GENESIS ALKALI, LLC

Hourly Under 65 Retirees

Medical Benefit Booklet

Effective January 1, 2021

Claims Supervisor:

BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross and Blue Shield Association

GENESIS ALKALI, LLC
HOURLY UNDER 65 RETIREES

Effective January 1, 2021

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

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dii kwe'é atah nilínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídíłkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló̜ díí t'áá hazaadk'ehjį háká a'doowołgo bee haz'ą́ doo bą́ą́h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 800-442-2376.

NOTICE OF NON-DISCRIMINATION PRACTICE

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

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

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

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

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

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

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

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

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

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

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TABLE OF CONTENTS

APPROVAL 1

INTRODUCTION 2

GENERAL INFORMATION 3

SCHEDULE OF BENEFITS 4

DEFINITIONS 8
A. AGGREGATE DEDUCTIBLE 8
B. ALLOWABLE CHARGES 8
C. BARIATRIC SURGERY 8
D. BENEFIT PERIOD 8
E. BILLING SERVICE DATE 8
F. BLUECARD® PROGRAM 8
G. CLAIMS SUPERVISOR 8
H. COINSURANCE 9
I. COPAYMENT 9
J. COVERED SERVICE 9
K. DEDUCTIBLE 9
L. DEPENDENT 9
M. DIAGNOSTIC SERVICE 10
N. EXPERIMENTAL/INVESTIGATIONAL 10
O. FACILITY OTHER PROVIDER 11
P. FAMILY COVERAGE 11
Q. FORMULARY 12
R. GROUP 12
S. HOSPITAL 12
T. INPATIENT 12
U. MEDICAL CARE 13
V. MEDICAL EMERGENCY 13
W. MEDICAL NECESSITY 13
X. MEMBER 13
Y. MENTAL ILLNESS 14
Z. NETWORK 14
AA. OUT-OF-POCKET MAXIMUM 14
BB. OUTPATIENT 15
CC. PARTICIPATING 15

DD. PHARMACY 15
EE. PHYSICIAN 15
FF. PLAN ADMINISTRATOR 15
GG. PRESCRIPTION DRUGS 15
HH. PROFESSIONAL OTHER PROVIDER 15
II. PROTECTED HEALTH INFORMATION (PHI) 16
JJ. REHABILITATIVE ADMISSIONS 16
KK. RETIREE COVERAGE 16
LL. RETIREE PLUS ONE COVERAGE 16
MM. SUBSCRIBER or EMPLOYEE 16
NN. SURGERY 16
OO. THERAPY SERVICE 16

FUNDING LEVELS 17

ELIGIBILITY REGULATIONS 18
A. RETIREE ELIGIBILITY 18
B. DEPENDENT ELIGIBILITY 18

HOW TO ADD, CHANGE, OR END COVERAGE 19

HOW BENEFITS WILL BE PAID 20
A. HOSPITALS AND FACILITY OTHER PROVIDERS 21
B. PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS 21
C. DEDUCTIBLE REQUIREMENTS 22
D. PAYMENT ALLOWANCES UNDER THIS COVERAGE 22
E. INPATIENT COPAYMENTS 23
F. NETWORK OFFICE COPAYMENTS 23
G. CALCULATION OF OUT OF AREA PAYMENTS 24

BENEFITS 26
A. ACCIDENTS 27
B. ACUPUNCTURE 28
C. AMBULANCE SERVICES 29
D. ANESTHESIA SERVICES 30
E. BLOOD EXPENSES 31
F. CARDIAC REHABILITATION 32
G. CHIROPRACTIC CARE 33
H. CONSULTATIONS 35
I. DENTAL SERVICES (Medical Plan) 36
J. DIABETES SERVICES 39
K. HEMODIALYSIS AND PERITONEAL DIALYSIS 40
L. HOME HEALTH CARE 41
M. HOSPICE BENEFITS 42
N. HUMAN ORGAN TRANSPLANTS 43
O. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, & MAGNETIC RESONANCE SERVICES 45

P. MATERNITY AND NEWBORN CARE 46
Q. MEDICAL CARE FOR GENERAL CONDITIONS 49
R. MEDICAL EMERGENCIES 51
S. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE 52
T. PRESCRIPTION DRUGS AND MEDICINES 54
U. PREVENTIVE CARE 55
V. PRIVATE DUTY NURSING SERVICES 58
W. REHABILITATION FACILITY 59
X. ROOM EXPENSES AND ANCILLARY SERVICES 60
Y. SKILLED NURSING FACILITY 62
Z. SUPPLIES, EQUIPMENT AND APPLIANCES 63
AA. SURGERY 66
BB. SURGICAL ASSISTANTS 69
CC. THERAPIES ....
(CHEMOTHERAPY, RADIATION, RESPIRATORY, PHYSICAL, OCCUPATIONAL, SPEECH, BIOFEEDBACK) 70

GENERAL LIMITATIONS AND EXCLUSIONS 73
A. ALTERNATIVE MEDICINE 73
B. ARTIFICIAL CONCEPTION 73
C. AUTHORIZATION REVIEW 73
D. AUTOPSIES 73
E. COMPLICATIONS OF NON-BENEFIT SERVICES 73
F. CONVALESCENT CARE 73
G. COSMETIC SURGERY 74
H. CUSTODIAL CARE 74
I. DIAGNOSTIC ADMISSIONS 74
J. DOMICILIARY CARE 74
K. EAR WAX 74
L. EDUCATIONAL PROGRAMS 74
M. ENVIRONMENTAL MEDICINE 75
N. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES 75
O. EYE CARE 75
P. FOOT CARE SERVICES 75
Q. GENETIC AND CHROMOSOMAL TESTING/COUNSELING 75
R. GOVERNMENT INSTITUTIONS AND FACILITIES 75
S. HAIR LOSS 76
T. HOSPITALIZATIONS 76
U. HYPNOSIS 76
V. LEARNING DISABILITIES 76
W. LEGAL PAYMENT OBLIGATIONS 76
X. MANAGED CARE PROVISIONS 76
Y. MEDICAL SERVICES RECEIVED AS A RESULT OF CONTRACTUAL OBLIGATIONS OR A THIRD PARTY'S GUARANTEE TO PAY 76
Z. MEDICALLY NECESSARY SERVICES OR SUPPLIES 77
AA. OBESITY AND WEIGHT LOSS 77

BB. PAYMENT IN ERROR....77
CC. PERSONAL COMFORT OR CONVENIENCE....77
DD. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS....77
EE. PROCEDURES RELATED TO STUDIES....77
FF. PROPHYLAXIS/PROPHYLACTIC MEDICINE....78
GG. REHABILITATIVE ADMISSION....78
HH. REPORT PREPARATION....78
II. ROUTINE HEARING EXAMINATIONS....78
JJ. ROUTINE PHYSICALS....78
KK. SERVICES AFTER COVERAGE ENDS....78
LL. SERVICES NOT IDENTIFIED....78
MM. SERVICES PRIOR TO THE EFFECTIVE DATE....78
NN. SEX CHANGE OPERATIONS....79
OO. SUBLUXATION....79
PP. TAXES....79
QQ. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)....79
RR. THERAPIES....79
SS. TRAVEL EXPENSES....79
TT. UNRELATED SERVICES....79
UU. WAR....79
VV. WEIGHT LOSS PROGRAMS....79
WW. WORK RELATED INJURIES....79

GENERAL PROVISIONS....80
A. ASSIGNMENT OF BENEFITS....80
B. CHANGE TO THE PLAN....80
C. CLAIM FORMS....80
D. CLERICAL ERROR....80
E. COORDINATION OF BENEFITS....80
F. DISCLAIMER OF LIABILITY....81
G. DISCLOSURE OF MEMBER'S MEDICAL INFORMATION....82
H. EXECUTION OF PAPERS....82
I. GENERAL INFORMATION ABOUT FILING CLAIMS....82
J. LIMITATION OF ACTIONS....82
K. MEMBER'S LEGAL OBLIGATIONS....83
L. PLAN IS NOT AN EMPLOYMENT CONTRACT....83
M. PHYSICAL EXAMINATION AND AUTOPSY....83
N. PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)....83
O. PRUDENT MEDICAL CARE....84
P. SELECTION OF DOCTOR....85
Q. SENDING NOTICES....85
R. STATEMENTS AND REPRESENTATIONS....85
S. SUBROGATION AND REFUND....85
T. TIME OF CLAIM PAYMENT....86
U. WRITTEN NOTICE OF CLAIM....86

RESPONSIBILITIES FOR PLAN ADMINISTRATION 88
A. PLAN ADMINISTRATOR 88
B. DUTIES OF THE PLAN ADMINISTRATOR 88
C. PLAN ADMINISTRATOR COMPENSATION 89
D. FIDUCIARY 89
E. FIDUCIARY DUTIES 89
F. THE NAMED FIDUCIARY 89

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 90
A. PLAN BOOKLETS AND FINANCIAL REPORTS 90
B. FIDUCIARIES AND THEIR OBLIGATIONS 90
C. LEGAL RIGHTS TO BENEFITS 90
D. CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW 91
E. CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS 92
F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES 92
H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS 93
I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW 93
J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES 93
K. INTERNAL APPEALS OF CLAIMS FOR ALL OTHER SERVICES OR BENEFITS 94
L. EXTERNAL CLAIMS REVIEW PROCEDURE 94
M. DISCRETION OF PLAN ADMINISTRATOR 95
N. ANSWERS TO QUESTIONS 95

APPROVAL

BENEFIT BOOKLET

ACKNOWLEDGMENT OF RECEIPT AND APPROVAL

The Benefit Booklet for Genesis Alkali, LLC

is approved.

Effective date is January 1, 2021.

INTRODUCTION

This document describes the Medical Plan (The Plan) maintained for the exclusive benefit of the Hourly Under 65 Retirees of Genesis Alkali, LLC. The Employer intends to maintain this Plan indefinitely, but reserves the right to terminate or change the Plan at any time and for any reason. Changes in the Plan may be made in any or all parts of the Plan including, but not limited to, services covered, Deductibles, Copayments, maximums, exclusions or limitations, definitions, eligibility, etc.

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

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

GENERAL INFORMATION

NAME OF PLAN: Genesis Alkali, LLC Medical Benefit Plan

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

PLAN NUMBER: ******

TAX ID NUMBER: ******

PLAN YEAR: January 1 through December 31

PLAN SPONSOR: Genesis Alkali, LLC

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

PLAN ADMINISTRATOR: Genesis Alkali, LLC

AGENT FOR SERVICE OF LEGAL PROCESS: Genesis Alkali, LLC

NAMED FIDUCIARY: Genesis Alkali, LLC

CLAIMS SUPERVISOR: Blue Cross Blue Shield of Wyoming (BCBSWY)
4000 House Avenue
PO Box 2266
Cheyenne, WY 82003
307.634.1393

SCHEDULE OF BENEFITS

EMPLOYER NAME: Genesis Alkali, LLC Hourly Under 65 Retirees
GROUP NUMBER: 10357870
EFFECTIVE DATE: January 1, 2021

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

A Member's coverage may not include all the benefits shown in this Benefit Booklet and may instead be limited to medical benefits only.

Hospital care benefits are based on Allowable Charges.

Physician benefits are based on Allowable Charges.

Benefit levels for covered services depend on whether services are obtained from Network Providers or from Non-network Providers. Because some benefits may differ from the following outline, please consult sections within this Agreement on HOW BENEFITS WILL BE PAID and BENEFITS for specific details:

NETWORK BENEFITS:

Copayments:

$25 for each non-surgical Network office visit ($35 for specialists), after which benefits are payable at 100% of Allowable Charges without regard to Deductible and Out-of-Pocket expenses (this includes laboratory and diagnostic services performed as part of a routine office visit). This Copayment will be applied toward the Member's Network Out-of-Pocket Maximum. (All other Network services are subject to Deductible and Out-of-Pocket expenses as described below.)

Deductibles (per calendar year):

Single Coverage - $500
Family Coverage - $1,000

No one Member can apply more than the individual Deductible for that option toward meeting the family Deductible. Deductible expenses may be applied toward the Out-of-Pocket expenses described below.

Out-of-Pocket Expenses:

After the Deductible is satisfied, Members pay 10% of Allowable Charges for most Covered Services provided.

Members continue to pay their applicable Coinsurance and Copayments until they have paid:

Single Coverage - $1,500
Family Coverage - $3,000

Once the Network Out-of-Pocket maximum has been reached, Network benefits will be paid at 100% of Allowable Charges for the remainder of the calendar year.

NON-NETWORK BENEFITS:

Deductibles (per calendar year):

Single Coverage - $1,000
Family Coverage - $2,000

No one Member can apply more than the individual Deductible for that option toward meeting the family Deductible. Deductible expenses may be applied toward the Out-of-Pocket expenses described below.

Out-of-Pocket Expenses:

After the Deductible is satisfied, Members pay 40% of Allowable Charges for most Covered Services provided.

Members continue to pay their applicable Coinsurance and Copayments until they have paid:

Single Coverage - $3,000
Family Coverage - $6,000

Once the Non-network Out-of-Pocket maximum has been reached, Non-network benefits will be paid at 100% of Allowable Charges for the remainder of the calendar year.

INPATIENT COPAYMENT:

ALL inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission in addition to the required Network or Non-network Coinsurance. Any relevant Deductible charges are waived. The $220 Copayment will apply toward the Member's appropriate Out-of-Pocket Maximum.

Members will be responsible for charges for services not covered by this Plan. Payment for non-Covered Services will NOT count toward satisfaction of the Deductible, Copayments, or Coinsurance.

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

MEDICAL BENEFITS:

Ambulance Services
Anesthesia Services
Blood Expenses
Cardiac Rehabilitation
Chiropractic Care
Consultations
Dental Services
Hemodialysis and Peritoneal Dialysis
Hospice Benefits
Human Organ Transplant
Laboratory, Pathology, X-ray, and Radiology Services
Magnetic Resonance Services
Maternity & Newborn Care
Mental Health or Substance Use Disorder Care
Physician's Office Visits
Preventive Care*
Rehabilitation Facility
Room Expenses & Ancillary Services
Skilled Nursing Facilities
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)
Surgical Assistants
Therapy

* Members pay no Deductible, Copayments, or Coinsurance for Preventive Care when services are provided by a Network Physician. Please see PREVENTIVE CARE section for additional details.

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

YOUR COVERAGE ALSO INCLUDES THE FOLLOWING:

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

Non-Emergency Weekend Admission Limitation. (See HOW BENEFITS WILL BE PAID section for details.)

DEFINITIONS

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

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

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

C. *BARIATRIC SURGERY*
The field of medicine that focuses on the treatment and control of obesity and diseases associated with obesity, including, but not limited to, gastric bypass surgery and gastric banding procedures.

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

E. *BILLING SERVICE DATE*
The date used in assigning effective dates and issuing billings. This date will always be the first of the month.

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

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

H. COINSURANCE

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

I. COPAYMENT

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

J. COVERED SERVICE

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

K. DEDUCTIBLE

A specified amount of Allowable Charges for Covered Services that the Member is responsible for within a specified period of time before benefits are provided. (NOTE: Dental Expense Rider benefits are subject to separate Deductible requirements.)

L. DEPENDENT

A Retiree's Dependents are the following:

1. Legal spouse.

2. Domestic partner as defined by the employer.

3. Married or unmarried children, including newborn children, step children, adopted children, and the children of dependent children, along with any other dependent child who lives in the Retiree's house in a parent-child relationship and is dependent on the Retiree for support. Legal wards of the Retiree or the Retiree's spouse or domestic partner who are currently permanent residents in the home of the Retiree are also included. The limiting age for covered children is the end of the month in which age 26 is attained.

4. Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Retiree for their support and maintenance by reason of mental retardation or physical handicap. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to Blue Cross Blue

Shield of Wyoming within thirty-one (31) days of the end of the year in which the limiting age found in the Plan is attained. Incapacity and dependency upon the Retiree must both continue in order for the coverage to continue and, from time to time, proof of continued incapacity and dependency may be required. If the conditions of BOTH incapacity and dependency by reason of mental retardation or physical handicap are not continuously met, coverage will continue only as required by Federal or State law as applicable. Handicapped/incapacitated children of new Retirees are eligible for coverage by submitting proof their child became disabled/incapacitated prior to the child's 26th birthday.

M. DIAGNOSTIC SERVICE

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

N. 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.

O. *FACILITY OTHER PROVIDER*

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

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

P. *FAMILY COVERAGE*

Coverage that includes the Retiree and two or more eligible Dependents.

Q. *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.

R. *GROUP*

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

S. *HOSPITAL*

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

1. Is a duly licensed institution.

2. For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians.

3. Has organized departments of medicine and surgery.

4. Provides 24-hour nursing services by or under the supervision of registered graduate nurses, which are both physically present and on duty.

5. Is not other than incidentally a:

    a. skilled nursing facility,
    b. nursing home,
    c. custodial care home,
    d. health resort,
    e. spa or sanitarium,
    f. place for rest,
    g. place for the aged,
    h. place for the treatment of Mental Illness,
    i. place for the treatment of alcoholism or drug abuse,
    j. place for the provision of hospice care,
    k. place for the provision of rehabilitation care,
    l. place for the treatment of pulmonary tuberculosis.

T. *INPATIENT*

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

U. *MEDICAL CARE*

Services rendered by a Physician, Hospital, or Other Provider for the treatment of an illness or injury. Medical care does not include surgery.

V. *MEDICAL EMERGENCY*

A Medical Emergency condition is:

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

W. *MEDICAL NECESSITY*

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

X. *MEMBER*

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

Y. MENTAL ILLNESS

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

Z. NETWORK

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

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

AA. OUT-OF-POCKET MAXIMUM

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

There are separate Out of Pocket Maximums for Network and Non-network Covered Services.

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

BB. OUTPATIENT

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

CC. PARTICIPATING

A dentist who has entered into an agreement with Blue Cross Blue Shield of Wyoming to bill Blue Cross Blue Shield of Wyoming directly for Covered Services. Blue Cross Blue Shield of Wyoming's payment will be made directly to the Participating dentist.

DD. PHARMACY

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

EE. PHYSICIAN

A licensed doctor of medicine or osteopathy licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

FF. PLAN ADMINISTRATOR

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

GG. PRESCRIPTION DRUGS

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

HH. PROFESSIONAL OTHER PROVIDER

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

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

II. PROTECTED HEALTH INFORMATION (PHI)

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

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

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

JJ. REHABILITATIVE ADMISSIONS

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

KK. RETIREE COVERAGE

Coverage for the Retiree only.

LL. RETIREE PLUS ONE COVERAGE

Coverage provided to the Retiree plus one eligible Dependent.

MM. SUBSCRIBER or EMPLOYEE

The person who applies for coverage.

NN. SURGERY

1. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examination and other invasive procedures,
2. The correction of fractures and dislocations,
3. Usual and related pre-operative and post-operative care,

OO. THERAPY SERVICE

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

FUNDING LEVELS

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

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

ELIGIBILITY REGULATIONS

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

A. RETIREE ELIGIBILITY

Genesis Alkali, LLC will be responsible for determining which Retirees are eligible for coverage.

B. DEPENDENT ELIGIBILITY

1. All Dependents of the covered Retiree as defined in this Plan are eligible.

HOW TO ADD, CHANGE, OR END COVERAGE

Genesis Alkali, LLC will provide information to Blue Cross Blue Shield of Wyoming regarding the effective date of coverage for all Genesis Alkali, LLC Retirees and their Dependents.

HOW BENEFITS WILL BE PAID

Genesis Alkali, LLC has delegated the authority to interpret Plan provisions, determine benefits payments, and make decisions on medical claims to Blue Cross Blue Shield of Wyoming. Genesis Alkali, LLC and the Employee Welfare Benefit Plan Committee as the plan administrator have discretion to interpret and determine the meaning of Plan provisions and to review all decisions made by Blue Cross Blue Shield of Wyoming arising under the Plan, including eligibility for benefits. The decisions made by Genesis Alkali, LLC and the Committee are final and binding.

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

A Member's coverage may not include all the benefits shown in this Benefit Booklet and may instead be limited to medical benefits only.

AUTHORIZATION REVIEW

Authorization Review (AR) is designed to make sure that hospitalization is necessary and appropriate. Using AR will provide Members and their Physicians with information on how to use the health care system effectively.

Whenever a Physician recommends hospitalization for a Member or any covered Dependent, AR must be notified. This can be done by calling 1-800-251-1814.

Notification must be made prior to an elective admission to a Hospital or another facility other provider because of illness, injury, mental or nervous disorder, alcoholism, or substance dependence – or within 48 hours if a Member is admitted because of an emergency. If a Member cannot notify the AR unit, the Member's Physician must call AR directly to provide the necessary information for authorization.

In the case of pregnancy, it is suggested that notification of the expected delivery be made during the sixth month of pregnancy. If a Member is admitted to the hospital for any reason other than delivery, AR must be notified again.

After AR and a Member's Physician discuss the case, AR will send the Member a written confirmation authorizing the Hospital admission and length of stay. If the Member's condition changes during the Hospital stay, the Member's Physician should confirm the longer stay with AR before the extra days begin.

If AR is notified and the Member follows AR's recommendations about the need for hospitalization and the length of the stay, the level of coverage will remain the same.

NOTE: If Medicare is the Member's primary coverage, AR notification is not required to receive full benefits under the Plan.

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

A. *HOSPITALS AND FACILITY OTHER PROVIDERS*

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

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

Non-Emergency Weekend Admission Limitation: If a Member is admitted to the Hospital on a Friday or Saturday, no benefits are payable for any Hospital-related expenses incurred during that first weekend (Friday-Sunday). However, full benefits are payable if the Member is admitted because of an emergency or if surgery is being performed that weekend.

B. *PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS*

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

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

C. DEDUCTIBLE REQUIREMENTS

The Deductible amounts for both Network and Non-network providers for each calendar year are shown on the Schedule of Benefits page. Except as otherwise indicated elsewhere in this Plan, all required Deductibles must be satisfied before any benefits under this Plan will be provided. (The Deductibles do not apply to PREVENTIVE CARE. Please see the description of these benefits for details.)

Deductible amounts which Members pay for services provided by Network and Non-network Providers will apply toward satisfying <u>both</u> the Network <u>and</u> Non-network annual Deductible requirements.

The Deductible may be satisfied in any of the following ways:

<u>Network Providers:</u>

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

<u>Non-network Providers:</u>

1. When one family member meets half of the family Non-network Deductible, that member will be eligible for Non-network benefits. If the other family members satisfy the remaining balance of the Non-network family Deductible, then they will also be eligible for Non-network benefits.
2. When two family members each meet half of the family Non-network Deductible, all family members will then be eligible for Non-network benefits.
3. When no one family member meets half of the family Non-network Deductible, but all the members collectively meet that Deductible, then all family members will be eligible for Non-network benefits.

NOTE: Members may not apply more than the individual Deductible expenses per individual member to satisfy the family Deductible.

D. PAYMENT ALLOWANCES UNDER THIS COVERAGE

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

<u>Network Providers:</u>

1. Members pay 10% Coinsurance and applicable Copayment amounts until they have paid the Out-of-Pocket Maximum for Network providers shown on the Schedule of Benefits, unless otherwise specified in this Plan.
2. When the Out-of-Pocket Maximum for Network providers has been met, Covered Services will be reimbursed at one hundred percent (100%) of the Allowable Charge as indicated in the Schedule of Benefits.

<u>Non-network Providers:</u>

1. Members pay 40% Coinsurance and applicable Copayment amounts until they have paid the Out-of-Pocket Maximum for Non-network providers shown on the Schedule of Benefits, unless otherwise specified in this Plan.
2. When the Out-of-Pocket Maximum for Non-network providers has been met, Covered Services will be reimbursed at one hundred percent (100%) of the Allowable Charge as indicated in the Schedule of Benefits.

NOTE: No part of the Member's Out-of-Pocket Expenses can be applied toward future Deductible requirements.

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

E. INPATIENT COPAYMENTS

ALL inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges are waived. The $220 Copayment will apply toward the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been satisfied, this Inpatient Copayment will no longer be assessed.

NOTE: Member's Copayments do not apply to PREVENTIVE CARE.

F. NETWORK OFFICE COPAYMENTS

Office visits to Network providers are covered at a $25 flat Copayment rate per office visit ($35 for specialists) without regard to Deductible or Coinsurance. The Physician or specialist must be a Network provider. This Copayment will be applied toward the Member's Out-of-Pocket Maximum.

If these same services are provided *outside* the Physician's or specialist's office, or if they are billed by another provider, then the charges will be subject to the Plan's Deductible and 10% Coinsurance.

Office visits to a Non-network provider continue to be subject to the Deductible and 40% Coinsurance.

Routine Physician visits are not covered, except for Wellness exams and newborn child care benefits (which may be covered under other provisions). Also excluded from this

Copayment are office visits for MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE and physical therapy.

NOTE: Member's Copayments do not apply to PREVENTIVE CARE.

G. *CALCULATION OF OUT OF AREA PAYMENTS*

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

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

1. BlueCard® Program

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

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

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

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

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

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

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

   a. Member's Liability Calculation

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

   b. Exceptions

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

BENEFITS

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

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

A Member's coverage may not include all the benefits shown in this Benefit Booklet and may instead be limited to medical benefits only.

A. ACCIDENTS

DEFINITION - An "accident" is an internal or external injury which is not caused by disease processes or sources within the body. (Examples: A blow or fall, animal bites, burns, allergic reactions to insect bites or medication, and poisoning.)

BENEFITS –

Inpatient: See MEDICAL EMERGENCIES and ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: For accident or emergencies, both Network and Non-network emergency room and Physician services will be covered subject to a $90 Copayment in addition to the applicable Deductible and Coinsurance. This Copayment will be applied toward the Member's appropriate Out-of-Pocket Maximum. NOTE: Non-network Covered Services must be performed within forty-eight (48) hours to be covered at the Network level.

If the Member is subsequently admitted as an Inpatient, benefits for both Network and Non-network Covered Services will be subject to 10% Coinsurance after a $220 Copayment. Any relevant Deductible charges will be waived, as will the initial $90 Copayment. (Non-network Covered Services must be performed within forty-eight (48) hours to be covered at the Network level.)

NOTE: Use of a Hospital emergency room for a non-emergency medical condition will reduce the level of benefits to 50% of the Allowable Charges after satisfaction of the Deductible.

Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance.

See GENERAL LIMITATIONS AND EXCLUSIONS

B. ACUPUNCTURE

DEFINITION – A method originating in China, used for relief of pain, in which fine needles inserted at certain points and along certain meridians are twirled rapidly.

BENEFITS -

Coverage will be provided for fourteen (14) treatments per Member per calendar year <u>only</u> when provided by a Physician.

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance.

See GENERAL LIMITATIONS AND EXCLUSIONS

C. AMBULANCE SERVICES

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

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

1. For Inpatient care to the nearest Hospital with appropriate facilities or, under similar restrictions, from one Hospital to another.

2. For Outpatient care to the nearest Hospital with appropriate facilities when such care is related to Medical Emergency or an accident.

3. From the nearest Hospital to the Member's home, nursing home, or skilled nursing facility in the same locale.

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network and Non-network Providers .

LIMITATIONS AND EXCLUSIONS -

1. Air Ambulance: In most cases, ground ambulance is the normally approved method of transportation. Benefits will be paid for air ambulance only when terrain, distance, or the Member's condition warrants air ambulance services.

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

3. Patient Safety Requirement: If transportation could have been provided by automobile or public transportation without danger to the Member's health or safety, an ambulance trip will not be covered. Benefits will not be paid for such ambulance services even if other means of transportation were not available.

NOTE: Benefits will not be paid for ambulance charges for the convenience of the family or Member. (Example: Transportation of an infant to be closer to the family's home.)

See GENERAL LIMITATIONS AND EXCLUSIONS

D. ANESTHESIA SERVICES

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

BENEFITS –

For anesthesia services provided by a Physician or C.R.N.A. when necessary for covered surgery, benefits are provided as follows:

Inpatient: Benefits will be subject to 10% Coinsurance without regard to the Deductible, for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are also subject to a $220 Copayment per admission.

Outpatient: After the Deductible, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

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

LIMITATIONS AND EXCLUSIONS -

1. Hypnosis: Not covered for anesthesia purposes.

2. Other: The "Limitations and Exclusions" that apply to SURGERY benefits also apply to anesthesia services.

See GENERAL LIMITATIONS AND EXCLUSIONS

E. BLOOD EXPENSES

DEFINITION - "Blood" expenses include the following:

1. Charges for processing, transportation, handling, and administration.

2. Cost of blood, blood plasma, and blood derivatives.

BENEFITS -

Inpatient: Benefits for blood transfusions including the cost of blood (except when donated or replaced), blood products, and blood processing, will be subject to 10% Coinsurance for Covered Services when provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are also subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Outpatient: After the Deductible has been met, benefits for blood transfusions including the cost of blood (except when donated or replaced), blood products, and blood processing, will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance.

LIMITATIONS AND EXCLUSIONS -

General: The "Limitations and Exclusions" that apply to SURGERY benefits also apply to blood expenses.

See GENERAL LIMITATIONS AND EXCLUSIONS

F. CARDIAC REHABILITATION

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

BENEFITS –

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance.

A Member is eligible for benefits only if the regimen is prescribed by a Physician under the following conditions:

1. Stable angina pectoris (chest pain),
2. High-risk coronary artery disease,
3. Following a heart attack,
4. Following heart bypass surgery (or angioplasty), or
5. Clinical symptoms of heart disease.

Coverage includes an initial exam performed by a cardiologist, X-ray and laboratory tests, and exercise visits. Also covered is dietary instruction for insulin management for diabetes.

See GENERAL LIMITATIONS AND EXCLUSIONS

G. CHIROPRACTIC CARE

DEFINITION – "Chiropractic" care is a system of therapeutics based upon the theory that disease is caused by abnormal function of the nervous system; attempts to restore normal function are made through manipulation and treatment of the structures of the body, especially those of the spinal column.

BENEFITS –

Benefits for office visits and Covered Services provided by Network Physicians or chiropractors will be covered at a $35 flat Copayment rate per office visit without regard to any Deductible or Coinsurance. The Copayment will be applied toward the Member's Out-of-Pocket maximum.

Benefits for Covered Services provided by Non-network Physicians or chiropractors will be subject to 20% Coinsurance after the Non-network Deductible has been met.

Benefits for Network and Non-network services are limited to a combined calendar year maximum of $1200 per Member. (NOTE: The calendar year maximum does not apply if the Member is hospitalized or for the treatment of scoliosis, fracture care, or surgery.)

Benefits are provided for:

1. Case history
2. Physical findings (subjective and objective)
3. Spinal examination
4. Visual
5. Digital
6. X-rays
7. Spinal manipulations/adjustments
8. Other pertinent chiropractic procedures

The following are NOT covered under this benefit:

1. Maintenance care
2. Preventive examinations
3. Treatment for mental/nervous disorders
4. Local ambulance service
5. Oxygen and blood
6. Private duty nursing (RN or LPN)
7. Chemotherapy and radiation therapy
8. Prescribed, durable medical equipment and appliances (e.g. hospital beds, respirators, and wheel chairs) primarily used in treatment and generally not useful in the absence of illness or injury. Equipment or appliances for convenience, accommodation or household use are not considered durable equipment. A written prescription from a Physician is required.

LIMITATIONS AND EXCLUSIONS –

Physical and occupational therapists: Services provided by physical therapists or occupational therapists are subject to the Plan's Deductible and Coinsurance requirements.

See GENERAL LIMITATIONS AND EXCLUSIONS

H. CONSULTATIONS

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

BENEFITS -

Inpatient:

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Outpatient:

Office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance. The visit must be non-surgical in nature and the Physician or specialist must be a Network provider. The Copayment will be applied toward the Member's Out-of-Pocket maximum.

Benefits for Covered Services provided by Non-network will be subject to 40% Coinsurance after the Non-network Deductible has been met.

Second Surgical Opinion: Benefits will be provided for the Physician's services as well as for any charges for tests necessary to receive a second surgical opinion before undergoing any surgery. If possible, any test results provided by the first Physician should be taken when the second surgical opinion is obtained. Members may choose any Physician for the second opinion as long as the Physician is an appropriate board-certified specialist. If the first and second opinions differ, benefits will also be provided for covered expenses incurred if a third opinion is sought.

Second surgical opinions provided by Network providers are covered at a $25 flat Copayment rate ($35 for specialists) without regard to Deductible or Coinsurance. The Copayment will be applied toward the P Member's Out-of-Pocket maximum

Second surgical opinions provided by Non-network providers will be subject to 40% Coinsurance after the Deductible, and should be provided by a board certified surgeon if possible.

LIMITATIONS AND EXCLUSIONS -

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

See GENERAL LIMITATIONS AND EXCLUSIONS

I. DENTAL SERVICES (Medical Plan)

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

BENEFITS –

Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance.

<u>Hospital:</u>

Inpatient: Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived. If hospitalization occurs for one of the following reasons, benefits shown under ROOM EXPENSES AND ANCILLARY SERVICES will be paid when Covered Services are provided by a Hospital:

1. Excision of exostoses of the jaw, hard palate, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation of a prosthesis).

2. Surgical correction of accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a prosthesis).

3. Treatment of fractures of facial bones.

4. Incision and drainage of cellulitis not originating in the teeth or gums.

5. Incision of accessory sinuses, salivary glands or ducts.

6. Accidental injury (see limitation #1).

7. Reduction of dislocations of the temporomandibular joints when related to an accident.

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

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

written authorization is obtained from Blue Cross Blue Shield of Wyoming in advance of the date services are performed.

Outpatient: Benefits will be paid for services provided by a Hospital or Facility Other Provider for any one of the seven (7) procedures listed above under INPATIENT benefits. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Physician:

Inpatient and Outpatient: Benefits will be paid for the seven (7) procedures listed above under INPATIENT benefits when provided by a Physician, dentist or oral surgeon. The Allowable Charge for surgery includes payment for pre-operative visits, local infiltration of anesthesia, and follow-up care. Benefits will also be provided for the removal/extraction of bony impacted wisdom teeth. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Preventive Care:

Dental screenings as indicated under PREVENTIVE CARE.

LIMITATIONS AND EXCLUSIONS -

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

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

    b. Such injury must occur on or after the Member's effective date of coverage.

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

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

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

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

    g. All services must be performed while the Member's coverage is still in effect.

2. Hazardous Medical Conditions: If, due to a hazardous medical condition (e.g. a heart condition or severe diabetes), hospitalization occurs for a non-covered dental procedure, benefits may be provided for Inpatient or Outpatient Hospital charges. However, benefits

for the services provided by the Member's dentist or oral surgeon will be limited to those described under DENTAL EXPENSES (Dental Plan), if applicable.

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

4. Physician services are not covered for dentistry or services related to dental care. Benefits will be provided for general anesthesia only if the related hospitalization is covered.

5. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under DENTAL EXPENSES (Dental Plan), if applicable.

See GENERAL LIMITATIONS AND EXCLUSIONS

J. DIABETES SERVICES

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

BENEFITS -

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS -

See GENERAL LIMITATIONS AND EXCLUSIONS

K. HEMODIALYSIS AND PERITONEAL DIALYSIS

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

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

BENEFITS - After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

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

See GENERAL LIMITATIONS AND EXCLUSIONS

L. HOME HEALTH CARE

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

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

To obtain benefits, all of the following conditions must be met:

1. Admittance to a Hospital or skilled nursing facility would be required if the Member did not receive home health care.

2. A plan for home care must be submitted and approved, in writing, by a Physician.

3. Care must be provided by a licensed home health care agency.

4. The home health care program must be directly related to the condition for which hospitalization was required.

BENEFITS -

Inpatient: Not covered.

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

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

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

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

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

Benefits for Covered Services will be reimbursed at 100% of the Allowable Charges without reference to the Deductible, to a maximum of sixty (60) visits per Member per calendar year.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

M. HOSPICE BENEFITS

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

To obtain benefits, all of the following conditions must be met:

1. An illness must be diagnosed for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.

2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

3. The attending Physician must refer the Member to the program and must be in agreement with the plan for treatment of the condition.

BENEFITS -

1. Periodic nursing care by registered or practical nurses.

2. Home health aides.

3. Homemaker services.

4. Physical, occupational and respiratory therapy.

5. Medical social workers.

6. Room and board in a hospice facility.

Benefits will be reimbursed at 100% of the Allowable Charges without reference to the Deductible.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

N. HUMAN ORGAN TRANSPLANTS

DEFINITION - "Human Organ Transplant" services are those required in connection with the replacement of a diseased human organ by transplantation of a healthy human organ from a donor. Those transplants covered under this sub-section are as follows:

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

Authorization must be obtained through Blue Cross Blue Shield of Wyoming before benefits are payable.

BENEFITS -

Inpatient: Recipient expenses directly related to the transplant procedure, including pre-operative and post-operative care are covered. Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Outpatient: Recipient expenses directly related to the transplant procedure, including pre-operative and post-operative care are covered. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Physician:

Inpatient and Outpatient: Recipient expenses directly related to the transplant procedure including pre-operative and post-operative care are covered. Surgical costs directly related to the donation of the organ used in a covered organ transplant procedure are also covered. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Other:

Recipient expenses directly related to the transplant procedure, including pre-operative and post-operative care are covered. Surgical, storage, and transportation costs directly related to the donation of an organ used in a covered organ transplant procedure are also covered. Transportation to and from the site of the transplant surgery for the patient and one other individual are covered. If the recipient is a minor, however, coverage is extended to provide transportation for both parents. Meals and lodging costs will also be provided for the other individual, or parents of the recipient. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). In the event of an Inpatient admission, both Network and Non-network admissions are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges for Inpatient admissions will be waived.

LIMITATIONS AND EXCLUSIONS -

Maximum Benefits: Benefits for transportation, meals, and lodging costs shall not exceed $10,000.

See GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

BENEFITS - After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). If services are performed as part of a routine office visit, Network benefits will be subject to a $25 Copay ($35 for specialists) and the Deductible and Coinsurance will be waived.

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

<u>Mammograms:</u>

Network and Non-network: Covered at 100% of the Allowable Charges without reference to the Deductible. .

LIMITATIONS AND EXCLUSIONS -

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

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

3. Weight Loss Programs: Benefits will not be paid for laboratory or X-ray services related to weight loss programs.

See GENERAL LIMITATIONS AND EXCLUSIONS

P. MATERNITY AND NEWBORN CARE

DEFINITIONS - "Maternity" services are those required by covered female Retirees, covered female Dependents, and covered female spouses or domestic partners of Retirees for the diagnosis and care of a pregnancy and for delivery services.

Delivery services include the following:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Therapeutic or elective termination of pregnancy prior to full term.
5. Ectopic pregnancies.
6. Birth Centers (subject to Authorization by Blue Cross Blue Shield of Wyoming).
7. Home births (subject to Authorization by Blue Cross Blue Shield of Wyoming).

"Newborn" services include the following:

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

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 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. For information on Authorization, contact Blue Cross Blue Shield of Wyoming.

BENEFITS -

Hospital:

Inpatient: Benefits include charges for room expenses and ancillary services for the eligible female Member. See ROOM EXPENSES AND ANCILLARY SERVICES.). Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Outpatient: After the Deductible has been met, the following services are covered for the eligible female Member subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers):

1. Delivery in the Outpatient department of a Hospital or other facility.

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

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

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

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

Network Physician's office: The initial office visit for both pre- and post-natal care is covered without regard to any applicable Deductible or Coinsurance after a $25 Copayment ($35 for specialists). The Copayment will be applied toward the Member's Out-of-Pocket maximum. Subsequent pre- and post-natal visits, as well as the delivery charge, are subject to 10% Coinsurance after the Deductible.

Non-network settings: Benefits for Covered Service Services will be subject to 40% Coinsurance after the Deductible.

Newborn Care:

1. Routine nursery charges billed by a Hospital.

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

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). In the event of an Inpatient admission, both Network and Non-network admissions are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges for Inpatient admissions will be waived.

However, newborn office visits to Network providers are covered at the applicable Copayment rate per office visit without regard to Deductible or Coinsurance. The Copayment will be applied toward the Member's Out-of-Pocket maximum.

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

1. Artificial conception: Benefits will not be paid for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.

2. Genetic counseling: Benefits will not be paid for genetic counseling, such as discussions of family history and tests to determine the sex or physical characteristics of an unborn child. Amniocentesis will not be payable when performed to determine the sex of the child.

See GENERAL LIMITATIONS AND EXCLUSIONS

Q. MEDICAL CARE FOR GENERAL CONDITIONS

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

"Outpatient Medical Care" expenses are those billed by a Physician, a Hospital, or Other Provider for services provided in the Physician's office, the Outpatient department of a Hospital or other facility, or in the Members home, for a condition which does not require surgery.

BENEFITS -

Hospital:

Inpatient: Benefits will be provided for the room expenses and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES). Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

NOTE: If the Physician recommends that a Member be hospitalized, Authorization review must be obtained through Blue Cross Blue Shield of Wyoming. See AUTHORIZATION REVIEW under section on HOW BENEFITS WILL BE PAID.

Outpatient: Benefits include Medical Care provided at a Hospital or other facility when medically necessary. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Physician:

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

1. A condition requiring only Medical Care, or

2. A condition that, during an admission for surgery, requires Medical Care not normally related to surgical care. This is only payable after approval through Blue Cross Blue Shield of Wyoming's Medical Review Department.

3. Only one medical visit per day when charged by the same Physician will be covered.

Inpatient Medical Care benefits will be payable for only one Physician per covered hospitalization. (See CONSULTATIONS if more than one Physician is involved.) After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

However, Non-surgical office visits to Network providers are covered at a $25 flat Copayment rate ($35 for specialists) per office visit without regard to Deductible or Coinsurance. The visit must be non-surgical in nature and the Physician or specialist must be a Network provider. The Copayment will be applied toward the Member's Out-of-Pocket maximums.

Outpatient: Benefits will be paid for Medical Care by a Physician when required for the treatment of a specific illness or injury. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

LIMITATIONS AND EXCLUSIONS -

1. Private Room Expenses: Unless it is medically necessary, if a Member has a private room in a Hospital, Allowable Charges are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

R. MEDICAL EMERGENCIES

DEFINITION – A "medical emergency" is a sudden and unexpected condition which requires immediate Medical Care to prevent death or serious harm to health. Examples include heart attacks or suspected heart attacks, comas, loss of respiration, strokes, asthmatic attacks, dehydration, high fevers, and acute appendicitis.

BENEFITS –

For accidental or life-threatening emergencies, both Network and Non-network emergency room and Physician services will be covered subject to a $90 Copayment, in addition to the applicable Deductible or Coinsurance.

If the Member is admitted as an Inpatient, benefits will be provided for both Network and Non-network Covered Services subject to 10% Coinsurance after a $220 Copayment. Any relevant Deductible charges will be waived.

Authorization Review: If a Member is hospitalized, services must be submitted to Blue Cross Blue Shield of Wyoming within 48 hours of an emergency admission. See AUTHORIZATION REVIEW under section on HOW BENEFITS WILL BE PAID.

Covered Services include Hospital care and Physician provided within 48 hours of the onset of the illness. A chronic condition, in which symptoms have existed over a period of time, would not qualify for coverage under this benefit.

NOTE: Use of a Hospital emergency room for a non-emergency medical condition will reduce the level of benefits to 50% of the Allowable Charges after satisfaction of the Deductible.

See GENERAL LIMITATIONS AND EXCLUSIONS

S. MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE

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

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

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

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

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

BENEFITS -

Inpatient:

Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are also subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Outpatient:

Network:

Office visits are covered at a $25 flat Copayment rate per office visit without regard to Deductible or Coinsurance.

Outpatient non-office visits (e.g. partial Hospital, intensive outpatient, day treatment, electroshock therapy & psychological testing) are covered at 100% of the Allowable Charges without reference to the Deductible.

Non-network:

Office visits are subject to 40% Coinsurance for Covered Services after the Deductible.

Outpatient non-office visits (e.g. partial Hospital, intensive outpatient, day treatment, electroshock therapy & psychological testing) are covered at 100% of the Allowable Charges without reference to the Deductible.

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

LIMITATIONS AND EXCLUSIONS -

1. Diagnosis for Mental Health or Substance Use Disorder: Services must be for the diagnosis and/or treatment of manifest mental health or substance use disorders. These disorders are described in two publications:

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

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

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

T. PRESCRIPTION DRUGS AND MEDICINES

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

Insulin is also included as a prescription drug.

BENEFITS –

Benefits for prescription drugs and medications are provided under this Plan only as described under:

1. ROOM EXPENSES AND ANCILLARY SERVICES and

2. HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

LIMITATIONS AND EXCLUSIONS -

1. Non-Prescription Items: Drugs and medicines that can be purchased without a written prescription are not covered, even if the Physician has prescribed such "over-the-counter" medications.

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

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

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

See GENERAL LIMITATIONS AND EXCLUSIONS

U. PREVENTIVE CARE

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

1. (a) United States Preventive Services Task Force (USPSTF) recommendations Grade A and B only;
   (b) Center for Disease Control and Prevention's (CDC) and Prevention's Advisory Committee on Immunization Practices' (ACIP) recommendations for immunizations;
   (c) Health Resources and Services Administrations' (HRSA) recommendations for children and women preventive care and screenings;

2. (a) Testing procedures and examinations for cervical cancer and diabetes;
   (b) Testing procedures and examinations for covered Retirees and covered spouses for breast cancer and prostate cancer.

BENEFITS –

If services are provided by a Network Physician, benefits will be reimbursed at 100% of the Allowable Charges for Covered Services, without regard to any Deductible or Coinsurance that might otherwise apply. (If a Member is in an area where Network Physicians are available and the Member elects not to use a Network Physician, no benefits are provided under PREVENTIVE CARE.)

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

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

B. Birth through age 21:
   1. Sensory screening vision – 1 per calendar year

2. Sensory screening hearing – 1 per calendar year (in addition to screening listed above) through age 21
3. Tuberculin test
4. Oral fluoride: over the counter or prescription strength for children age 6 months-16 years old when sufficient fluoride is lacking in available drinking water

C. Members age 6 and older:
1. Routine physical examination (office visit) – males 1 per calendar year
2. Well-woman preventive care visits as medically appropriate
3. Adult aortic aneurysm screening for male Members ages 65-75– lifetime maximum of 1 screening
4. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
5. Asymptomatic bacteriuria screening – pregnant women only
6. Hepatitis B virus infection screening
7. Rh (D) incompatibility screening – pregnant women only
8. Osteoporosis screening once every 2 calendar years – females age 65 and older unless at risk, then age 60 and older
9. Iron deficiency anemia screening – pregnant women only
10. Sexually transmitted disease (STD) screening:
    a. Chlamydial infection screening – males age 16-18 and females
    b. Gonorrhea infection screening – males age 16-18 and females
    c. Syphilis infection screening – pregnant women and men and women at risk
11. Counseling for sexually transmitted infections
12. Screening for diabetes in pregnant women 24-28 weeks gestation
13. HPV Testing – 30 yrs of age every 3 years
14. Screening & counseling for interpersonal & domestic violence
15. Lactation support & counseling services – 2 visits per pregnancy
16. Breast Pump – 1 pump per pregnancy (manual or electric pump from a Participating home medical equipment provider only). Authorization is required for Hospital grade pumps.
17. Counseling and screening for HIV
18. Contraceptive methods & management (medical) – female sterilizations; IUD inserted or removed & inserted on the same day; injections used to prevent conception, sponges, female condoms, spermicide, emergency contraception, injections and implants
19. Diagnostic screening procedure for HIV testing for at risk Members and pregnant women
20. Type 2 diabetes mellitus screening
21. Immunizations as recommended by the CDC
22. Colorectal cancer screening for Members age 50 through 75:
    a. Fecal occult blood test (1 per calendar year)
    b. Colonoscopy (including related services) OR
    c. Sigmoidoscopy (including related services)

23. Cervical cancer screening and related office visit – 1 per calendar year
24. PSA test – 1 per calendar year for Employee and covered spouse only
25. Mammogram screenings – 1 per calendar year for Employee and covered spouse only
26. Tobacco cessation counseling – 8 visits per calendar year
27. Lipid disorders screening - 1 per calendar year
28. BRCA testing and genetic counseling if appropriate for women whose family history is associated with an increased risk for breast and ovarian cancer and ovarian cancer and for those with a family history of tubal and peritoneal cancer
29. Exercise and physical therapy for community-dwelling adults aged 65 years or older who are at increased risk for falls
30. Screening for hepatitis C virus for those with a high risk or routine diagnosis
31. Screening for lung cancer for Members age 55-80. Includes screening with low-dose computed tomography (LDCT)
32. Screening for gestational diabetes mellitus
33. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors – limit to 12 visits per year
34. Low dose aspirin for the prevention of morbidity and mortality from preeclampsia
35. Colonoscopy services to include preliminary office visit and polyp removal & pathology
36. Ambulatory Blood Pressure Monitoring (ABPM) for diagnostic confirmation of high blood pressure in adults before starting treatment at 100%
37. Bowel Prep Medications required for the preparation of a Preventive Colonoscopy – generic bowel prep medications at 100%, brand will continue to take cost-share
38. Screening for latent tuberculosis infection in adults
39. Primary care interventions to support breastfeeding
40. Statins (Lovastatin and Pravastatin) for the prevention of cardiovascular disease in adults aged 40-75
41. Counseling intervention for pregnant and postpartum persons who are at risk of perinatal depression. Requires a pregnancy or post-partum diagnosis and cannot have a current depression diagnosis – 12 visits per calendar year (additional visits will be subject to the normal cost-share)
42. PrEP with effective antiretroviral therapy to persons at high risk of HIV acquisition
43. Routine HPV vaccinations for those aged 27-45 subject to Deductible and Coinsurance

D. Prescription Drugs - Benefits for Prescription Drugs and medications are provided under this Plan only as described under ROOM EXPENSES AND ANCILLARY SERVICES.

See GENERAL LIMITATIONS AND EXCLUSIONS

V. PRIVATE DUTY NURSING SERVICES

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

BENEFITS -

Inpatient: After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (20% if provided by Non-network Providers).

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

1. The condition would ordinarily require that the Member be placed in an intensive or coronary care unit, but the Hospital does not have such facilities, or

2. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the condition.

3. The private duty nurse is not employed by the Hospital or Physician and is not a resident of the household or a relative.

4. The private duty nurse is an actively practicing RN.

5. The service is ordered by a Physician and rendered in an institution.

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS -

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

2. Claims Review: All claims will be carefully reviewed to be sure that private duty nursing services are absolutely required. The fact that private duty nursing services are covered under this Plan does not, in itself, guarantee that benefits will be paid for any or all services.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

W. REHABILITATION FACILITY

DEFINITION – A “rehabilitation facility” is a facility that offers comprehensive physical rehabilitation for victims of an accidental or medical injury (e.g. stroke, heart attack, spinal cord injury, closed or open head injury, etc.).

BENEFITS –

Benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Covered Services are based on Medical Necessity.

See GENERAL LIMITATIONS AND EXCLUSIONS

For outpatient rehabilitation benefits, see THERAPIES.

X. *ROOM EXPENSES AND ANCILLARY SERVICES*

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

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

1. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.

2. Drugs and medicines, biologicals, and pharmaceuticals.

3. Dressings and supplies, sterile trays, casts, and splints.

4. Diagnostic and therapeutic services.

5. Blood administration.

6. Intensive and coronary care units.

BENEFITS -

Inpatient: Benefits for room expenses and ancillary services will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Authorization Review: If the Physician recommends that the Member be hospitalized, services must be submitted in advance to Blue Cross Blue Shield of Wyoming. See AUTHORIZATION REVIEW under section on HOW BENEFITS WILL BE PAID.

Outpatient: Ancillary services billed by a Hospital or other facility are covered. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

For additional Outpatient benefits under this coverage, see the following sections:

1. Laboratory, Pathology, X-Ray, and Radiology Services.

2. Therapies.

LIMITATIONS AND EXCLUSIONS -

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

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

3. Personal or Convenience Items: Benefits will not be paid for services and supplies provided for personal convenience which are not related to the treatment of the condition. (Examples: Breast pumps, guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

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

See GENERAL LIMITATIONS AND EXCLUSIONS

Y. SKILLED NURSING FACILITY

DEFINITION – A "skilled nursing facility" may be a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital, or a section of a facility that is a geriatric center. An approved facility must be primarily engaged in providing skilled nursing care or rehabilitation services. At least one (1) registered nurse must be employed full-time and adequate nursing service (which may include practical nurses) must be provided at all times. Every patient must be under the supervision of a Physician and a Physician must always be available for emergency care. The facility must be certified by the state. It also must have a written agreement with a Hospital that is participating in the Medicare program for the transfer of patients. Not all nursing homes will qualify; those that offer only custodial care are excluded.

BENEFITS –

Inpatient and Outpatient:

After a Hospital stay, Members may still need special medical care, but to a lesser degree than a Hospital provides. That care can be received in an approved skilled nursing facility. A Physician must certify medical necessity for transfer from a Hospital to an approved skilled nursing facility within three (3) days of the Hospital discharge date.

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (20% if provided by Non-network Providers) for up to thirty (30) days per Member per calendar year.

LIMITATIONS AND EXCLUSIONS

Custodial Care: Charges from a skilled nursing facility will not be covered if the services received are personal or custodial care such as assistance with bathing, dressing, or eating.

See GENERAL LIMITATIONS AND EXCLUSIONS

Z. SUPPLIES, EQUIPMENT AND APPLIANCES

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

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

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

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

BENEFITS –

After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers, except as noted below):

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

2. Medical supplies, including but not limited to:

    a. Colostomy bags and other supplies for their use.

    b. Catheters.

    c. Dressings for cancer, diabetic and decubitus ulcers and burns.

    d. Syringes and needles for administering covered drugs, medicines, or insulin.

    e. Hyperalimentation.

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

    a. Artificial arms or legs

    b. Leg braces, including attached shoes

    c. Arm and back braces

d. Cervical collars

e. Surgical implants

f. Artificial eyes

g. Pacemakers

h. Breast prosthesis and special bras

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

5. Oxygen - Benefits will be paid for oxygen and the equipment needed to administer it.

6. Wigs – Benefits will be paid if hair loss is due to chemotherapy or radiation therapy. Limit one (1) wig per Member.

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

LIMITATIONS AND EXCLUSIONS -

1. Deluxe or Luxury Items: If the supply, equipment, or appliance ordered includes more features than needed for the condition being treated, benefits will be paid only up to the reasonable charges for the item that would have met medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars.")

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

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

3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered unless due to an accidental injury or illness that occurred while covered under the Plan.

4. Hospital Beds: Benefits may not be paid for hospital beds (including waterbeds or other floatation mattresses) without Authorization from Blue Cross Blue Shield of Wyoming.

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

6. Reasonable Charges: Benefits for all supplies, equipment, and appliances are limited to charges which are reasonable in relation to the average of those billed by most suppliers for comparable items.

See GENERAL LIMITATIONS AND EXCLUSIONS

AA. SURGERY

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

BENEFITS –

Among the surgical procedures covered under this benefit is reconstructive surgery to improve the function of a body part when the malfunction is the direct result of a birth defect, sickness or accidental injury.

Hospital:

Inpatient: Benefits for room expenses and ancillary services will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers) (see ROOM EXPENSES AND ANCILLARY SERVICES). Inpatient admissions (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

If the Physician recommends that the Member be hospitalized, services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming. See AUTHORIZATION REVIEW under section on HOW BENEFITS WILL BE PAID.

Outpatient: Ancillary and surgical services billed by a Hospital are covered. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

Physician:

Inpatient: The Allowable Charges for surgery performed by a Physician include payment for pre-operative visits, local administration of anesthesia, follow-up care and recasting. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

If the Physician recommends that the Member be hospitalized, services must be submitted in advance to Blue Cross Blue Shield of Wyoming. See AUTHORIZATION REVIEW under section on HOW BENEFITS WILL BE PAID.

More than one surgery performed by the same Physician during the course of only one operative period is called a "multiple surgery." Since the Allowable Charges for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced. The reduced benefit varies, depending upon the circumstances of the multiple surgeries.

Outpatient: Ancillary and surgical services are covered. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

LIMITATIONS AND EXCLUSIONS -

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

   Benefits for a cosmetic surgery procedure and related expenses are allowed only when reconstructive surgery is required to improve the function of a body part and when the malfunction is the direct result of a birth defect, sickness, or accidental injury that occurs while the Member is covered under the Plan. Blue Cross Blue Shield of Wyoming must give written authorization for cosmetic surgery benefits in advance of the date of services.

   NOTE: Subject to prior written approval by Blue Cross Blue Shield of Wyoming, 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 federal law:

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

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

3. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the main surgery. Additional benefits will not be paid for these procedures.

4. Obesity and Weight Loss: Benefits will be paid for bariatric surgery required as the result of obesity only when Authorized on the basis of the condition specified in section on GENERAL LIMITATIONS AND EXCLUSIONS.

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

6. Private Room Expenses: If the Member has a private room in a Hospital, Allowable Charges are limited to the semi-private room allowance, whether or not a semi-private room is actually available. However, if a private room is medically necessary, benefits will be provided for it.
7. Sex-Change Operations: Benefits will not be paid for sex change operations, or related expenses.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

BB. SURGICAL ASSISTANTS

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

BENEFITS -

Inpatient and Outpatient: Benefits will be paid when services are provided by a surgical assistant. After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers).

LIMITATIONS AND EXCLUSIONS -

1. Eligible Procedures: Surgical assistant benefits are available only for surgical procedures which are of such complexity that they require a surgical assistant.

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

See GENERAL LIMITATIONS AND EXCLUSIONS

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

DEFINITIONS - "Chemotherapy" is the treatment of malignant disease by chemical or biological antineoplastic agents.

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

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

"Physical therapy" is the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and is devised to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

“Pain therapy” is treatment prescribed by a Physician for the evaluation and treatment of chronic pain due to a non-occupational injury or illness. The program should help the Member develop pain management techniques that will help to lead as normal a life as possible.

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

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

“Biofeedback” is the technique of providing a Member with ongoing sensory awareness of the state of one or more of his or her body processes, through such means as monitoring devices which produce visual displays or tones of varying pitch, in order to facilitate the exercise of conscious control over normally involuntary or unconscious body functions.

BENEFITS - After the Deductible has been met, benefits will be subject to 10% Coinsurance for Covered Services provided by Network Providers (40% if provided by Non-network Providers, except for physical, occupational, and speech therapy which will be subject to 15% Coinsurance after the Deductible).

However, in the event an Inpatient admission is required, benefits (both Network and Non-network) are subject to a $220 Copayment per admission *in addition to* the required Network or Non-network Coinsurance. Any relevant Deductible charges will be waived.

Hospital:

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

1. Chemotherapy (drug and administration charges) for malignant conditions

2. Radiation therapy

3. Physical therapy provided by a registered physical therapist or Physician

4. Respiratory therapy

5. Occupational therapy

6. Speech therapy

Outpatient: When provided by a Hospital or Facility Other Provider, the following types of therapy are covered:

1. Chemotherapy (drug and administration charges) for malignant conditions

2. Radiation therapy

3. Physical therapy provided by a registered physical therapist or Physician

4. Respiratory therapy

5. Pain therapy when due to an injury or illness (Requires Authorization of Blue Cross Blue Shield of Wyoming and limited to lifetime maximum of two [2] one to four [1-4] week programs per Member.)

6. Occupational therapy

7. Speech therapy

8. Biofeedback (Requires Authorization of Blue Cross Blue Shield of Wyoming and limited to calendar year maximum of 25 treatments per Member.)

Physician:

Inpatient: When provided by a Physician, the following types of therapy are covered in lieu of one medical day if charged by the same Physician:

1. Chemotherapy (drug and administration charges) for malignant conditions

2. Radiation therapy

3. Respiratory therapy

4. Physical therapy

5. Occupational therapy

6. Speech therapy

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

1. Chemotherapy (drug and administration charges) for malignant conditions

2. Radiation therapy

3. Physical therapy provided by a registered physical therapist or Physician

4. Respiratory therapy

5. Pain therapy (Requires Authorization of Blue Cross Blue Shield of Wyoming and limited to lifetime maximum of two (2) one to four (1-4) week programs per Member.)

6. Occupational therapy

7. Speech therapy

8. Biofeedback (Requires Authorization of Blue Cross Blue Shield of Wyoming and limited to calendar year maximum of 25 treatments per Member.)

LIMITATIONS AND EXCLUSIONS -

1. Physical Therapy: Outpatient benefits for limited to a maximum of thirty-five (35) visits per Member per calendar year.

2. Occupational Therapy: Outpatient benefits are limited to a maximum of thirty-five (35) visits per Member per calendar year.

3. Speech Therapy: Outpatient benefits are limited to a maximum of thirty-five (35) visits per Member per calendar year.

See GENERAL LIMITATIONS AND EXCLUSIONS

GENERAL LIMITATIONS AND EXCLUSIONS

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

A. ALTERNATIVE MEDICINE

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

B. ARTIFICIAL CONCEPTION

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

C. AUTHORIZATION REVIEW

If the Physician recommends that the Member be hospitalized, services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming.

The following services must be certified for payment in advance before benefits will be paid. A Member must contact Blue Cross Blue Shield of Wyoming at (800) 442-2376 to obtain Authorization <u>*before*</u> receiving these Healthcare Services. The failure to obtain Authorization may result in a denial or reduction in coverage for the Healthcare Service:

1. Reconstructive surgery.
2. Dental-related services.
3. Obesity and weight loss services.
4. Human Organ Transplants.
5. Breast reconstruction surgery.
6. Hospital beds.
7. Hospital-grade breast pumps.

D. AUTOPSIES

Services related to autopsies are not covered.

E. COMPLICATIONS OF NON-BENEFIT SERVICES

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

F. CONVALESCENT CARE

Convalescent care is that care provided during the period of recovery from illness or the effects of injury and surgery. Benefits for convalescent care are limited to those normally received for a specific condition.

G. *COSMETIC SURGERY*

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

Benefits for a cosmetic surgery procedure and related expenses are allowed only when reconstructive surgery is required to improve the function of a body part and when the malfunction is the direct result of a birth defect, sickness, or accidental injury that occurs while the Member is covered under the Plan. Blue Cross Blue Shield of Wyoming must give written authorization for cosmetic surgery benefits in advance of the date of services.

NOTE: Subject to prior written approval by Blue Cross Blue Shield of Wyoming, 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 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, and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

H. *CUSTODIAL CARE*

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

I. *DIAGNOSTIC ADMISSIONS*

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

J. *DOMICILIARY CARE*

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

K. *EAR WAX*

Services for the removal of ear wax are not covered.

L. *EDUCATIONAL PROGRAMS*

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

M. *ENVIRONMENTAL MEDICINE*

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

N. *EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES*

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

O. *EYE CARE*

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

P. *FOOT CARE SERVICES*

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

Q. *GENETIC AND CHROMOSOMAL TESTING/COUNSELING*

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

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

R. *GOVERNMENT INSTITUTIONS AND FACILITIES*

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

amended, or comparable peer review programs, and the operation of the institution is subject to review according to Federal and State laws.

S. *HAIR LOSS*

Wigs, artificial hairpieces, hair transplants, implants, prescription drugs, and medications are not covered, regardless of whether there is a medical reason for hair loss. The only exception is for hair loss due to radiation therapy or chemotherapy, in which case benefits will be provided for the cost of a wig. (Please see the section on SUPPLIES for details.)

T. *HOSPITALIZATIONS*

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

U. *HYPNOSIS*

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

V. *LEARNING DISABILITIES*

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

W. *LEGAL PAYMENT OBLIGATIONS*

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

X. *MANAGED CARE PROVISIONS*

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

Y. *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.

Z. MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

AA. OBESITY AND WEIGHT LOSS

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

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

BB. PAYMENT IN ERROR

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

CC. PERSONAL COMFORT OR CONVENIENCE

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

DD. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

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

EE. PROCEDURES RELATED TO STUDIES

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

1. Is a "Phase I", "Phase II", or "Phase III" program, protocol, project, trial, or study, or
2. Is arranged so that the Members selected to take part are randomized, with some Members receiving the prescribed drugs, treatment, technologies, services, or procedures, and other Members receiving a different drug, treatment, technology, service, or procedure, or
3. Is a "research" program, protocol, project, trial, or study, or
4. Is an "investigational" program, protocol, project, trial, or study, or

5. Is utilizing investigational or experimental drugs and medicines, technologies, treatments, or procedures, or
6. Has individuals administering the program, protocol, project, trial, or study who are identified as "investigators", or
7. Is a "controlled" program, protocol, project, trial, or study.

FF. PROPHYLAXIS/PROPHYLACTIC MEDICINE

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

GG. REHABILITATIVE ADMISSION

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

HH. REPORT PREPARATION

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

II. ROUTINE HEARING EXAMINATIONS

Services will not be covered for the testing of hearing acuity. Services will not be covered for the prescription or fitting of a hearing aid or for the services related to the prescription or fitting unless due to an accidental injury or illness that occurred while covered under the Plan.

JJ. ROUTINE PHYSICALS

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

KK. SERVICES AFTER COVERAGE ENDS

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

LL. SERVICES NOT IDENTIFIED

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

MM. SERVICES PRIOR TO THE EFFECTIVE DATE

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

NN. SEX CHANGE OPERATIONS

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

OO. SUBLUXATION

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

PP. TAXES

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

QQ. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

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

RR. THERAPIES

Benefits will not be provided for special therapies except as described under the Therapies section of this Plan. Such non-covered Services include (but are not limited to): recreational and sex therapies, Z therapy, self-help programs, transactional analysis, sensitivity training, assertiveness training, encounter groups, transcendental meditation (TM), religious counseling, rolfing, primal scream therapy, and stress management programs.

SS. TRAVEL EXPENSES

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

TT. UNRELATED SERVICES

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

UU. WAR

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

VV. WEIGHT LOSS PROGRAMS

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

WW. WORK RELATED INJURIES

No benefits will be provided for expenses incurred as a result of a work-related injury or illness, regardless of coverage under workers compensation or other employer liability laws. This includes self-employment.

GENERAL PROVISIONS

A. *ASSIGNMENT OF BENEFITS*

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

B. *CHANGE TO THE PLAN*

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

C. *CLAIM FORMS*

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

D. *CLERICAL ERROR*

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

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

E. *COORDINATION OF BENEFITS*

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Members often have other coverage providing duplicate benefits. In the event of other coverage, the Plan will not duplicate benefits if otherwise provided for (or should have been provided had the 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 coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage. If the Plan is determined to be secondary payer, the sum of the benefits payable by the primary payer plus the sum of the benefits payable under this Plan shall not exceed the amount payable under this Plan had this Plan been determined to be the primary payer.

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

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision will be primary payer.
2. Group coverage will be primary over an individual policy with a non-duplication provision.
3. Coverage of a plan, which covers the patient as an Employee will be primary over a plan covering the patient as a Dependent.
4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payer.
5. The above applies for children, except in situations where the parents are separated or divorced.

    a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the benefits of a plan covering the child as a Dependent of the parent without custody
    b. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the step-parent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.
    c. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical other health care expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.

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

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

F. DISCLAIMER OF LIABILITY

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

G. *DISCLOSURE OF MEMBER'S MEDICAL INFORMATION*

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

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

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

H. *EXECUTION OF PAPERS*

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

I. *GENERAL INFORMATION ABOUT FILING CLAIMS*

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

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

J. *LIMITATION OF ACTIONS*

No action at law or equity may be brought to recover benefits under the Plan prior to the expiration of sixty (60) days after written proof of a claim is furnished. No such action

shall be brought later than three (3) years after the time written proof of claim for benefits is required to be furnished.

K. MEMBER'S LEGAL OBLIGATIONS

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

L. PLAN IS NOT AN EMPLOYMENT CONTRACT

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

M. PHYSICAL EXAMINATION AND AUTOPSY

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

N. PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

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

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

1. The Group must ensure it takes the steps necessary to reasonably and appropriately safeguard all PHI it creates, receives, maintains or transmits on behalf of the Plan.
2. The Group must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
3. The Group will neither use nor further disclose a Member's PHI except as permitted by this Benefit Booklet or as required by law.

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

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

O. PRUDENT MEDICAL CARE

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

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

P. *SELECTION OF DOCTOR*

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

Q. *SENDING NOTICES*

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

R. *STATEMENTS AND REPRESENTATIONS*

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

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

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

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

S. *SUBROGATION AND REFUND*

The Member may incur medical charges due to injuries for which benefits are paid by the Plan. The injuries may be caused by the act or omission of another person. If so, the Member may have a claim against that other person for payment of the medical or charges. The Plan will be subrogated to all rights the Member may have against that other person.

The Member must:

1. Assign to the Plan his or her rights to recover when this provision applies; and

2. Repay to the Plan out of the recovery made from the other person or the other person's insurer.

Amount Subject to Subrogation or Refund: Only the amount recovered for medical charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of medical benefits paid for the injury or sickness under the Plan.

When a right of recovery exists, the Member will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the right of subrogation. In addition, the Member will do nothing else to prejudice the right of the Plan to subrogate.

Defined terms: "Recovery" means monies paid to the Member by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries.

"Subrogation" means the Plan's right to pursue the Member's claims for medical charges against the other person.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the injury.

Recovery from another plan under which the Member is covered: This right of refund also applies when a Member recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, or any liability plan.

T. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of the Plan not more than thirty (30) days after receipt of written proof of the claim and supporting evidence. Such supporting evidence may include, but not be limited to, medical records required for claim analysis and payment in accordance with the plan. In the event Blue Cross Blue Shield of Wyoming determines that certain medical records are necessary to determine benefits under the Plan, the above 30-day claim payment time will not start to run until all such necessary records are received by Blue Cross Blue Shield of Wyoming from any source.

U. WRITTEN NOTICE OF CLAIM

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

3. Failure to give notice to Blue Cross Blue Shield of Wyoming within the time specified above will not invalidate nor reduce any claim for benefits if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. PLAN ADMINISTRATOR

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

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

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

B. DUTIES OF THE PLAN ADMINISTRATOR

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

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

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

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

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

6. To appoint a Claims Supervisor to pay claims.

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

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

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

C. *PLAN ADMINISTRATOR COMPENSATION*

All administrative expenses are paid by the Genesis Alkali, LLC.

D. *FIDUCIARY*

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

E. *FIDUCIARY DUTIES*

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Retirees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. In accordance with the Plan Booklets to the extent that they agree with ERISA.

F. *THE NAMED FIDUCIARY*

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following explanation is provided as an overview and is not intended to be legal advice or provide other specific information to the Member as to all their rights under ERISA. Members should consult their employer to determine whether their Plan is covered under ERISA.

A. *PLAN BOOKLETS AND FINANCIAL REPORTS*

Members in an employee benefit plan are entitled to certain rights and protection under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all benefit, or plan Members shall be entitled to:

1. Examine, without charge, at the plan Administrator's, or Employer's, offices, as applicable, and at other specified locations, such as union halls or worksites, all benefit (plan) Booklets including insurance contracts, and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and benefit (plan) descriptions.

2. Obtain copies of all benefit Booklets and other information upon written request to the plan Administrator, or Employer, as appropriate. A reasonable charge may be made for these copies.

3. Receive a summary of a benefit financial report. The plan Administrator is required by law to furnish each Member with a copy of this summary annual report upon request.

B. *FIDUCIARIES AND THEIR OBLIGATIONS*

In addition to creating rights for employment benefit Members, ERISA imposes duties upon the people who are responsible for the operation of the employment benefit plan (fiduciaries). These people have a duty to operate and/or administer Members' employment benefits prudently and in the best interests of the Members.

C. *LEGAL RIGHTS TO BENEFITS*

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

2. If any claim for a benefit that Members are legally entitled to is denied or ignored, in whole or in part, Members must receive a written explanation of the reason for the denial. This explanation may come in various formats. Members have the right to have Blue Cross Blue Shield of Wyoming review and reconsider their claim in accordance with the steps below.

3. Under the provisions of ERISA, there are various steps Members can take to enforce the above rights. For instance, if Members request materials and do not receive them within 30 days, Members may seek assistance from the U.S. Department of Labor, or

they may file a lawsuit in Federal Court. In such a case the court may require the entity from whom the Members requested materials to provide the materials and pay the Members up to $110.00 a day until they receive the materials, unless the materials the Members requested were not sent because of reasons beyond the control of the entity from whom materials were requested.

4. If Members have a claim for benefits that is denied or ignored, in whole or in part, the Members may file a lawsuit in a state or Federal Court. If it should happen that fiduciaries misuse the plan's money, or if the Members are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Members are successful the court may order the person being sued to pay these costs and fees. If the Members lose, the court may order them to pay these costs and fees; for example, if the court finds the Members' claim is frivolous.

5. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, D.C. 20210.

D. CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW

Upon receipt of a claim for benefits under this Plan from a Member and/or Member's authorized representative that is conditioned on a Member's obtaining approval in advance of obtaining the benefit or service, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination within a reasonable period of time, but no later than 15 days from receiving the claim. Blue Cross Blue Shield of Wyoming may extend this initial time period an additional 15 days if it is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's authorized representative notice of the need for additional time prior to the expiration of the initial 15 day time period.

If the Member and/or the Member's authorized representative improperly submits a claim for benefits, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative as soon as possible, but no later than 5 days after receipt of the claim for benefits and provide the Member and/or the Member's authorized representative with the proper procedures to be followed when filing a Claim for benefits. Blue Cross Blue Shield of Wyoming may also request additional or specified information after receiving a claim for benefits, but any such request will be made prior to the expiration of the initial 15 day time period after receiving the claim for benefits. Upon receiving notice of an improperly filed claim for benefits or a request for additional or specified information, the Member and/or the Member's authorized representative has 45 days in which to properly file the Claim for benefits and submit the requested information. After receiving the properly filed claim for benefits or additional or specified information, Blue Cross Blue Shield of Wyoming shall notify the Member and/or the Member's authorized

representative of its determination within a reasonable period of time, but no later than 15 days after receipt of the properly filed claim for benefits and additional information.

E. CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For services or benefits requiring Authorization review and involving an ongoing course of treatment taking place over a period of time or number of treatments, Blue Cross Blue Shield of Wyoming will provide the Member and/or the Member's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Member and/or the Member's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

Upon receipt of a claim for benefits for emergency services from a Member and/or a Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination as soon as possible but no later than 72 hours after receiving the claim for benefits.

If the Member and/or the Member's authorized representative improperly submits a claim for benefits or the claim for benefits is incomplete and Blue Cross Blue Shield of Wyoming requests additional or specified information, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative as soon as possible, but no later than 24 hours after receipt of the claim for benefits. Upon receiving notice of an improperly filed claim of benefits or the request from Blue Cross Blue Shield of Wyoming for additional or specified information, the Member and/or the Member's authorized representative has 48 hours to properly file the claim for benefits or to provide the requested information. After receiving the properly filed claim for benefits or requested information, Blue Cross Blue Shield of Wyoming shall notify the Member and/or the Member's authorized representative of its determination as soon as possible, but no later than 48 hours after receipt of the additional or specified information requested by Blue Cross Blue Shield of Wyoming, or within 48 hours after expiration of the Member's time period to respond.

G. CLAIMS FOR BENEFITS NOT REQUIRING AUTHORIZATION REVIEW, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For a claim for benefits that does not require Authorization review but involves services or benefits involving an ongoing course of treatment taking place over a period of time or a number of treatments, Blue Cross Blue Shield of Wyoming will provide the Member and/or the Member's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Member and/or the

Member's authorized representative to extend such treatment, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

Upon receipt of a claim for benefits under the Plan from a Member and/or the Member's authorized representative, Blue Cross Blue Shield of Wyoming will notify the Member and/or the Member's authorized representative of its determination within a reasonable period of time, but no later than 30 days from receiving the claim for benefits and only if the determination is adverse to the Member. Blue Cross Blue Shield of Wyoming may extend this initial time period in reviewing a claim for benefits an additional 15 days if Blue Cross Blue Shield of Wyoming is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's authorized representative notice of the need for additional time prior to the expiration of the initial 30 day time period.

Blue Cross Blue Shield of Wyoming may request additional or specified information after receiving a claim for benefits, but any such request will be made prior to the expiration of the initial 30 day time period after receiving the claim for benefits. Upon receiving a request for additional or specified information, the Member and/or the Member's authorized representative has 45 days in which to submit the requested information. After receiving the additional or specified information, Blue Cross Blue Shield of Wyoming shall notify the Member and/or the Member's authorized representative of its determination within a reasonable period of time, but not later than 30 days after receipt of the additional information.

I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING AUTHORIZATION REVIEW

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

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

J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

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

representative may request an appeal from a determination involving a claim for benefits for emergency services orally or in writing, and Blue Cross Blue Shield of Wyoming will accept needed materials by telephone or facsimile.

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

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

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

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

L. *EXTERNAL CLAIMS REVIEW PROCEDURE*

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

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

1. Medical Necessity Denials:

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

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

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

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

2. All Other Denials:

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

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

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 120 days of the date of the internal appeal denial.

M. DISCRETION OF PLAN ADMINISTRATOR

The Plan Administrator has full, conclusory, exclusive, and binding discretion to act with respect to the management, operation, and administration of this Plan in accordance with the provisions of the Plan.

N. ANSWERS TO QUESTIONS

1. If Members have any questions about any of the benefits associated with this health insurance agreement or their rights under this agreement, they should contact their employer or Blue Cross Blue Shield of Wyoming at (307) 634-1393. They can also call Blue Cross Blue Shield of Wyoming toll free at:

   In-State: 1-800-442-2376

2. If Members have any questions about their rights under ERISA, they should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.