Covered	Not Covered
Custodial Care	Not Covered	Not Covered
Dental Services (Pediatric "Kid's Dental" and limited other Benefits) *Certain Dental Services require Authorization Review	Pediatric Preventive Dental paid at 100%. All other Pediatric Dental and other dental services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Dental Benefits are limited to Members through the end of the calendar year in which they turn age 19.	Pediatric Preventive Dental paid at 100%. All other Pediatric Dental and other dental services subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Pediatric Dental Benefits are limited to Members through the end of the calendar year in which they turn age 19.
Diabetes Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Domiciliary Care	Not Covered	Not Covered

Durable Medical Equipment (DME)/ Supplies/Prosthetics and Orthotics *Some items require Authorization Review	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Diabetic supplies purchased through a BlueSelect Pharmacy are subject to the Prescription Drug Cost Sharing Amounts outlined above.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Diabetic supplies purchased through a BlueSelect Pharmacy are not covered Out-of-Network.
Environmental Medicine	Not Covered	Not Covered
Experimental/Investigational Procedures	Not Covered	Not Covered
Fertility Testing and Treatment (Excludes artificial methods of fertilization)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Foot Care Services (Routine)	Not Covered	Not Covered
Gender Reassignment *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. For Prescription Drugs, please see Prescription Drugs above under Cost Sharing Amounts.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. For Prescription Drugs, please see Prescription Drugs above under Cost Sharing Amounts.
Hearing Aids	Not Covered	Not Covered
Hearing Tests (Only Medically Necessary testing is covered.)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Hemodialysis and Peritoneal Dialysis *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Human Organ Transplants *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Hypnosis	Not Covered	Not Covered
Inherited Enzymatic Disorders	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum

Laboratory, Pathology, X-Ray, Radiology, & Related Testing Services *Certain items require Authorization Review	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum HealthPlus laboratory services for monitoring and treatment of certain chronic diseases are paid at 100%	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Mammograms	Preventive paid at 100%. Medically Necessary services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum.	Preventive not covered Out-of-Network. Medically Necessary services subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum.
Mastectomy and Reconstructive Surgery *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Maternity and Newborn Care	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Mental Health and Substance Use Disorders Care (Inpatient)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Mental Health and Substance Use Disorders Care (Outpatient)	Subject to $20 Copayment Waive Deductible	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Midwife Services (licensed)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Outpatient Medications *Authorization Review Required	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Prescription Drugs *Certain drugs require Authorization Review	See above under Cost Sharing Amounts	Not Covered
Private Duty Nursing Services	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Spinal Manipulations	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Limited to a maximum of 15 visits per calendar year.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Limited to a maximum of 15 visits per calendar year.

Subluxation	Not Covered	Not Covered
Surgical Sterilization	Female sterilization services paid at 100% Male sterilization services subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum	Female sterilization services not covered Out-of-Network Male sterilization services subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum
Temporomandibular Joint Dysfunction (TMJ)	Not Covered	Not Covered
Therapy (Occupational, Physical, Speech, and Respiratory)	Subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year. Occupational, physical, and speech therapy for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain Surgery, severe burns, and amputations are limited to a maximum of sixty (60) visits per calendar year per Member.	Subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year. Occupational, physical, and speech therapy for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain Surgery, severe burns, and amputations are limited to a maximum of sixty (60) visits per calendar year per Member.
Vision Services (Pediatric "Kids Vision")	Pediatric Vision subject to Deductible and Coinsurance Amount of 25% up to Out-of-Pocket Maximum. Pediatric Vision Benefits are limited to Members through the end of the calendar year in which they turn age 19.	Pediatric Vision subject to Deductible and Coinsurance Amount of 50% up to Out-of-Pocket Maximum. Pediatric Vision Benefits are limited to Members through the end of the calendar year in which they turn age 19.
Weight Loss Services	Not Covered	Not Covered
Wigs	Not Covered	Not Covered

Section 9: Benefits (Covered Services)

The following pages describe the various Healthcare Services that Blue Cross Blue Shield of Wyoming covers as Benefits under this Agreement, and to what extent these Benefits are Covered Services.

Benefits are only provided for Healthcare Services related to and required for the treatment of a Member's Condition.

All Benefits are subject to all other provisions in this Agreement including, but not limited to Section 10: Limitations and Exclusions on Benefits.

A. ACCIDENTS

1. Covered Services

Unexpected traumatic incidents which are 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 will be covered as accidents under this Plan. Examples include a blow or fall, animal bites, allergic reactions to insect bites or medication, or poisoning. The following services when received in connection with an accident may be covered:

a. Medical or surgical treatment by a Healthcare Provider in connection with treatment for injury to sound, natural teeth.

b. Confinement and covered care in a Hospital.

c. Laboratory and X-ray examinations.

d. Ambulance service.

e. Any Medically Necessary supply or service.

2. Limitations and Exclusions

a. Accidents are not the result of 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).

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

B. ACUTE REHABILITATIVE SERVICES

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

1. Covered Services

a. Services rendered at an Acute Rehabilitation Unit.

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

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

2. Limitations and Exclusions

a. Inpatient Rehabilitative Benefits are limited to a maximum of forty-five (45) days per calendar year per Member.

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

c. This section does not apply to Mental Health and Substance Use Disorder Services. Benefits for these services are described under the Section on MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.

d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

C. ADVANCED THERAPIES

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

1. Covered Services

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

a. FDA-approved biologics utilizing gene therapy

b. FDA-approved biologics utilizing cellular immunotherapy

c. FDA-approved biologics utilizing regenerative medicine technologies

2. Limitations and Exclusions

a. Advanced therapy services not listed https://www.bcbswy.com/providers/policy/ are not a covered benefit.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

D. ALLERGY SERVICES

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

1. Covered Services

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

a. Allergy Testing:

(1) Direct skin or,

(2) Patch testing.

(3) Onsite administrations of allergy shots.

2. Limitations and Exclusions

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

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

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

E. AMBULANCE SERVICES

1. Covered Services

Ambulance services to the nearest available facility capable of treating the Member's acute symptoms are covered when the Member, due to his or her Condition, cannot be safely transported by any other means:

a. From Member's home or site of an emergency.

b. Between Hospitals.

c. Between a Hospital and Skilled Nursing Facility.

d. Transportation to the closest facility with the appropriate level of care will be required, unless otherwise approved by Blue Cross Blue Shield of Wyoming.

2. Limitations and Exclusions

a. If the Member could have been safely transported by Ground Ambulance, Air Ambulance is not a Covered Service.

b. If Member could have been transported by automobile or public transportation without danger to Member's health or safety, Ambulance services will not be a Covered Service, even if other means of transportation were not available to the Member.

c. Ambulance service provided for the convenience of the Member or the Member's family is not a Covered Service. (Example: Transportation of an infant to be closer to the family's home.)

d. Transportation services, such as private automobile or wheelchair Ambulance charges, which have not specifically been listed as a Benefit are not a Covered Service.

e. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

F. ANESTHESIA SERVICES

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

1. Covered Services

Anesthesia services provided by specially trained Healthcare Providers are Covered Services when Medically Necessary for a covered Surgery. The Maximum Allowable Amount is determined by the type of Surgery and the amount of time necessary for Anesthesia services.

2. Limitations and Exclusions

a. Hypnosis for Anesthesia purposes is not a Covered Service.

b. The "Limitations and Exclusions" that apply to SURGERY Benefits also apply to Anesthesia Benefits.

c. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

G. BLOOD EXPENSES

1. Covered Services

The following blood related services are Covered Services:

a. Blood transfusions.

b. Blood, blood plasma and blood derivatives, except when donated or replaced.

c. The processing, transportation, handling and administration of blood.

2. Limitations and Exclusions

a. The "Limitations and Exclusions" that apply to SURGERY Benefits also apply to Blood Expense Benefits.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

H. CARDIAC REHABILITATION

1. Covered Services

a. Covered up to 36 visits per calendar year.

b. Phase I and II only.

2. Limitations and Exclusions

a. Phase III is not covered.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

I. CHEMOTHERAPY AND RADIATION THERAPY

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

1. Covered Services

a. Inpatient chemotherapy.

b. Outpatient chemotherapy.

c. Inpatient radiation.

d. Outpatient radiation.

e. Prescription chemotherapy.

2. Limitations and Exclusions

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

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

J. CONSULTATIONS

1. Covered Services

a. Physician Consultations

Physician Consultations are Covered Services.

b. Second Surgical Opinions

Physician's services, as well as any charges for tests necessary to receive a second surgical opinion before undergoing any Surgery are Covered Services. If possible, a Member should provide any medical records and test results created or obtain by Member's initial treating Physician to the Physician giving the second surgical opinion.

c. Third Surgical Opinions

If the first and second surgical opinions differ, Physician's services, as well as any charges for tests necessary to receive a third surgical opinion before undergoing any Surgery are Covered Services. If possible, a Member should provide any medical records and test results created or obtain by Member's first two treating Physicians to the Physician giving the third surgical opinion.

2. Limitations and Exclusions

a. Staff Consultations that are required by rules and regulations of a Hospital are not covered.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions of Benefits.

K. DENTAL SERVICES

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

1. Covered Services

a. Accident-Related Dental Expenses

Accident-related dental services are Covered Services, but only under the following conditions:

(1) Services, supplies, and appliances must be required due to an accidental injury.

(2) Treatment must be for injuries to sound natural teeth.

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

(4) All services must be performed while the Member's coverage under this Agreement is still in effect.

b. Dental Related Hospital Expenses

(1) Inpatient

If a Member is hospitalized for one of the following reasons, HOSPITALIZATION Benefits as defined in this Benefit Booklet will be Covered Services:

(a) 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).

(b) 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).

(c) Treatment of fractures of facial bones.

(d) Incision and drainage of cellulitis not originating in the teeth or gums.

(e) Incision of accessory sinuses, salivary glands or ducts.

(f) Reduction of dislocations of the temporomandibular joints.

(g) Accidental injury (provided the procedure is not done in preparation for a Prosthesis).

(h) If a Member has a hazardous medical Condition (such as heart Condition) which makes it necessary for the Member to have an otherwise non-covered dental procedure performed in the Hospital.

Benefits will be provided for general Anesthesia if the hospitalization is a Covered Service.

(2) Outpatient
The initial services provided by a Hospital or other facility for any one of the procedures specifically listed above under Dental Related Hospital Expenses - Inpatient Benefits are Covered Services.

c. Dental Related Physician Expenses
Inpatient and Outpatient services provided for the specific procedures listed above under the Dental Related Hospital Expenses - Inpatient Benefits, when provided by a Healthcare Provider, are Covered Services. The Benefit allowance for Surgery includes payment for pre-operative visits, local infiltration of Anesthesia, and follow-up care.

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

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

e. Pediatric Dental Services
See PEDIATRIC DENTAL for coverage.

f. Preventive Care
Pediatric dental screenings as indicated under PREVENTIVE CARE are Covered Services.

2. Limitations and Exclusions

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

b. Restorations of the mouth, tooth, or jaw which are necessary due to an accidental

injury are limited to those services, supplies, and appliances to be appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement or serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.

c. Accidental-related dental expenses for restoring the mouth, tooth, or jaw because of injuries from biting or chewing are not Covered Services.

d. If, due to a hazardous medical Condition (e.g. a heart Condition), a Member must be hospitalized for a non-covered dental procedure, the Member may receive Benefits for Inpatient Hospital charges as indicated under Covered Services. However, the services provided by the dentist or oral surgeon for these procedures are not Covered Services.

e. Before dental benefits will be allowed for hazardous medical Conditions, the Member must receive from Blue Cross Blue Shield of Wyoming *in advance* of the date the Member is hospitalized, a written authorization that such services will be Covered Services. A Physician other than a dentist or oral surgeon must certify to Blue Cross Blue Shield of Wyoming that hospitalization is necessary to safeguard the life or health of the Member.

f. If a Healthcare Provider needs to perform a dental procedure for non-dental reasons, the Member must receive from Blue Cross Blue Shield of Wyoming in advance of the date the Member is to receive the dental procedure, a written authorization that such services will be Covered Services.

g. Orthodontic procedures, services and supplies, except as provided in PEDIATRIC DENTAL, are not Covered Services.

h. Mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible are not Covered Services.

i. Physician services for dentistry or services related to dental care are not Covered Services.

j. Dental services not specifically detailed above, or in PEDIATRIC DENTAL are not Covered Services.

k. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

L. DIABETES SERVICES

1. Covered Services

Diabetes services, including 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 certified, registered or licensed Healthcare Provider with expertise in diabetes and who is legally authorized to prescribe such items under law are Covered Services when provided on an Outpatient basis.

2. Limitations and Exclusions

a. Inpatient diabetes services are not covered.

b. Covered Outpatient self-management training and education are limited to a one-time evaluation and training program when Medically Necessary. Any 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.

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

d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

M. GENDER REASSIGNMENT

1. Covered Services

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

a. Psychotherapy.
b. Hormone therapy.
c. Puberty-suppressing medication.
d. Laboratory testing to monitor the safety of continuous hormone therapy.
e. Surgery, including:

1) Male to Female:

a) Clitoroplasty (creation of clitoris)
b) Labiaplasty (creation of labia)
c) Orchiectomy (removal of testicles)
d) Penectomy (removal of penis)
e) Urethroplasty (reconstruction of female urethra)
f) Vaginoplasty (creation of vagina)
g) Breast enlargement, including augmentation mammoplasty and breast implants
h) Mastopexy (breast lift)

2) Female to Male:

a) Bilateral mastectomy or breast reduction
b) Hysterectomy (removal of uterus)
c) Metoidioplasty (creation of penis, using clitoris)
d) Penile prosthesis
e) Phalloplasty (creation of penis)
f) Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
g) Scrotoplasty (creation of scrotum)
h) Testicular prosthesis
i) Urethroplasty (reconstruction of male urethra)
j) Vaginectomy (removal of vagina)
k) Vulvectomy (removal of vulva)

NOTE: Authorization Review by Blue Cross Blue Shield of Wyoming is required before benefits are payable.

2. LIMITATIONS AND EXCLUSIONS

a. Coverage of this benefit is subject to all Authorization Review and requirements.

b. Covered surgeries are limited to one (1) per lifetime for each specified Surgery except when medically necessary due to complications.

c. Cosmetic procedures, including the following, are not covered services:

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

d. As otherwise limited and excluded in Section 10: Limitations and Exclusions on Benefits.

For a description of benefits related to drugs purchased through the pharmacy, see Section on PRESCRIPTION DRUGS.

N. HABILITATIVE SERVICES

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

1. Covered Services

a. Habilitative Services

Healthcare Services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

2. Limitations and Exclusions

a. Inpatient Habilitative Benefits are limited to a maximum of forty-five (45) days per calendar year per Member. Outpatient Habilitative Benefits are limited to a maximum of twenty (20) visits per calendar year per Member. This does not apply to Mental Health or Substance Use Disorder Services. Benefits for these services are described under the Section on MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

O. HEMODIALYSIS AND PERITONEAL DIALYSIS

1. Covered Services

a. Hemodialysis

Hemodialysis for the treatment of a kidney disorder by removal of blood impurities with dialysis equipment is a Covered Service when a Healthcare Provider treats a Member as an Inpatient, in the Outpatient department of a Hospital, or in the Member's home. Blue Cross Blue Shield of Wyoming 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 Healthcare Provider and required for therapeutic use.

b. Peritoneal Dialysis

Peritoneal dialysis as a treatment, where blood impurities are removed by using the lining of the peritoneal cavity as the filter, is a Covered Service when a Healthcare Provider treats a Member as an Inpatient, in the Outpatient department of a Hospital, or in the Member's home. Blue Cross Blue Shield of Wyoming 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 Healthcare Provider and required for therapeutic use.

2. Limitations and Exclusions

a. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

P. HOME HEALTHCARE

1. Conditions That Must Be Met Before Benefits Are Available

To obtain Home Healthcare Benefits, the Member must meet all of the following conditions:

a. The need for Home Healthcare must be directly related to the Condition for which the Member's hospitalization was required.

b. The Member would have to be admitted to a Hospital or Skilled Nursing Facility if he or she did not receive Home Healthcare.

c. The Member's Home Healthcare is ordered by a Healthcare Provider.

d. The Member's Home Healthcare must be provided by a licensed Home Healthcare Agency.

2. Covered Services

If the conditions listed above are met, the following Outpatient Home Health Care services are Covered Services:

a. Nursing Care

Part-time or periodic home nursing care by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed public nurse, or licensed vocational nurse under the supervision of a registered nurse.

b. Home Health Aide Care

Part-time or periodic home nursing care by home health aides.

c. Therapy

Physical, occupational, or speech therapy if provided by the Home Healthcare Agency.

d. Medical Supplies

Medical supplies ordered by a Healthcare Provider and provided by the Home Healthcare Agency.

3. Limitations and Exclusions

a. Inpatient Home Healthcare is not a Covered Service.

b. Custodial care such as the provision of meals, housekeeping or other non-medical assistance or for services provided by a member of the Member's immediate

family or a person ordinarily residing in the Member's home are not Covered Services.

c. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Q. HOSPICE SERVICES

1. Conditions That Must Be Met Before Benefits Are Available
To obtain Hospice Services, the Member must meet all of the following conditions:

a. The Member must be diagnosed with a terminal illness for which the attending Physician's prognosis for life expectancy is estimated to be six (6) months or less.

b. Palliative care (pain control and symptom relief) that cannot be obtained at a lower level of care, rather than curative care, is considered most appropriate.

c. The attending Physician must refer the Member to the program and must be in agreement with the plan for treatment of the Member's Condition.

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

3. Outpatient Covered Services
If the conditions listed above are met, the following Outpatient Hospice Services will be Covered Services:

a. Periodic nursing care by registered or practical nurses.

b. Home health aides.

c. Physical, occupational, speech and respiratory therapy.

d. Medical social workers.

4. Limitations and Exclusions

a. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

R. HOSPITALIZATION

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

1. Covered Services

a. Room Expenses

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

b. Ancillary Services

Ancillary services that Hospitals bill for and regularly make available to Members when Covered Services are provided for the treatment of Member's Condition are Covered Services. Ancillary 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.

2. Limitations and Exclusions

a. Authorization Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospital services.

b. If Member has a private room in a Hospital, the Maximum Allowable Amount for this HOSPITALIZATION Benefit will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

c. Hospitalizations, or portions thereof, which do not require twenty-four (24) hour continuous bedside nursing care, or hospitalizations for services which could be safely provided on an Outpatient basis, are not Covered Services.

d. Benefits will not be provided for services and supplies provided for Member's personal convenience which are not related to the treatment of the Member's Condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

e. Services or supplies provided by Skilled Nursing Facilities, extended care facilities, or similar facilities are not covered except as expressly provided in this Benefit Booklet.

f. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

S. HUMAN ORGAN TRANSPLANTS

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

1. Covered Services

Human organ transplant services required in connection with the replacement of a diseased human organ by transplantation of a healthy human organ from a donor are a Covered Service under this Agreement. Those transplants covered under this Benefit include, but are not limited to, the following:

a. Heart Transplants

b. Liver Transplants

c. Heart-Lung Transplants

d. Pancreas Transplants

e. Kidney Transplants

f. Corneal Transplants

g. High dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support.

Where the Member is the organ recipient, Benefits will be provided for Member's 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.

2. Limitations and Exclusions

a. Authorization Review is required prior to obtaining non-maternity and non-emergency Inpatient Human Organ Transplant services.

b. Donor expenses are not Covered Services if the donor is a Member but the recipient is not.

c. Donor expenses for which Benefits are available from another source are not Covered Services.

d. The cost of transportation, meals, and lodging related to a Human Organ Transplant are not Covered Services.

e. Services and supplies for which government funding of any kind is available are not Covered Services.

f. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

T. INHERITED ENZYMATIC DISORDERS

1. Covered Services

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

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

2. Limitations and Exclusions

a. Outpatient self-management training and education must be provided by a certified, registered or licensed Healthcare Provider with expertise in Inherited Enzymatic Disorders.

b. Outpatient self-management training and education is limited to:

(1) A one (1) time evaluation and training program when Medically Necessary;

(2) Additional Medically Necessary self-management training shall only be provided upon a significant change in symptoms, Condition or treatment.

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

U. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, & RELATED TESTING SERVICES

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

1. Covered Services

a. HealthPlus Laboratory Services

HealthPlus laboratory services provided by a Healthcare Provider, Hospital or Independent Pathology Laboratory for monitoring and treatment of certain chronic diseases including chronic heart disease, coronary artery disease, diabetes, and hypertension are Covered Services.

b. Other Laboratory, Pathology, X-ray, and Radiology

Laboratory and pathology, X-ray, and radiology provided by a Hospital, Healthcare Provider, independent pathology laboratory, or independent radiology laboratory are Covered Services.

(1) Laboratory and pathology services include 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).

(2) X-ray and radiology include services which 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.

c. Routine Pap Smears

Routine Pap Smears will be paid as indicated under PREVENTIVE CARE.

2. Limitations and Exclusions

a. Laboratory, pathology, X-ray, and radiology which are not related to Member's specific Condition are not Covered Services.

b. Laboratory or X-ray services related to weight loss programs are not Covered Services.

c. As otherwise limited or excluded in Section 10: Limitations and Exclusions on Benefits.

V. MATERNITY AND NEWBORN CARE

1. Covered Services

a. Maternity Services

Maternity services required for the diagnosis and care of a pregnancy and for delivery services are Covered Services. Maternity services include services related to the following Conditions:

(1) Complications of pregnancy.

(2) Spontaneous termination of pregnancy prior to full term.

(3) Ectopic pregnancies.

(4) Termination of pregnancy if the life of the mother would be in danger by the continuation of the pregnancy or the pregnancy is the result of rape or incest, to the extent permitted by State and Federal Law.

(5) Normal vaginal delivery.

(6) Caesarean section.

b. Newborn Services

Newborn services include the following:

(1) Routine nursery charges for a newborn billed by a Hospital.

(2) Routine care of a newborn billed by a Physician.

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

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

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

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

2. Limitations and Exclusions

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

b. Benefits will not be provided for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.

c. Genetic molecular testing is not a Covered Service except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed. As used herein, "genetic molecular testing" means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

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

d. Elective termination of pregnancy prior to full term to the extent permitted by State and Federal Law.

e. As otherwise limited and excluded in Section 10: Limitations and Exclusions on Benefits.

W. MEDICAL CARE FOR GENERAL CONDITIONS

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

1. Covered Services

Medical Care services rendered by the appropriate Healthcare Provider for the Medically Necessary treatment of a Member's Condition are Covered Services as follows:

a. Inpatient

Medical Care provided by a Healthcare Provider 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.

b. Outpatient

Medical Care provided by a Healthcare Provider when required for the treatment of a Member's specific Condition.

2. Limitations and Exclusions

a. Authorization Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospitalization Services.

b. Inpatient Medical Care Benefits are limited to one Physician per covered hospitalization unless services performed by other Physicians are CONSULTATION Services as defined in this Benefit Booklet.

c. Inpatient Medical Care Benefits are limited to one Medical Care visit per day when charged by the same Physician.

d. If Member has a private room in a Hospital, the Maximum Allowable Amount for this HOSPITALIZATION Benefit will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

e. Services related to routine examinations and immunizations (such as yearly physicals or screening examinations for school, camp or other activities) are not Covered Services except as described under PREVENTIVE CARE.

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

g. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

X. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

1. Covered Services

Mental Health Disorder Services and/or Substance Use Disorder Services for Conditions requiring psychotherapeutic treatment, applied behavioral analysis (ABA) therapy services, nutritional counseling, and/or rehabilitation from a Mental Health Disorder and/or a Substance Use Disorder are Covered Services.

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

2. Limitations and Exclusions

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

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

b. Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Member's education or training. (It makes no difference what the diagnosis is or what symptoms may be present.)

c. Benefits will not be paid for marital counseling or related services.

d. Mental Health Disorder Services and/or Substance Use Disorder Services must be provided by a properly licensed or certified Healthcare Provider.

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

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

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

h. Benefits provided through the psychiatric Collaborative Care Model as defined by the American Medical Associations' most recent procedural terminology codes and where a licensed and credentialed primary care team consists of a primary care provider, a care manager and a psychiatric consultant, and pursuant to Wyo. Stat. Ann. § 26-20-702, are not Covered Services.

i. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Y. OUTPATIENT MEDICATIONS

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

1. Covered Services

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

a. Outpatient Facility

b. Provider's Office

c. Infusion Clinic

d. Home Health Administration

e. Other Appropriate Outpatient Locations

2. Limitations and Exclusions

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

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

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

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

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

f. For Chemotherapy medications, please see Section CHEMOTHERAPY AND RADIATION THERAPY.

g. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Z. PEDIATRIC DENTAL SERVICES

IMPORTANT NOTE: Blue Cross Blue Shield utilizes UCD Dental as a Third Party Administrator to provide Pediatric Dental benefits to eligible Members. Authorization Review is required for Medically Necessary orthodontic treatment or if the estimated charges for pediatric dental services exceeds five hundred dollars ($500.00), an Authorization Review should be handled as follows:

The dentist or orthodontist should complete a claims form outlining the services to be performed, including the charges to be made, and forward it to Blue Cross Blue Shield of Wyoming at the address shown on the claim form.

After review by Blue Cross Blue Shield of Wyoming, the claim form will be returned to the dentist or orthodontist indicating the coverage available.

When the work is completed the dentist or orthodontist should indicate on the claim form:

1. **The specific service performed.**

2. **Identify the tooth, or teeth, involved in the procedure.**

3. **The date the specific service was completed.**

4. **The actual charges for the service or supply.**

The claim form should be forwarded to Blue Cross Blue Shield of Wyoming for processing.

1. **Covered Services**
   The following pediatric dental services are Covered Services for Members through the end of the calendar year in which they turn age nineteen (19):

   a. **Preventive and Diagnostic**
      Except as indicated below, the following preventive and diagnostic pediatric dental services are Covered Services payable at one-hundred percent (100%) of the Maximum Allowable Amount:

      (1) Oral examination.

      (2) Comprehensive periodontal evaluation.

      NOTE: Oral examinations and comprehensive periodontal evaluations are combined under one limitation of no more than two per calendar year.

      (3) Prophylaxis - Teeth cleaning and scaling (but not more than twice per calendar year).

(4) Bite wing X-rays (but not more than two sets per calendar year).

(5) Panoramic film (1 film every 60 (sixty) months). Subject to Cost Sharing Amounts.

(6) Intraoral periapical film. Subject to Cost Sharing Amounts.

(7) Intraoral occlusal film. Subject to Cost Sharing Amounts.

(8) Cephalometric X-ray (cephalometric X-ray will only be covered in conjunction with Orthodontic Treatment and is subject to all limits and exclusions applicable to Orthodontic Treatment under this Plan).

(9) Emergency palliative treatment.

(10) Fluoride treatments.

(11) Space maintainers.

(12) Sealant – One (1) per un-restored permanent molar every thirty-six (36) months subject to Cost Sharing Amounts.

(13) Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - one (1) sealant per tooth every thirty-six (36) months. Subject to Cost Sharing Amounts.

b. Restorative Procedures

The following restorative pediatric dental services are Covered Services:

(1) X-rays as follows:

(a) Full mouth X-rays (but not more than one (1) set in thirty-six (36) consecutive months).

(b) X-rays required in connection with diagnosis of a specific Condition requiring treatment, except X-rays provided in connection with orthodontic procedures and treatment.

(2) Extractions (except extractions for orthodontics).

(3) Oral Surgery (excluding procedures covered under the Dental Services portion of this Benefit Booklet).

(4) Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).

(5) General Anesthetics.

(6) Periodontal treatment, diseases of gums.

(7) Endodontic treatment (Pulp infection and root canal therapy).

(8) Injection of antibiotic drugs.

(9) Pin retention - per tooth, in addition to restoration.

c. Prosthodontic Treatment

The following prosthodontic pediatric dental services are Covered Services:

(1) Initial installation of fixed bridgework.

(2) Initial installation of partial or full removable dentures.

(3) Inlays, onlays, crowns.

(4) Gold fillings.

(5) Repair or replacement or addition to bridgework, dentures, crowns, inlays including re-cementing where necessary because of:

(a) One (1) or more teeth extracted after existing denture or bridgework was installed.

(b) Existing denture or bridgework was installed five (5) years prior to its replacement and cannot be made serviceable.

(6) Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth) when determined to be a dental necessity and Authorization Review is obtained.

d. Orthodontic Treatment

Orthodontic treatment that is Medically Necessary is available for Members through the end of the calendar year in which they turn age nineteen (19). Authorization Review must be obtained before Medically Necessary orthodontic treatment will be payable under this Agreement. Failure to obtain Authorization Review may result in a denial of coverage for this benefit. Medically Necessary orthodontic treatment is subject to certain Limitations and Exclusions.

e. Treatment in Progress

Benefits are not provided for treatment received prior to the Member's Effective Date of coverage. If a course of treatment is started prior to, and completed after, the Effective Date of this Pediatric Dental Services Benefit, Blue Cross Blue Shield of Wyoming will reimburse a pro-rated portion of the Maximum Allowable Amount for the Covered Service provided after the Effective Date.

In the event a Member transfers from the care of one dentist or orthodontist to that

of another during the course of treatment, or if more than one dentist or orthodontist provides service for the same dental/orthodontic procedure, Covered Services will be determined and paid as if only one dentist or orthodontist had provided the service.

2. Limitations and Exclusions

a. Authorization Review for Covered Services over $500.00 is required as described above.

b. Before Benefits will be allowed for hazardous medical Conditions, Blue Cross Blue Shield of Wyoming must give written authorization of such Benefits in advance of the date the Member is hospitalized. A Physician other than a dentist or oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. If a Healthcare Provider 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 Covered Services are performed.

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

d. 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.

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

f. Benefits will not be provided for replacement of existing dentures or bridgework, except in the following cases:

(1) When existing partial dentures, full removable dentures or fixed bridgework cannot be made serviceable and were installed five years before replacement, and/or

(2) When replacement or installation of a denture or bridgework is due to

necessary additional extractions or loss of teeth while the Member is covered under this Agreement.

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

h. Replacement of stolen or lost prosthetic devices.

i. Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.

j. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.

k. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.

(1) Extra sets of dentures or other prosthetic devices or appliances.

(2) Temporary or treatment dentures.

l. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

AA. PEDIATRIC VISION SERVICES

Blue Cross Blue Shield utilizes Davis Vision as a Third Party Administrator to provide Pediatric Vision benefits to eligible Members.

1. Covered Services

The following Pediatric Vision Services are Covered Services for Members through the end of the calendar year in which they turn age nineteen (19):

a. Vision Examinations

Benefits will be provided for one (1) vision exam for each Member per calendar year.

b. Frames

Benefits will be provided for one (1) frame for each Member per calendar year. Covered Services include but are not limited to facial measurements, determination of interpupillary distances, and assistance in frame selection, fitting and adjustment.

c. Lenses

Benefits will be provided for one (1) pair of lenses for each Member per calendar year, providing there were no Benefits paid for contact lenses during the same calendar year.

Lenses include the choice of glass, plastic or polycarbonate lenses, lens power (single vision, conventional (lined) bifocal or trifocal and lenticular), fashion gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Optional lenses and treatments are available including, ultraviolet protective coating, blended segment lenses, intermediate vision lenses, standard progressives, premium progressives, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, premium AR coating, ultra AR coating, scratch resistant coating and hi-index lenses.

d. Contact Lenses

Contact lenses are covered as a substitute for conventional lenses and frames as indicated above. Benefits will be provided for contact lenses for each Member per calendar year, providing there were no Benefits paid for conventional lenses or frames during the same calendar year.

e. Laser Vision Correction

A discount of up to 25% off of the provider's charge for the laser vision correction procedure may be available when you see an In-Network provider. This discount is negotiated with the provider and no dollar amounts associated with it will update the Deductible or Out-of-Pocket Maximum Amount. Requires Authorization Review.

f. Low Vision

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision services can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision.

Low vision services include:

(1) One comprehensive low vision evaluation every five (5) years. (Maximum allowance of $300 per evaluation)

(2) Follow-up care limited to four (4) visits in any five (5) year period. (Maximum allowance per visit is $100)

2. Limitations and Exclusions

a. Services for the Conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia, and presbyopia will be a Covered Service only as described under Pediatric Vision Services. In addition, benefits for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, the servicing of corrective lenses, and consultations related to such services will also be limited only to those Benefits, if any, described above.

b. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

BB. PRESCRIPTION DRUGS

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

1. Covered Services

Blue Cross Blue Shield utilizes Prime Therapeutics as a Third Party Administrator to provide Prescription Drug benefits to eligible Members. Prescription Drugs are covered under this BlueSelect PPO Plan when purchased from a Pharmacy participating in the BlueSelect Network ("BlueSelect Pharmacy"). When a Member needs a prescription filled, the Member should go to a BlueSelect Pharmacy and present his or her BlueSelect PPO Identification Card. The BlueSelect Pharmacy will only charge the Member for the Cost Sharing Amounts as shown in the Schedule of Benefits.

a. When Purchased at a Retail BlueSelect Pharmacy

Tier 1: Consists of the lowest-cost prescription medications; primarily Generic, but includes some Preferred Brand medications.

Tier 2: Consists of medium-cost prescription medications; mostly Preferred Brands, but may have Generics, as well as Generic-appearing Brand medications.

Tier 3: Consists of higher-cost prescription medications; most are Non-Preferred Brand-name medications, but may have Generic-appearing Brand medications.

Members may purchase up to a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed) through Pharmacies participating in Prime's Extended Supply Network (ESN). Members may purchase Specialty Medications up to a thirty (30) day supply, unless otherwise authorized by BCBSWY (when taken in the quantity prescribed).

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

Member prescription Cost Shares are dependent on both Tier level medication and each respective benefit policy.

b. When Purchased by Mail through a BlueSelect Pharmacy

Tier 1: Consists of the lowest-cost prescription medications; primarily Generic, but includes some Preferred Brand medications.

Tier 2: Consists of medium-cost prescription medications; mostly Preferred Brands, but may have Generics, as well as Generic-appearing Brand medications.

Tier 3: Consists of higher-cost prescription medications; most are Non-Preferred Brand-name medications, but may have Generic-appearing Brand medications.

Members may purchase up to a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed) through Pharmacies participating in Prime's Extended Supply Network (ESN). Members may purchase Specialty Medications up to a thirty (30) day supply, unless otherwise authorized by BCBSWY (when taken in the quantity prescribed).

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

Member prescription Cost Shares are dependent on both Tier level medication and each respective benefit policy.

c. When HealthPlus Drugs are Purchased at a Retail BlueSelect Pharmacy

HealthPlus Drugs include drugs that treat certain chronic or long-term Conditions. Use of these medications has shown the potential to improve health outcomes.

HealthPlus Tier 1: Consists of the lowest-cost prescription medications; primarily Generic, but includes some Preferred Brand medications.

HealthPlus Tier 2: Consists of medium-cost prescription medications; mostly Preferred Brands, but may have Generics, as well as Generic-appearing Brand medications.

HealthPlus Tier 3: Consists of higher-cost prescription medications; most are Non-Preferred Brand-name medications, but may have Generic-appearing Brand medications.

Members may purchase up to a ninety (90) day supply of Prescription Drugs at a time

(when taken in the quantity prescribed) through Pharmacies participating in Prime's Extended Supply Network (ESN). Members may purchase Specialty Medications up to a thirty (30) day supply, unless otherwise authorized by BCBSWY (when taken in the quantity prescribed).

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

Member prescription Cost Shares are dependent on both Tier level medication and each respective benefit policy.

d. When HealthPlus Drugs are Purchased by Mail through a BlueSelect Pharmacy

HealthPlus Drugs include drugs that treat certain chronic or long-term Conditions. Use of these medications has shown the potential to improve health outcomes.

HealthPlus Tier 1: Consists of the lowest-cost prescription medications; primarily Generic, but includes some Preferred Brand medications.

HealthPlus Tier 2: Consists of medium-cost prescription medications; mostly Preferred Brands, but may have Generics, as well as Generic-appearing Brand medications.

HealthPlus Tier 3: Consists of higher-cost prescription medications; most are Non-Preferred Brand-name medications, but may have Generic-appearing Brand medications.

Members may purchase up to a ninety (90) day supply of Prescription Drugs at a time (when taken in the quantity prescribed) through Pharmacies participating in Prime's Extended Supply Network (ESN). Members may purchase Specialty Medications up to a thirty (30) day supply, unless otherwise authorized by BCBSWY (when taken in the quantity prescribed).

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

Member prescription Cost Shares are dependent on both Tier level medication and each respective benefit policy.

For a current list of HealthPlus Drugs, go to www.yourwyoblue.com.

NOTE: HealthPlus Drugs are determined by Blue Cross Blue Shield of Wyoming.

Copayment tier exceptions are not available. The HealthPlus Drug list is subject to change at any time.

e. When Specialty Drugs are Purchased Through the Preferred Specialty Pharmacy

Specialty Medications are generally prescribed for people with complex or ongoing Conditions and have one or more of the following characteristics: (i) they may be injected or infused; (ii) they have unique storage or shipping requirements; (iii) additional education and support is required from a Healthcare Provider; (iv) they are usually not stocked at retail Pharmacies.

Specialty Medications are only a Covered Service when the prescriptions are filled through the Preferred Specialty Pharmacy, when available. A small number of limited distribution drugs may not be available at the Preferred Specialty Pharmacy. In this instance, Blue Cross Blue Shield of Wyoming will make accommodations for prescription fulfillment at an alternative Pharmacy that carries the limited distribution drug.

Specialty medication prescriptions on the Specialty Pharmacy Drug Management List are to be filled through the Preferred Specialty Pharmacy by calling (877) 627-6337.

Tier 4: Consists of Specialty drugs; most are highest-cost Brand Specialty medications, but some may also be Generic Specialty medications.

Members may purchase Specialty Medications up to a thirty (30) day supply, unless otherwise authorized by BCBSWY (when taken in the quantity prescribed).

For a current list of Specialty Medications, go to: www.yourwyoblue.com.

NOTE: Drug Tiers are determined by Blue Cross Blue Shield of Wyoming. Copayment tier exceptions are not available. The Specialty Pharmacy Drug Management List is subject to change at any time.

f. FlexAccess Copay Program

FlexAccess copay program is designed to help both you and the Plan save money on certain specialty medications by obtaining copay assistance from drug manufacturers when it is available.

The cost share for program medications may be set to the maximum of the current benefit design or the amount determined by the manufacturer-funded copay assistance program.

NOTE: The Plan reserves the right not to apply manufacturer or provider cost share

assistance program payments (e.g. manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket Maximums.

2. Limitations and Exclusions

a. Prescription Drugs purchased from a Pharmacy that is not in the BlueSelect PPO Network are not Covered Services under this Agreement. Payment for Prescription Drugs from a Pharmacy not participating in the BlueSelect PPO Network will be the sole responsibility of the Subscriber/Member.

b. Specialty Medications purchased from a Pharmacy other than the Preferred Specialty Pharmacy (unless approved by BCBSWY and/or the medication is not available through the Preferred Specialty Pharmacy) are not Covered Services under this Agreement.

c. Prescription Drug and Specialty Medication Benefits may be subject to Utilization Management. Utilization Management policies, in collaboration with the Pharmacy Benefit Management (PBM), are used by Blue Cross Blue Shield of Wyoming to manage the clinical appropriateness and the cost of healthcare decision-making. These Utilization Management policies are applied prior the delivery of the Prescription Drug or Specialty Medication to the Member and decisions are made on a case-by-case assessment of appropriateness. The following Utilization Management policies are in effect:

(1) Authorization Review
Prescription Drugs and Specialty Medications are selected for Authorization Review because of actual or potential misuse or overuse that may be of clinical and/or economic concern. Prescription Drugs and Specialty Medications selected for Authorization Review require that specific clinical criteria be met before the drugs will be a Covered Service. Clinical criteria are based on product labeling, clinical studies and clinical practice standards. The lists of Prescription Drugs and Specialty Medications that require Authorization Review are published on Blue Cross Blue Shield of Wyoming's Preferred Drug List found on www.yourwyoblue.com.

(2) Quantity Level Limits
The Quantity Level Limits program limits certain Prescription Drugs and Specialty Medications to a maximum number (or amount) within a certain time period. These limits are in place to encourage appropriate prescribing quantities and are typically based on the Federal Drug Administration's approved product labeling.

(3) Step Therapy
Step Therapy programs are focused on the use of cost-effective Prescription

Drugs and Specialty Medications as first-line treatment when they are clinically appropriate based on current medical guidelines and best practice standards. First-line Prescription Drugs and Specialty Medications are usually Generic Drugs. Most costly Prescription Drugs and Specialty Medications are covered for Members who have tried and failed a first-line Prescription Drug or Specialty Medication. The lists of Prescription Drug and Specialty Medication categories subject to Step Therapy are published on Blue Cross Blue Shield of Wyoming's website at www.yourwyoblue.com.

d. Drugs that can be purchased without a written prescription, even if the Healthcare Provider has prescribed such "over-the-counter" medications are not Covered Services, except as described under PREVENTIVE CARE and specific OTC drugs classes determined to be a covered benefit by BCBSWY.

e. Drugs and medicines which are provided as "take-home supply" by a Hospital are not Covered Services.

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

g. Prescription Drugs related to hair loss are not Covered Services.

h. Prescription Drugs used for cosmetic purposes are not Covered Services.

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

j. Rebates are the sole property of Blue Cross Blue Shield of Wyoming and will not be considered in calculating any Member's Cost Sharing Amounts. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the BlueSelect PPO Network program.

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

l. As otherwise limited and excluded in Section 10: Limitations and Exclusions on Benefits.

CC. PREVENTIVE CARE

1. Covered Services

Preventive Care includes the preventive health services recommended by:

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

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

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

Preventive Care also includes the following testing procedures:

a. Testing procedures and examinations for cervical cancer, breast cancer, and diabetes.

b. Testing procedures and examinations for Subscriber and Subscriber's covered Spouse for prostate cancer.

When Preventive Care is provided by a BlueSelect Provider or by a licensed health fair, Preventive Care Covered Services will be provided at one-hundred percent (100%) of the Maximum Allowable Amount, without regard to any Cost Sharing Amounts that might otherwise apply.

A list of covered preventive services and their limitations can be found on our website at www.bcbswy.com/wellness/.

2. Limitations and Exclusions

a. Unless not available through a BlueSelect Network Provider, Preventive Care provided by Healthcare Providers who are not BlueSelect Providers will not be Preventive Care Covered Services under this Agreement and will only be Covered Services if the services fall under another covered Benefit in this Benefit Booklet. Any such Covered Services will be subject to Member's Cost Sharing Amounts and those additional amounts Member is responsible for when receiving services from a Healthcare Provider not participating in the BlueSelect PPO Network as described in Section 7: The BlueSelect PPO Network. Where there are no BlueSelect Network Providers available to provide the Preventive Care services, those Preventive Care services performed by a Non-Network Provider will be

covered at one-hundred percent (100%) of the Maximum Allowable Amount, without regard to any Cost Sharing Amounts that might otherwise apply. You may still be responsible for any amounts above the Maximum Allowable Amount if you choose to receive care from a Non-Network Provider, up to the amount of the provider's billed charges.

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

c. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

DD. PRIVATE DUTY NURSING SERVICES

1. Covered Services

Inpatient Private Duty Nursing Services are Covered Services only when:

a. The Member's Condition would ordinarily require that the Member be placed in an intensive or coronary care unit, but the Hospital does not have such facilities; or

b. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Member's Condition; and

c. The private duty nurse is not employed by the Hospital or Healthcare Provider and is not a resident of the household or a relative of the Member.

2. Limitations and Exclusions

a. Outpatient Private Duty Nursing Services are not Covered Services.

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

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

d. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

EE. SKILLED NURSING FACILITY

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

A "Skilled Nursing Facility" is a facility 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 minimal care, custodial care, ambulatory care, or part-time care services, or care or treatment of Mental Health Disorder, alcoholism, drug use or pulmonary tuberculosis.

1. Covered Services

a. Inpatient and Outpatient: Benefits are provided subject to any appropriate Deductible and Coinsurance for daily charges for room and board and general nursing services in a licensed, skilled nursing facility. This coverage is to become available if the attending Physician certifies that twenty-four (24) hour skilled nursing care is essential for recuperation.

2. Limitations and Exclusions

a. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

FF. SUPPLIES, EQUIPMENT AND APPLIANCES

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

1. Covered Services

a. Durable Medical Equipment

The rental or the purchase of Medically Necessary durable medical equipment, whichever is less expensive, is a Covered Service. When a purchase is authorized, Benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment.

b. Medical Supplies

Medical Supplies including, but not limited to, the following are Covered Services:

(1) Colostomy bags and other supplies for their use.

(2) Catheters.

(3) Dressings for cancer, diabetic and decubitus ulcers and burns.

(4) Syringes and needles for administering covered drugs, medicines, or insulin.

c. Prosthesis and Orthopedic Appliances

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

(1) Artificial arms or legs.

(2) Leg braces, including attached shoes.

(3) Arm and back braces.

(4) Cervical collars.

(5) Surgical implants.

(6) Artificial eyes.

(7) Pacemakers.

(8) Breast prosthesis and special bras.

(9) Cochlear implants and bone-anchored hearing aids (BAHAs).

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

d. Prescription Glasses/Lenses

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

e. Oxygen

Oxygen and the equipment needed to administer it are Covered Services.

f. Breast pumps

Breast pumps as indicated under PREVENTIVE CARE are Covered Services. **Authorization Review is required for any Hospital-grade breast pumps.**

g. Diabetic Supplies

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

1) Syringes

2) Blood glucose monitors, lancets and test strips

3) Continuous glucose monitors and sensors

4) Insulin pumps

When purchased at a BlueSelect Pharmacy

Tier 1: Consists of the lowest cost equipment and supplies

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

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

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

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

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

2. Limitations and Exclusions

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

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

c. Durable Medical Equipment 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.

d. Hearing aids and related services and supplies are not Covered Services.

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

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

g. Benefits will not be provided for special braces or special equipment.

h. Diabetic supplies purchased from a Pharmacy that is not in the BlueSelect PPO Network are not Covered Services under this Agreement. Payment for diabetic supplies from a Pharmacy not participating in the BlueSelect PPO Network will be the sole responsibility of the Subscriber/Member.

i. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

GG. SURGERY

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

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

1. Covered Services

a. General Surgical Treatment

Surgery for the Medically Necessary treatment of diseases or injuries, including specialized instrumentations, endoscopic examinations and other invasive procedures, the correction of fractures and dislocations, usual and related pre-operative and post-operative care are Covered Services.

b. Orthognathic Surgery

Orthognathic Surgery will be a Covered Service only where Member has a congenital defect or restoration due to accidental injury as follows:

(1) Upper or lower jaw augmentation or reduction procedures.

(2) Reconstructive procedures which correct deformities of the jaw.

(3) Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and re-contouring of the facial bones).

c. Cosmetic Surgery

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

d. Reconstructive Surgery

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

(1) Reconstruction of the breast on which the mastectomy has been performed.

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

(3) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

e. Prophylactic Surgery

The following prophylactic surgeries will be a Covered Service:

(1) Mastectomy

(2) Oophorectomy

(3) Hysterectomy

f. Sterilization Procedures

Sterilization procedures and related expenses are Covered Services. See Section on PREVENTIVE CARE for certain Sterilization Procedures covered at one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services without regard to Member's Cost Sharing Amounts that might otherwise apply.

2. Limitations and Exclusions

a. Authorization Review is required prior to obtaining non-maternity and non-emergency Inpatient Hospitalization Services.

b. More than one Surgery performed by the same Physician during the course of only one (1) 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.

c. 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.

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

e. Surgery for obesity procedures covered under this Benefit Booklet is limited to a lifetime maximum of one (1) per Member.

f. Surgery for obesity is only a Covered Service for the treatment of morbid obesity. This type of Surgery is not covered for any other Condition.

g. Reversals of sterilization procedures are not Covered Services.

h. Incidental procedures which are routinely performed during the course of the primary Surgery are not Covered Services.

i. For a description of benefits allowed for dental Surgery, see Section on DENTAL SERVICES.

j. For a description of benefits related to Human Organ Transplants see Section on HUMAN ORGAN TRANSPLANTS.

k. For a description of benefits related to Member's Hospitalization for a Surgery, see Section on HOSPITALIZATION.

l. As otherwise limited by Section 10: Limitations and Exclusions on Benefits.

HH. THERAPY (OCCUPATIONAL, PHYSICAL, SPEECH, RESPIRATORY)

1. Covered Services

a. Healthcare Provider

The following therapies are Covered Services when provided and/or prescribed by a Healthcare Provider:

(1) Physical therapy provided by a Physician or by a registered physical therapist.

(2) Occupational, physical, and speech therapy for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

(3) Occupational and physical therapy for the treatment of severe burns and amputations.

(4) Speech therapy related to cochlear implants.

(5) Respiratory therapy.

2. Limitations and Exclusions

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

b. Outpatient occupational, physical, and speech therapy for Cerebral Vascular Accidents (CVA), head injury, spinal cord injury or as required as a result of post-operative brain Surgery, severe burns, and amputations and speech therapy related to cochlear implants are limited to a maximum of sixty (60) visits per calendar year per Member. This is in addition to the forty (40) physical therapy treatments per calendar year.

c. Spinal Manipulations are limited to fifteen (15) visits per Member per calendar year.

d. Benefits will not be provided for occupational or speech therapy services (except as described under the covered services of this section and under the Section on HABILITATIVE SERVICES).

e. This section does not apply to Mental Health and Substance Use Disorder Services. Benefits for these services are described under the Section on MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.

f. As otherwise limited or excluded by Section 10: Limitations and Exclusions on Benefits.

Section 10: Limitations and Exclusions on Benefits

The limitations and exclusions listed in this section apply to all Covered Services described in this Benefit Booklet. Benefits will not be provided for any of the following Healthcare Services, supplies, situations, hospitalizations or related expenses, or will be limited as specifically indicated below:

A. ACUPUNCTURE
Services related to acupuncture, whether for medical or Anesthesia purposes, are not Covered Services.

B. ALTERNATIVE MEDICINE
Treatments and services for alternative medicine are not Covered Services under this Benefit Booklet. 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 Services.

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

E. AUTOPSIES
Services related to autopsies are not Covered Services.

F. BIOFEEDBACK
Services related to biofeedback are not Covered Services.

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

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

I. CONVALESCENT CARE
Benefits for convalescent care provided during the period of recovery from illness or the effects of injury and Surgery are limited to those Medically Necessary Covered Services normally received for a specific Condition.

J. COSMETIC SURGERY/RECONSTRUCTIVE SURGERY

Cosmetic Surgery for beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic are not Covered Services and do not become reconstructive Surgery because of Member's 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. Authorization Review is required before Benefits for cosmetic Surgery are payable.

NOTE: Any Member who receives Benefits in connection with a mastectomy and who elects breast reconstruction Surgery in connection with the covered mastectomy shall also be covered for the following in accordance with Federal Law:

1. Reconstruction of the breast on which the mastectomy has been performed.

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

K. CUSTODIAL CARE

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

L. DIAGNOSTIC ADMISSIONS

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

M. DOMICILIARY CARE

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

N. EDUCATIONAL PROGRAMS

Educational, vocational, or training services and supplies are not Covered Services except as explicitly described in this Benefit Booklet.

O. ENVIRONMENTAL MEDICINE AND CLINICAL ECOLOGY

Treatment and services for environmental medicine and clinical ecology are not Covered Services under this Benefit Booklet. Environmental medicine and clinical ecology encompass

the diagnosis or treatment of environmental illness, including, but not limited to: chemical sensitivity or toxicity from past or continued exposure to atmospheric contaminants, pesticides, herbicides, fungi, molds, or foods exposed to atmospheric or environmental contaminants.

P. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Except as explicitly described in this Benefit Booklet, procedures which are Experimental or Investigational in nature (as defined in this Benefit Booklet) are not Covered Services.

Q. EYE CARE

Except as indicated under PREVENTIVE CARE and PEDIATRIC VISION, there are no Covered Services for the Conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eyeglasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

R. FOOT CARE SERVICES

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

S. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Except as indicated under PREVENTIVE CARE, Genetic Molecular Testing is not a Covered Service 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.

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

T. 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 Services 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.

U. 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 Services.

V. HOSPITALIZATIONS

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

W. HYPNOSIS

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

X. ILLEGAL SERVICES

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

Y. LEGAL PAYMENT OBLIGATIONS

Services for which a Member does not legally have to pay, or charges that are made only because benefits are available under this Benefit Booklet are not Covered Services except as required by the Federal, State, or Local Law. This includes services provided by any person related to the Member or residing in the Member's household.

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

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

AA. MISSED APPOINTMENTS

Charges for missed appointments are not Covered Services.

BB. NON-MEDICALLY NECESSARY SERVICES OR SUPPLIES

No Benefits will be provided for services or supplies that are not Medically Necessary, as defined in this Benefit Booklet.

CC. OBESITY AND WEIGHT LOSS

Except as described under Preventive Care or Clinical Programs, 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.

DD. 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;

2. Reconstructive procedures which correct deformities of the jaw;

3. Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and re-contouring of the facial bones).

EE. OUT-OF-NETWORK BENEFITS

Services are not covered Out-of-Network when received outside Wyoming unless required by Federal or State Law.

FF. PERSONAL COMFORT OR CONVENIENCE

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

GG. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Services rendered by a physician's assistant or nurse practitioner when the sponsoring Physician sees the patient or becomes directly involved in the medical service being provided are not Covered Services. (A sponsoring Physician is a licensed Physician approved to sponsor a physician assistant by the State Board of Medical Examiners.)

HH. PROPHYLAXIS/PROPHYLACTIC MEDICINE

Except as explicitly allowed as a Covered Service in this Benefit Booklet, Healthcare Services and supplies that are of a preventive or prophylactic nature are not Covered Services. Preventive or prophylactic treatments and services are those which are rendered to a person for purposes other than treating a present and existing Condition in that person including, but not limited to, immunizations or Surgery on otherwise healthy body organs and/or parts.

II. REPORT PREPARATION

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

JJ. RESEARCH STUDIES

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

KK. 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.

LL. SERVICES AFTER COVERAGE ENDS

No Benefits are provided after this Agreement is terminated. (EXAMPLE: If the Member is

hospitalized on July 30th and had terminated coverage effective August 1st, no Benefits are provided for any services received on or after August 1st.)

MM. SERVICES NOT IDENTIFIED

Any Healthcare Service or supply not specifically identified as a Benefit in this Benefit Booklet is not a Covered Service.

NN. SERVICES PRIOR TO THE EFFECTIVE DATE

Charges incurred for supplies and services received prior to the Effective Date of coverage are not Covered Services.

OO. SUBLUXATION

Services 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, are not Covered Services.

PP. SUBROGATION

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

1. All recoveries the Member obtains (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse Blue Cross Blue Shield of Wyoming in full for benefits Blue Cross Blue Shield of Wyoming has paid to or on behalf of the Member. Blue Cross Blue Shield of Wyoming's share of any recovery extends only to the amount of Benefits Blue Cross Blue Shield of Wyoming has paid or will pay to or on behalf of the Member or Member's heirs, administrators, legal representatives, parents (if Member is a minor), successors, or assignees. This is Blue Cross Blue Shield of Wyoming's right of recovery.

2. Blue Cross Blue Shield of Wyoming is entitled under its right of recovery to be reimbursed for the Benefit payments it has made to or on behalf of the Member even if the Member has not been "made whole" for all of his or her damages in the recoveries that the Member has received. Blue Cross Blue Shield of Wyoming's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

3. Blue Cross Blue Shield of Wyoming will not reduce its share of any recovery unless, in the exercise of its discretion, it agrees in writing to a reduction (a) because the Member did not receive the full amount of damages that Member claimed or (b) because the

Member had to pay attorneys' fees.

4. The Member must cooperate in doing what is reasonably necessary to assist Blue Cross Blue Shield of Wyoming with its right of recovery. The Member must not take any action that may prejudice Blue Cross Blue Shield of Wyoming's right of recovery.

5. If the Member does not seek damages for his or her Condition, the Member must permit Blue Cross Blue Shield of Wyoming to initiate recovery on Member's half (including the right to bring suit in Member's name). This is called subrogation.

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

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

NOTE: Blue Cross Blue Shield of Wyoming will pay the costs of any Covered Services the Member receives that are in excess of any recoveries made.

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

1. When a third party injures the Member, for example, in an automobile accident or through medical malpractice.

2. When the Member is injured on a premises owned by a third party.

3. When the Member is injured and Benefits are available to Member or Member's dependents, under any law or under any type of insurance, including, but not limited to:

a. No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by the Member to treat those benefits as secondary to this Plan.

b. Uninsured and underinsured motorist coverage.

c. Workers' Compensation benefits.

d. Medical reimbursement coverage.

QQ. SUBSCRIPTION SERVICES

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

RR. TAXES

Income, sales, service, mailing charges or other taxes imposed by law that apply to Benefits covered under this Benefit Booklet are not Covered Services.

SS. TELEMEDICINE

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

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

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

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

TT. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Except as explicitly allowed as a Covered Service in this Benefit Booklet, Benefits are not provided for the treatment of temporomandibular joint disorders and myofascial pain-dysfunction syndrome.

UU. THERAPIES

Except as explicitly allowed as a Covered Service in this Benefit Booklet, special therapies are not Covered Services. Such non-Covered Services include (but are not limited to): recreational and sex therapies, Z therapy, wilderness programs, self-help programs, transactional analysis, sensitivity training, assertiveness training, encounter groups, transcendental meditation (TM), religious counseling, rolfing, primal scream therapy, activity therapy, hippotherapy, equine therapy, and stress management programs.

VV. TOBACCO DEPENDENCY

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

WW. TRAVEL EXPENSES

Travel expenses are not Covered Services.

XX. ULTRA-RAPID OPIATE DETOXIFICATION

Services related to ultra-rapid opiate detoxification are not Covered Services.

YY. UNRELATED SERVICES

Services and supplies which are not related to a specific Condition are not Covered Services.

ZZ. WAR

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

AAA. WEIGHT LOSS PROGRAMS

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

BBB. WORKERS' COMPENSATION

No Benefits will be provided for Covered Services for any Condition which occurs in the course of Member's employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not the Member claims the benefits or compensation and whether or not the Member recovers losses from a third party.

Section 11: How to File a Claim for Benefits

A. WRITTEN CLAIM FOR BENEFITS

A Claim for Benefits must be furnished to Blue Cross Blue Shield of Wyoming at its office at 4000 House Avenue, PO Box 2266, Cheyenne, Wyoming 82003-2266.

Blue Cross Blue Shield of Wyoming will not be liable under this Benefit Booklet unless a proper Claim for Benefits is furnished to Blue Cross Blue Shield of Wyoming demonstrating that Covered Services have been rendered to a Member. The Claim for Benefits must be submitted to Blue Cross Blue Shield of Wyoming within ninety (90) days after completion of the Covered Service. The Claim for Benefits must include all of the information necessary for Blue Cross Blue Shield of Wyoming to determine whether or not the Healthcare Service was a Covered Service and the Maximum Allowable Amount of the benefit.

Failure to submit a Claim for Benefits 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 submit the Claim for Benefits within the time specified above and that the Claim for Benefits was submitted as soon as it was reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the date the Claim for Benefits was first due.

B. CLAIM FORMS

Blue Cross Blue Shield of Wyoming shall furnish to the person making a claim (claimant) the forms it usually furnishes for filing Claims for Benefits. If such forms are not furnished within fifteen (15) days of the filing of a notice of claim, the claimant shall be deemed to have complied with the requirements of this Agreement as to Claims for Benefits upon submitting, within the time fixed in the Agreement for filing Claims for Benefits, written proof regarding the date(s) Healthcare Services were rendered, and the character and extent of Healthcare Services for which a claim is made.

Section 12: How Claims For Benefits Will Be Paid

A. TIME OF CLAIM PAYMENT

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

B. COORDINATION OF BENEFITS

Members often have other coverage providing duplicate benefits. In the event of other coverage, Blue Cross Blue Shield of Wyoming will not duplicate benefits if otherwise provided for (or should have been provided had the Member elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one (1) coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay for Covered Services to the full extent of its aggregate coverage, and the coverage secondarily liable shall then pay for Covered Services to the extent of any unpaid balance thereof, not exceeding its aggregate coverage or 110% (whichever is greater) of the Maximum Allowable Amount.

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

C. EXPLANATION OF BENEFITS

Blue Cross Blue Shield of Wyoming will provide an Explanation of Benefits (EOB) document to Member after a Claim for Benefits has been processed. The EOB will include the Member's name, claim number, type of Healthcare Services received, the identity of the Healthcare Provider rendering the Healthcare Services, the Covered Services and the Healthcare Services not covered, the amount of the Healthcare Provider's charges, the Maximum Allowable Amount paid, and the Member's Cost Sharing Amounts. Members should carefully review each EOB they receive and keep them with other important records.

D. PAYMENT IN ERROR

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

Section 13: Appealing an Adverse Benefit Determination of a Claim for Benefits

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

If a Member is not satisfied with the results of the processing of his or her Claim for Benefits or request for Authorization Review, the Member may make a written appeal. When making the request for review or reconsideration, Member should include his or her Identification Card numbers and claim numbers.

1. Medical Emergency Services

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

2. Non-Emergency Medical Services

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

Members should mail or hand-deliver their requests for an Internal Claims Review to:

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

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

The adjudication committee of Blue Cross Blue Shield of Wyoming will review the

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

B. EXTERNAL CLAIMS REVIEW PROCEDURE

If Blue Cross Blue Shield of Wyoming denies the Member's request for the provision of, or payment for, a Healthcare Service or course of treatment on the basis that it is not Medically Necessary, or Experimental/Investigational, the Member may have a right to have the adverse determination reviewed by healthcare professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending healthcare professional or the healthcare professional's partner by following the procedures outlined in this notice.

The Member must submit a request for external review within one-hundred twenty (120) days after receipt of the claims denial to Blue Cross Blue Shield of Wyoming's appeals office. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.

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

1. Medical Necessity Denials

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

a. The timeframe for the completion of a standard review would seriously jeopardize the Member's life or health or would jeopardize his or her ability to regain maximum function; or

b. The Member's claim concerns a request for an admission, availability of care, continued stay or Healthcare Service for which he or she received Medical Emergency services, but has not been discharged from a healthcare facility.

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

The Member's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Avenue, PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

2. Experimental/Investigational Denials

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

a. The timeframe for the completion of a standard review would seriously jeopardize the Member's life or health or would jeopardize his or her ability to regain maximum function; or

b. The Member's claim concerns a request for an admission, availability of care, continued stay or Healthcare Service for which he or she received Medical Emergency services, but has not been discharged from a healthcare facility.

To request an external review or an expedited review for his or her claims or Authorization Review denial, the Member's request must be made in writing and sent to Blue Cross Blue Shield of Wyoming, 4000 House Ave., PO Box 2266, Cheyenne, WY 82003-2266 within one-hundred twenty (120) days of the date on the Notice of Appeal Rights.

C. PRESCRIPTION DRUG EXCEPTION REQUEST

1. Internal Exception Request

Unless excluded, the Member may request access to clinically appropriate drugs not otherwise covered by Blue Cross Blue Shield of Wyoming through a request for exception. The Member and/or the Member's legal representative have up to one-hundred eighty (180) days to request an internal Prescription Drug exception. For a standard exception request, Blue Cross Blue Shield of Wyoming will notify the Member, the prescribing physician, and/or the facility of its coverage determination no later than seventy-two (72) hours following receipt of the request.

If exigent circumstances exist, the Member may request an expedited review. The need for expedited review must be certified by the prescribing physician and their signature must accompany the request. For information about sending this request, please go to www.bcbswy.com/providers/rxtools. In these cases, Blue Cross Blue Shield of Wyoming will notify the Member, the prescribing physician and/or the facility of its coverage determination no later than twenty-four (24) hours following receipt of the request. Exigent circumstances exist when:

a. The Member is suffering from a health Condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function; or

b. The Member is undergoing a current course of treatment using a non-formulary drug.

2. External Exception Request

If Blue Cross Blue Shield of Wyoming denies either a standard or an expedited exception request, the Member, the Member's designee, the prescribing physician and/or the facility may request, within one-hundred twenty (120) days, that the original exception

request and subsequent denial of such request be reviewed by an independent review organization. Blue Cross Blue Shield of Wyoming will make its coverage determination on the external exception request and notify the Member, the Member's designee, the prescribing physician and/or the facility no later than seventy-two (72) hours following its receipt of a standard request, or twenty-four (24) hours following an expedited request.

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

Section 14: Additional Provisions

The following general provisions apply to all Benefits (Covered Services) and Limitations and Exclusions described in this Agreement.

A. ASSIGNMENT OF BENEFITS

This Agreement, and all Benefits stated in this Agreement, is personal to the Member. This Agreement, the Benefits stated in this Agreement, and Blue Cross Blue Shield of Wyoming's payments to the Member pursuant to this Agreement may not be assigned to any person, corporation, or entity. Any attempted assignment shall be void. Although Blue Cross Blue Shield of Wyoming may make direct payment to the Member's healthcare providers at its election, this payment will not constitute an assignment of Benefits under this Agreement or any waiver of this provision.

B. DISCLOSURE OF A MEMBER'S MEDICAL INFORMATION

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

1. Upon a written, dated, and signed authorization by the Member or prospective Member or by a person authorized to provide consent for a minor or an incapacitated person;

2. If the data or information does not identify either the Member or prospective Member or the Healthcare Provider, the data or information may be disclosed upon request for use for statistical purposes or research;

3. Pursuant to statute or court order for the production or discovery of evidence; or

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

This section may not be construed to prevent disclosure necessary for Blue Cross Blue Shield of Wyoming to conduct healthcare 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 healthcare records data, to conduct disease management programs with Healthcare Providers, or to reconcile or verify claims. This section does not apply to PHI disclosed by Blue Cross Blue Shield of Wyoming to the Wyoming Department of Insurance for access to records of Blue Cross Blue Shield of Wyoming for purposes of enforcement or other activities related to compliance with State or Federal Laws.

C. ELECTRONIC COMMUNICATIONS

If you provide us with your email or phone number, BCBSWY may communicate with you through (a) electronic delivery of communications about existing benefits, programs, products, services, or tools and/or general health information via email, websites, and mobile applications (collectively, "**Informational Electronic Communications**") and (b)

informational calls and text messaging ("**Informational Calls and Texts**"), regarding the programs, products, or services that we make available to you. At any time, you may opt out of informational electronic communications. View BCBSWY's Terms and Conditions and our Privacy Statements for more information regarding informational electronic communications.

D. EXECUTION OF PAPERS

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

E. INCENTIVES

Incentives may be provided to encourage you to take part in various programs. It is your decision whether or not to take part in a program. You will be notified of the opportunity to participate in programs that are available to you based on eligibility. In some instances, these programs may be offered in combination with another entity or program. Incentives will be provided in accordance with State and Federal Law and may include, but are not limited to, gift cards for completing certain activities throughout the plan year.

F. LIMITATION OF ACTIONS

No action at law or equity may be brought to recover benefits against Blue Cross Blue Shield of Wyoming prior to the expiration of sixty (60) days after a written Claim for Benefits is furnished. No such action shall be brought later than three (3) years after the time the written Claim for Benefits is required by Blue Cross Blue Shield of Wyoming to be furnished.

G. PHYSICAL EXAMINATION AND AUTOPSY

Blue Cross Blue Shield of Wyoming, at its own expense, has the right to examine the person of the Subscriber, or any Dependent, when and as often as it may reasonably require during the pendency or review of a Claim for Benefits under this Agreement or, upon death, require an autopsy where it is not otherwise prohibited by law.

H. RESERVE FUNDS

No Member is entitled to share in any reserve or other funds that may be accumulated or established by Blue Cross Blue Shield of Wyoming, unless a right to share in such funds is granted by Blue Cross Blue Shield of Wyoming's Board of Directors.

I. SENDING NOTICES

All notices to the Member are considered to be sent to and received by the Member when deposited in the United States Mail with postage prepaid and addressed to the Subscriber at the last known address appearing on Blue Cross Blue Shield of Wyoming's membership records, or where email is used, upon the sending of the email.

J. SUBSCRIBER'S LEGAL OBLIGATIONS

The Subscriber and Subscriber's Dependents are liable for any actions which may prejudice Blue Cross Blue Shield of Wyoming's rights under this Agreement. If Blue Cross Blue Shield of Wyoming must take legal action to uphold its rights, then it can require the Subscriber and Subscriber's Dependents to pay its legal expenses, including attorney's fees and court costs.

K. TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of the three (3) year period, unless otherwise provided for under Wyoming Law.

Section 15: Definitions

This section defines many of the terms and words that are found throughout this Benefit Booklet. The terms and words defined here are capitalized wherever they are used in the Benefit Booklet.

A. ACCIDENT

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.

B. ADVANCE PREMIUM TAX CREDIT (APTC)

Some Subscribers will be eligible for financial assistance to help them off-set the cost of their Premium for this Plan. Eligible Subscribers may elect to receive this assistance in the form of an Advance Premium Tax Credit (APTC). APTCs are tax credits advanced to the Subscriber, meaning that instead of the Subscriber having to wait until after the end of the tax year to receive the tax credit, the Subscriber will receive the APTC in advance in the form of monthly payments to coincide with the time the Subscriber's monthly Premiums are due.

The Marketplace will determine a Subscriber's eligibility for an APTC at the time of enrollment on the Marketplace. The Marketplace will collect all the necessary information from the Subscriber and determine the amount of any APTC available to the Subscriber in accordance with Section 36B of the Internal Revenue Code.

The amount of the APTC will vary from Subscriber to Subscriber depending on the individual Subscriber's financial situation and other factors. In some instances, the Subscriber's full Premium will be covered by the APTC. In others, the Subscriber may be required to pay for a portion of the Premium.

Where the Subscriber qualifies for an APTC, the APTC will be paid directly to Blue Cross Blue Shield of Wyoming each month to cover part or all of the Subscriber's monthly premium. The Subscriber will be responsible for timely payment of any portion of the Premium on Subscriber's monthly billing statement that is not covered by the APTC.

C. AGREEMENT

This Benefit Booklet, including the enrollment submitted to enroll in the health insurance coverage offered in this Benefit Booklet, Member's Blue Cross Blue Shield of Wyoming BlueSelect PPO Identification Card, Member's monthly Premium billing statements and any amendments or endorsements that are or may become attached to this Benefit Booklet, constitute the entire Agreement between Subscriber and Blue Cross Blue Shield of Wyoming, and supersedes and replaces all previous Agreements between Subscriber and Blue Cross Blue Shield of Wyoming. This Agreement may also be referred to as the "Plan." This Agreement describes the Benefits available to Subscriber and Subscriber's

Dependents, if any, as Members in this Blue Cross Blue Shield of Wyoming BlueSelect PPO Plan. The Benefits offered in this Plan are limited to the express written terms of this Agreement.

D. ANESTHESIA

Services performed by a Healthcare Provider specially trained in Anesthesia. Anesthesia includes general anesthesia that produces unconsciousness in varying degrees with muscular relaxation and reduced or absent pain sensation and regional or local anesthesia that produces similar muscular and pain effects in a limited area with no loss of consciousness.

E. AUTHORIZATION REVIEW

Also referred to as preauthorization, an Authorization Review is the process of a Member formally requesting that Blue Cross Blue Shield of Wyoming approve specified Healthcare Services for the Member. Authorization Review does not guarantee payment of Benefits. An Authorization Review will be processed within 5 days, 72 hours for urgent care, or otherwise required by Federal and State Law. An Authorization Review will not be required for combinations of specific procedure codes performed by specific providers, as outlined in Wyoming Statute § 26-55-112, which shall apply to this Agreement in all instances.

F. BENEFIT

The reimbursement to a Member by Blue Cross Blue Shield of Wyoming for Covered Services received under this Plan.

G. BENEFIT BOOKLET

This Agreement.

H. BILLING SERVICE DATE

The date used by Blue Cross Blue Shield of Wyoming in assigning Effective Dates and issuing billings. This date will always be the 1st of the month.

I. BLUECARD® PROGRAM

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

J. BLUESELECT PHARMACY

A Pharmacy that has entered into an agreement with Blue Cross Blue Shield of Wyoming's Pharmacy Benefits Manager to provide Covered Services at an agreed upon reimbursement methodology for Members in the BlueSelect PPO network. Covered Services are not available from a Pharmacy that is not a BlueSelect Pharmacy.

K. BLUESELECT PPO

The BlueSelect Preferred Provider Organization (PPO) is a comprehensive network of BlueSelect Pharmacies and BlueSelect Providers who have agreed to provide Covered Services to Members with BlueSelect PPO Plans and Members of health plans issued or

administered by other Blue Cross and/or Blue Shield licensees that have PPO network benefit booklets comparable to the BlueSelect PPO Benefit Booklets and who are receiving Covered Services in Blue Cross Blue Shield of Wyoming's service area, in compliance with the BlueCard® Program.

L. BLUESELECT PROVIDER

A Healthcare Provider that has entered into an agreement with Blue Cross Blue Shield of Wyoming to provide Covered Services at an agreed upon reimbursement methodology for Members in the BlueSelect PPO network.

M. CHEMOTHERAPY

Drug therapy administered as treatment for Conditions of certain body systems.

N. CLAIM FOR BENEFITS

A request by a Member (or a request by a BlueSelect Provider on behalf of the Member) for reimbursement for Covered Services in accordance with the terms of this Agreement.

O. CLASS OF COVERAGE

The type of coverage a Subscriber has enrolled for under this Agreement, identifying who is eligible to receive Benefits for Covered Services under this Plan. Classes of Coverage are as follows:

1. **Single Coverage:** Coverage under this Plan for the Subscriber only.

2. **Family Coverage:** Coverage under this Plan for the Subscriber, the Subscriber's Dependent Spouse, and one or more eligible Dependent Children.

P. CLINICAL PROGRAMS

Program(s) as offered by BCBSWY to Members with specific health Conditions to improve health outcomes. Program(s) may waive cost share services related to the program.

Q. COINSURANCE AMOUNT

A percentage of the cost of Covered Services, as described below, that is a Member's responsibility after the Deductible has been met.

Blue Cross Blue Shield of Wyoming calculates a Member's Coinsurance Amount, when Member obtains the Covered Services from Healthcare Providers in Blue Cross Blue Shield of Wyoming's service area, off of the Maximum Allowable Amount.

However, if the Member obtains Covered Services outside of the Blue Cross Blue Shield of Wyoming service area, the local Blue Cross Blue Shield Plan's (Host Plan's) contract with the Healthcare Provider may require that the Coinsurance Amount be based on the full amount of the Healthcare Provider's billed charges rather than the Maximum Allowable Amount. This may result in a significantly higher Coinsurance Amount to the Member for these Covered Services. It is not possible for Blue Cross Blue Shield of Wyoming to detail the specific information for each out-of-area Healthcare Provider in this Benefit Booklet because of the many different arrangements the various Host Plans have with their local Healthcare Providers. However, if a Member contacts Blue Cross Blue Shield of Wyoming prior to

incurring out-of-area Healthcare Services, a Blue Cross Blue Shield of Wyoming member services representative may be able to provide the Member with more specific information on the applicable Coinsurance Amount.

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

R. CONDITION

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

S. CONSULTATION

The service of one Physician, at the request of another Physician, to provide advice in the diagnosis or treatment of a Condition which requires the consulted Physician's special skill or knowledge.

T. COPAYMENT AMOUNT

A specified dollar amount payable by the Member to the Healthcare Provider for certain Covered Services. Healthcare Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not accumulate toward the Member's satisfaction of the Deductible Amount or Coinsurance Amount, but will accumulate toward the Member's satisfaction of the Out-of- Pocket Maximum where applicable.

U. COST SHARING AMOUNTS

Cost Sharing Amounts are those dollar amounts that a Member is responsible for paying when Covered Services are received from a Healthcare Provider. Cost Sharing Amounts include Copayment Amounts, Deductible Amounts and Coinsurance Amounts. Healthcare Providers may either bill a Member directly for these amounts or request payment of these amounts from the Member at the time the Covered Services are provided. Cost Sharing Amounts do not include the difference between the Maximum Allowable Amount and a Non-Network Provider's billed charges.

V. COST SHARING ASSISTANCE

Some Subscribers who qualified for the Advance Premium Tax Credit (APTC) and enroll in this BlueSelect PPO Plan will also be eligible for financial assistance to help them reduce their Cost Sharing Amounts incurred when Covered Services are provided by BlueSelect Providers.

The Health Insurance Marketplace (Marketplace) will determine the Subscriber's eligibility for Cost Sharing Assistance at the time of enrollment on the Marketplace. The Marketplace will collect all the necessary information from the Subscriber and determine the amount of any Cost Sharing Assistance the Subscriber is entitled to in accordance with applicable Federal Law.

The amount of the Cost Sharing Assistance will vary from Subscriber to Subscriber depending on the individual Subscriber's financial situation and other factors.

Where the Subscriber qualifies for Cost Sharing Assistance, the Cost Sharing Assistance will

be paid directly to Blue Cross Blue Shield of Wyoming each month to reduce the Cost Sharing Amount the Subscriber would otherwise be responsible for.

The Subscriber will be responsible for timely payment of any portion of Subscriber's Cost Sharing Amounts not covered by the Cost Sharing Assistance.

NOTE: Cost Sharing Assistance does not apply, and will not be used to reduce a Member's Cost Sharing Amounts incurred when Covered Services are provided by an Out-of-Network Healthcare Provider.

W. COVERED SERVICE

Healthcare Services, including Prescription Drugs, for which reimbursement will be made by Blue Cross Blue Shield of Wyoming under this Plan.

X. DEDUCTIBLE AMOUNT

A specified dollar amount that a Member must pay to the Healthcare Provider for Covered Services within a calendar year before Benefits for Covered Services are provided under this Agreement.

How the Deductible Amount can be met during the calendar year depends upon the applicable Class of Coverage:

1. **Single Coverage:** If only the Subscriber is covered under this Plan, the Subscriber alone must meet the entire Single Deductible Amount.

2. **Family Coverage:** The Deductible Amount for each calendar year will be satisfied when any of the following scenarios occurs:

a. When one (1) Member meets the Single Deductible Amount, that Member will be eligible for Benefits. The remaining Members will be eligible for Benefits when they have collectively satisfied the remaining balance of the Family Coverage Deductible Amount.

b. When no one (1) Member meets the Single Deductible Amount, but all the Members collectively meet the Family Coverage Deductible Amount, then all Members will be eligible for Benefits.

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

NOTE: The Deductible Amount does not apply to PREVENTIVE CARE.

Y. DEPENDENT

A Subscriber's Dependents are the following:

1. Dependent Spouse: Subscriber's legal spouse who is currently a permanent resident in the home of the Subscriber. A Domestic Partner will be treated as a Dependent Spouse.

2. Domestic Partner: See definition for Dependent Spouse.

3. Dependent Children: The children, stepchildren, adopted children and legal wards of the Subscriber. Dependent Children are eligible to be Dependents under this Agreement until the end of the calendar year in which they turn age twenty-six (26).

However, eligibility will be continued past the end of the calendar year in which a Dependent Child turns age twenty-six (26) if the Dependent Child is unmarried and is BOTH incapable of self-sustaining employment and chiefly dependent upon the Subscriber or the Subscriber's Dependent Spouse for their support and maintenance by reason of intellectual disability or physical handicap. Continuous coverage will be established at the same level of benefits. Premiums may be adjusted accordingly. 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 year in which the Dependent Child turned age twenty-six (26). Incapacity and dependency upon the Subscriber or Subscriber's covered Spouse must both continue in order for the coverage to continue and Blue Cross Blue Shield of Wyoming may, from time to time, require continued proof of such incapacity and dependency. If the Conditions of BOTH incapacity and dependency by reason of intellectual disability or physical handicap are not continuously met, coverage will continue as required by Federal or State Law as applicable.

Z. DESIGNATED PROVIDER

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

AA. DIAGNOSTIC SERVICE

A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite Condition. A Diagnostic Service must be ordered by a Healthcare Provider. Diagnostic Services include, but are not limited to, X-rays and other imaging services and laboratory and pathology Services.

BB. DURABLE MEDICAL EQUIPMENT

Equipment that can withstand repeated use, is made to serve a medical purpose and is useless to a person who is not suffering from a Condition, and is appropriate for use in the home.

CC. EFFECTIVE DATE

The calendar date coverage under this Agreement begins.

DD. 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.

EE. 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.

FF. HEALTH INSURANCE MARKETPLACE (MARKETPLACE)

The Health Insurance Marketplace (Marketplace) is a structured marketplace for the sale and purchase of health insurance. The Marketplace is not the insurer of the health insurance products sold on the Marketplace. Rather, the Marketplace works with health insurers such as Blue Cross Blue Shield of Wyoming to make Blue Cross Blue Shield of Wyoming's products available for purchase through the Marketplace. Individuals (and families) may purchase health insurance products on the Marketplace. The Marketplace performs the administrative functions to facilitate the sale and purchase of these health insurance products on the Marketplace.

GG. HEALTHCARE PROVIDER

Healthcare Providers, for purposes of this Agreement can mean professional physicians or other types of individuals who provide Healthcare Services (Professional Healthcare Providers), or it can mean the Hospitals, institutions, facilities or other entities (Institutional Healthcare Providers) where Healthcare Services are performed. Healthcare Providers must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed. Where there is no appropriate state agency, the Healthcare Provider must be registered or certified by the appropriate professional body. Benefits will only be provided under this Agreement where the Covered Services were performed by a Healthcare Provider acting within the scope of the Healthcare Provider's license as provided by law. Healthcare Providers include, but are not limited to:

1. **Advanced Practice Registered Nurse:** A Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner or Psychiatric Nurse.

2. **Ambulance:** A specially designed or equipped vehicle used only for transporting the critically ill or injured to a healthcare facility. The ambulance service must meet state and local requirements for providing transportation for the sick and injured and must be operated by qualified personnel who are trained in the application of basic life support.

3. **Ambulatory Surgical Facility:** A facility with an organized staff of Professional Healthcare Providers that:

   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 direct supervision of a Professional Healthcare Provider;

   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 Professional Healthcare Provider.

4. **Audiologist:** A trained professional who measures hearing loss and can fit hearing aids.

5. **Certified Diabetes Educator (C.D.E.):** A healthcare professional who is specialized and certified to teach people with diabetes how to manage their Condition.

6. **Chiropractor:** A Board Qualified and licensed Doctor of Chiropractic who treats disease by manipulation of the joints of the body.

7. **Clinical Psychologist:** A licensed clinical psychologist, or where there is no licensure law, a psychologist must be certified by the appropriate professional body.

8. **Dentist:** A Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

9. **Dialysis Facility (freestanding):** A facility that is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

10. **Durable Medical Equipment Supplier:** Supplier of Durable Medical Equipment.

11. **Home Health Agency:** A private or public organization certified by the U.S. Department of Health and Human Services, providing, under the direction of a Professional Healthcare Provider, skilled nursing services and other therapeutic

services to patients in their homes.

12. **Home Infusion Therapy Provider:** A provider who administers infusion drug therapies in the home.

13. **Hospice:** A coordinated program of Home Healthcare 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.

14. **Hospital:** A duly licensed institution that is engaged in providing short-term acute Inpatient and Outpatient Diagnostic Services and Therapeutic Services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Professional Healthcare Providers. A Hospital has organized departments of medicine and Surgery and provides twenty-four (24) hour nursing care by or under the supervision of a registered nurse which is physically present and on duty. Hospitals are not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Mental Health Disorders, place for the treatment of alcoholism or drug use, place for the provision of hospice care, place for the provision of rehabilitative and habilitative care, or a place for the treatment of pulmonary tuberculosis.

15. **Independent Clinical Laboratory:** A medical laboratory providing Diagnostic Services that is approved for reimbursement by Blue Cross Blue Shield of Wyoming and is not affiliated or associated with a Hospital or Professional Healthcare Provider otherwise providing patient services.

16. **Licensed Addiction Counselor:** A licensed counselor who assists patients with Substance Use Disorders.

17. **Licensed Clinical Psychologist:** A licensed psychologist with a doctorate degree in psychology who is eligible for listing in the National Register of Health Service Providers in Psychology.

18. **Licensed Independent Clinical Social Worker:** An individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the appropriate state agency for third party reimbursement.
19. **Licensed Professional Clinical Counselor:** A licensed counselor who assists patients in a clinic for Mental Health or Substance Use Disorders.

20. **Licensed Registered Dietician:** A licensed food and nutrition expert.

21. **Long Term Acute Care Facility:** A facility that provides long-term acute Hospital care for medically complex Conditions or specialized treatment programs.

22. **Occupational Therapist:** A licensed Occupational Therapist who treats patients with injuries, illnesses, or disabilities through the therapeutic use of everyday activities.

23. **Optometrist:** A Doctor of Optometry (O.D.) who measures the eye's refractive powers, performs medical eye examinations and fits glasses to correct ocular defects.

24. **Pharmacist:** A person who is professionally qualified to prepare and dispense Prescription Drugs.

25. **Pharmacy:** A licensed establishment where Prescription Drugs are dispensed by a licensed Pharmacist.

26. **Physical Therapist:** A licensed Physical Therapist, or where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

27. **Physician:** A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

28. **Physician Assistant:** An individual who is qualified by academic and clinical training to provide primary care patient services and must be certified by the state to practice.

29. **Podiatrist:** A Doctor of Podiatry (D.P.), a Doctor of Surgical Chiropody (D.S.C.), a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Podiatry (D.S.P.).

30. **Psychiatric Care Facility:** An institution or a distinct part of an institution, accredited by a nationally recognized organization and licensed by the state, providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders, Substance Use Disorders or other behavioral problems under the direct supervision of a Professional Healthcare Provider. Continuous clinical care is provided 24 hours a day, seven days a week. This may include Psychiatric Residential Treatment Facilities and Residential Treatment Centers.

31. **Rehabilitation Facility:** An institution or a distinct part of an institution providing rehabilitative services.

32. **Respiratory Therapist:** A licensed provider who assists patients with respiratory disease such as asthma or emphysema.

33. **Skilled Nursing Facility:** An institution or a distinct part of an institution providing Skilled Nursing Services and related services to persons on an Inpatient basis under the direct supervision of a Professional Healthcare Provider. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or part-time care services, or care or treatment of Mental Health Disorders, alcoholism, drug use or pulmonary tuberculosis.

34. **Sleep Lab:** A medical lab in which sleep specialists study patient's sleep disorders and sleep disturbances.

35. **Speech Language Pathologist:** A therapist who treats speech defects and disorders.

36. **Substance Abuse Facility or Chemical Dependency Unit:** An institution or a distinct part of an institution with nursing and medical Professional Healthcare Providers providing 24 hours, seven days a week, on-site clinical supervision and treatment at an appropriately licensed and credentialed facility.

37. **Transitional Care Unit:** A sub-acute unit of a Hospital that provides skilled services necessary for the transition between Hospital and home or to a lower level of care.

HH. HEALTHCARE SERVICES

Medical Care provided by a Healthcare Provider for the treatment of a Condition.

II. HOME HEALTHCARE

Medical Care provided in the Member's home in lieu of Inpatient hospitalization.

JJ. IDENTIFICATION CARD

A card issued in the Subscriber's name identifying the Plan selected by the Subscriber under this Agreement.

KK. INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

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

LL. IN-NETWORK

A term meant to include all Healthcare Providers who are in the BlueSelect PPO network.

MM. INPATIENT

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

NN. MAXIMUM ALLOWABLE AMOUNT

The Maximum Allowable Amount Blue Cross Blue Shield of Wyoming will reimburse for Covered Services under this Agreement. The Maximum Allowable Amount is the lesser of (1) the Healthcare Provider's billed charges for the Covered Service, or (2) the maximum reimbursement rate Blue Cross Blue Shield of Wyoming has negotiated with BlueSelect Providers for the Covered Service as determined by the Blue Cross Blue Shield of Wyoming payment system in effect at the time the Covered Services are provided.

OO. MEDICAL CARE

Healthcare Services rendered by a Healthcare Provider for the treatment of a Condition.

PP. MEDICAL EMERGENCY

A medical Condition manifesting itself by acute symptoms of sufficient severity (including

severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. 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

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part, or

4. With respect to a pregnant woman who is having contractions if there is inadequate time to affect a safe transfer to another hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.

QQ. MEDICAL NECESSITY

1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

a. Is medically appropriate for the symptoms, diagnosis or treatment of the Condition, illness, disease or injury;

b. Provides for the diagnosis, direct care and treatment of the Member's Condition, illness, disease or injury;

c. Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care, including Medical Policy;

d. Is not primarily for the convenience of the Member, Physician or other Healthcare Provider.

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.

RR. MEDICAL POLICY

Policies or clinical criteria that Blue Cross Blue Shield of Wyoming relies on to determine whether a medical service, procedure or supply meets the definition of Medical Necessity.

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

SS. MEDICAL SUPPLIES

Expendable items (except Prescription Drugs) which are required for the treatment of a Condition.

TT. MEMBERS

The Subscriber and the Subscriber's covered Dependents.

UU. MENTAL HEALTH OR SUBSTANCE USE DISORDER

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

VV. OCCUPATIONAL THERAPY

Educational, vocational, and rehabilitative techniques used in order to improve a Member's functional ability to achieve independence in daily living.

WW. ORTHOPEDIC APPLIANCE

A rigid or semi-rigid support used to eliminate, restrict or support motions in a part of the body that is diseased, injured, weak or deformed.

XX. OUT-OF-NETWORK

A term meant to include all Healthcare Providers who are not included in the BlueSelect PPO network.

YY. OUT-OF-POCKET MAXIMUM AMOUNT

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

How the Out-of-Pocket Maximum Amount can be met during the calendar year depends upon the applicable Class of Coverage:

1. **Single Coverage:** If only the Subscriber is covered under this Plan, the Subscriber alone must meet the entire Single Out-of-Pocket Maximum Amount.

2. **Family Coverage:** The Out-of-Pocket Maximum Amount for each calendar year will be satisfied when any of the following scenarios occurs:

a. When one (1) Member meets the Single Out-of-Pocket Maximum Amount, that Member's Covered Services will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for the remainder of that calendar year. The remaining Members Covered Services will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for Covered Services for the remainder of that calendar year when they have collectively satisfied that remaining balance of the Family Coverage Out-of-Pocket Maximum Amount.

b. When no one (1) Member meets the Single Out-of-Pocket Maximum Amount, but all the Members collectively meet the Family Coverage Out-of-Pocket Maximum Amount, then Covered Services for all Members will be reimbursed at one-hundred percent (100%) of the Maximum Allowable Amount for the remainder of that calendar year.

There are separate Cost Sharing Amounts and Out-of-Pocket Maximum Amounts for In-Network and Out-of-Network Covered Services. Satisfaction toward one type of Out-of-Pocket Maximum Amounts (i.e. In-Network Out-of-Pocket Maximum Amounts) will not work to satisfy the other type of Out-of-Pocket Maximum Amount (i.e. Out-of-Network Out-of-Pocket Maximum Amounts).

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

ZZ. OUTPATIENT

A Member who receives Healthcare Services while not an Inpatient.

AAA. PHYSICAL THERAPY

The use of physical agents for the treatment of disability resulting from a Condition. Physical Therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries.

BBB. PLAN YEAR

January 1 to December 31 of each calendar year.

CCC. PREMIUM

The specified amount of payment periodically required from the Subscriber in order to receive coverage under this Plan for a defined period of time.

DDD. PRESCRIPTION DRUGS

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

EEE. PRIMARY CARE

Medical Services provided by a Physician, Physician's Assistant or Nurse Practitioner

specializing in a general medical practice, family practice, obstetrics, gynecology, or pediatrics.

FFF. PRIVATE DUTY NURSING SERVICES

Services which require the training, judgment and technical skills of an actively practicing Registered Nurse (R.N.). Private Duty Nursing Services must be prescribed by the attending Healthcare Provider for the continuous treatment of Member's Condition.

GGG. PROSTHESIS

Any device that replaces all or part of a missing body organ or body member.

HHH. PROTECTED HEALTH INFORMATION (PHI)

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

1. Is created by or received from a Healthcare Provider, healthcare employer, or healthcare clearinghouse;

2. Relates to a Member's past, present or future physical or mental health or Condition;

3. Relates to the provision of Healthcare Services to a Member;

4. Relates to the past, present, or future payment for Healthcare Services to or on behalf of a Member; or

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

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

III. QUALIFIED PAYMENT AMOUNT

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

JJJ. RADIATION THERAPY

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.

KKK. RESPIRATORY THERAPY

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.

LLL. SPEECH THERAPY (also called speech pathology)
Services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

MMM. SUBSCRIBER
The person who applies for coverage under this Agreement and whose name appears on the BlueSelect PPO Identification Card.

NNN. SURGERY
Surgery includes:

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.

OOO. SURGICAL ASSISTANT
Either a licensed Physician who actively assists the operating surgeon in the performance of a covered Surgery 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 Surgery is being performed.

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

MDLIVE is a Telemedicine service where Blue Cross Blue Shield of Wyoming Members can visit with board-certified doctors and mental health professionals by video or phone. MDLIVE is a low-cost, convenient option for non-emergency medical Conditions, and mental health services. MDLIVE doctors are available to diagnose and treat urgent care needs and can have a prescription sent directly to your pharmacy, if appropriate. Appointments must be scheduled for mental health visits.

Appendix: Important Notices

NOTICE OF
PROTECTION PROVIDED BY
WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming Law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming Law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association are:

- Life Insurance
    - $300,000 in death benefits
    - $100,000 in cash surrender or withdrawal value
- Health Insurance
    - $300,000 in health benefit plan benefits
    - $300,000 in disability insurance benefits
    - $300,000 in disability income insurance
    - $300,000 in long-term care insurance benefits
    - $100,000 in other types of health insurance benefits
- Annuities
    - $250,000 in present value of benefits including new withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000

NOTE: Certain Policies and contracts may not be covered or fully covered.

For example, coverage does not extend to any portion(s) of a policy or contract that the insurer or health maintenance organization does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming Law.

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policy holders, certificate holders and enrollees are *not* protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- the insurer or health maintenance organization was not authorized to do business in this state;

- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange, or by an entity similar to those listed here.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;

- any policy of reinsurance (unless an assumption certification was issued pursuant to the reinsurance policy or contract);

- interest rates yields that exceed an average rate or interest earned on an equity indexed policy;

- dividends;

- experience rating credits given in connection with the administration of a policy by a group contract holder;

- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;

- unallocated annuity contracts (which give rights to group contract holders, not individuals);

- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at www.wylifega.org or contact:

Wyoming Life and Health
Insurance Guaranty Association
6700 N Linder Rd, Suite 156, Box 139
Meridian, ID 83646

Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming Law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming Law, then Wyoming Law will control.