

KID CARE CHIP

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 tinutulongan, 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 사람이 Blue 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 위해서는 800-442-2376 로 전화하십시오.

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

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

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

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

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

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

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

જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમાંથી કોઈને [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 nilinígíí Blue Cross Blue Shield of Wyoming haada yit'éego bina'idilkidgo éi doodago háida biká anilyeedígíí t'áadoo le'é yina'idilkidgo beehaz'áanii hóló díi t'áa hazaadk'ehjí háká a'doowolgo bee haz'á doo báqáh ilinígóó. Ata' halne'ígíí kojí' bich'í' hodiilnil

800-442-2376.

Non-Discrimination Notices

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

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

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

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

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

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

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Section I. Schedule of Benefits

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

Hospital Room Benefits are based on Allowable Charges

Physician Benefits are subject to Allowable Charges

Other Provider Benefits are subject to Allowable Charges

Cost Sharing

Most Kid Care CHIP families will have to pay a co-payment for medical, pharmacy, and dental services. The amount you pay is based on the income that you supplied to Kid Care CHIP when you enrolled your child. The cost sharing plan that your child is on will be provided to you by Kid Care CHIP and listed on your Blue Cross Blue Shield of Wyoming and Delta Dental Insurance cards. The tables below outline the co-payments required for each plan. Preventive care services like immunizations and well child exams do not have a co-payment. The benefit year is from January 1st to December 31st of each year. The enrollment year is based on when your child was enrolled in Kid Care CHIP.

Benefit Year Out Of Pocket Maximums	Plan A	Plan B	Plan C
Medical Out of Pocket Maximum per Benefit Year	None	\$200 per child	\$300 per child
Pharmacy Out of Pocket Maximum per Benefit Year	None	\$100 per child	\$200 per child
Dental Out of Pocket Maximum per Benefit Year	None	\$15 per child	\$75 per child
Dental or Medically Necessary Orthodontia Out of Pocket Maximum per Benefit Year	None	\$15 per child	\$75 per child

Enrollment Year Out Of Pocket Maximums	Plan A	Plan B	Plan C
Total Family Out of Pocket Maximum per Enrollment Year	None	5% of the family's gross yearly income***	

Benefits	Plan A Co-Payment	Plan B Co-Payment	Plan C Co-Payment
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Medical			
Office Visits (including mental health)	None	\$5	\$10
Well Child Exams	None	None	None
Immunizations	None	None	None
Benefits	Plan A Co-Payment	Plan B Co-Payment	Plan C Co-Payment
Lab and X-ray	None	None	None
Outpatient Hospital	None	\$5	\$10
Inpatient Hospital	None	\$30	\$50
Emergency Room	None	\$5	\$25
Pharmacy			
Generic Prescriptions	None	\$3	\$5
Preferred Brand Name Prescriptions	None	\$5	\$10
Non-Preferred Brand Prescriptions	No Coverage	No Coverage	No Coverage
Dental			
Diagnostic and Preventive Services (exams, cleaning, fluoride, sealants)	None	None	None
Basic Services (fillings, extractions, etc.)	None	\$5 per visit	\$25 per visit
Medically Necessary Orthodontia	None	\$5 per visit	\$25 per visit

**Kid Care CHIP will send you an approval letter or an approved renewal letter telling you the out of pocket maximum amount for your family. This out of pocket maximum could possibly change each enrollment year.

Maximum Out of Pocket Costs:

You will not pay more than 5% of your family’s gross income for the cost of co-payments each enrollment year. Kid Care CHIP will tell you what your out of pocket maximum is for your family in the Approval letter or Renewal Approval letter you receive from them.

Once you have reached 5% of your family’s income, your family will no longer have to pay co-payments for that enrollment year.

Tracking of Expenses:

You will need to start tracking your expenses the day your child becomes eligible for Kid Care CHIP. You must keep all of your receipts for co-payments for all of the children in your family who are enrolled in Kid Care CHIP.

Only money you spend on covered services will be counted towards your out of pocket limit. If you feel you have met or paid more than the cost sharing limit listed on your letter from Kid Care CHIP, you will need to send your receipts and your claim form into the Kid Care CHIP office at:

Kid Care CHIP
6101 Yellowstone Rd, Ste 210
Cheyenne, WY 82002

You can get more out of pocket claim forms by calling 1-855-294-2127 or downloading it from the Kid Care CHIP website at www.health.wyo.gov/CHIP.

What happens after I turn in my receipts?

Kid Care CHIP will make sure you have met your 5% maximum for your family.

If you have met your maximum, Kid Care CHIP will send you a letter verifying your out of pocket maximum is met and that you do not owe any further co-payments through the end of the enrollment year.

You can use the letter to show your healthcare provider or pharmacist that you do not owe co-payments.

Kid Care CHIP PPO providers have agreed not to bill you for amounts over the Allowable Charge established by Blue Cross Blue Shield of Wyoming. However, you will be responsible for charges for services provided by providers who do not take part in the Kid Care CHIP PPO network except in the case of a medical emergency. Blue Cross Blue Shield of Wyoming and Delta Dental of Wyoming will not pay for services that are not authorized by Kid Care CHIP. In the event that a parent/guardian agrees to a non-covered service, the parent/guardian is responsible for payment in full to the medical or dental provider.

Your coverage provides benefits for many Covered Services, including those listed below under MEDICAL BENEFITS. Please see Sections on HOW BENEFITS WILL BE PAID and BENEFITS for a more complete explanation of your benefits.

MEDICAL BENEFITS:

Ambulance Services
Anesthesia Services
Blood Expenses
Consultations
Diabetes Services
Hemodialysis and Peritoneal Dialysis
Laboratory, Pathology, X-ray, and Radiology Services
Magnetic Resonance Imaging (MRI)
Maternity Care
Treatment for Mental Health, Alcoholism, or Drug Abuse
Physician's Office Visits
Prescription Drugs & Medicine
Rehabilitation
Room Expenses & Ancillary Services
Supplies, Equipment, & Appliances
Surgery (Inpatient & Outpatient)

Surgical Assistants
Therapy (Chemotherapy, Radiation Therapy, Physical Therapy, & Respiratory Therapy)
Vision Care
Well Child and Adolescent Care (including immunizations)

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:

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

Section II. Definitions

- A. *Agreement*
This Agreement as limited and extended in its effect by the application and by any endorsement or fee schedule, now or hereafter in effect.
- B. *Alcoholism Treatment Center*
A detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism.
- C. *Allowable Charges*
The maximum amount for covered services allowed under this Agreement. Allowable charges are determined by the Blue Cross Blue Shield of Wyoming payment system in effect at the time the services are provided.
- D. *Applicant*
The person who applies for coverage.
- E. *Benefit Year*
A period of twelve (12) months commencing on (and including) January 1 and ending on the following December 31. In the benefit year in which the enrolled child's coverage becomes effective, the "benefit period" will be the period between the effective date of the enrolled child's coverage and December 31 of that benefit year.
- F. *BlueCard® Program*
A nationwide program coordinated by the Blue Cross Blue Shield of Wyoming Association that enables members to reduce claims filing paperwork and to take advantage of available local provider networks, medical discounts, and cost saving measures when they receive care in states other than Wyoming.
- G. *Copayment*
A specified amount of allowable charges for covered services that the enrolled child must pay each time a specific occurrence takes place.
- H. *Covered Service*
A service or supply specified in this Subscription Agreement for which benefits will be provided when rendered by a provider.
- I. *Creditable Coverage*
Means creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 as amended, 42 U.S.C. Section 300 gg *et seq.*
- J. *Diagnostic Service*
A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A diagnostic service must be ordered by a physician or professional other provider.

- K. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)*
Comprehensive health care to assess a child's health status, identify risks or concerns and be able to intervene to correct or improve physical, developmental, and mental health conditions.
- L. Enrolled Child*
The applicant whose name appears on the insurance card.
- M. Enrollment Year*
The twelve (12) month period commencing on the effective date during which time the enrolled child is covered unless the child turns age 19, fails quality control, becomes eligible for specific Medicaid plans, moves out of Wyoming, or enters a public institution as defined in II.
- 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 Provider*
An alcoholism treatment center, hospital, or other facility as defined herein.
- P. Family*
One or more children residing in the same household with one or both natural parents, adoptive parents, or a legal guardian.
- Q. Fiduciary*
As used herein, Blue Cross Blue Shield of Wyoming as a fiduciary of this health insurance Agreement exercises any authority or control regarding the management or disposition of the Plan's assets in accordance with this Agreement, the operation, and administration of this Agreement.

R. *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.

S. *Home Health Agency*

A private or public organization licensed by the State of Wyoming. It provides skilled nursing services and other therapeutic services to patients in their homes.

T. *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 or rehabilitation care,
 - k. place for the treatment of pulmonary tuberculosis.

U. *Incurred Date*

The date that a service or supply for which a charge is being made was provided or received. The incurred date may also be referred to as the date of service.

V. *Inpatient*

An enrolled child 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 enrolled child is still a patient.

W. *Institution for Mental Disease (IMD)*

An IMD is a facility with more than sixteen (16) beds and having as its primary function the treatment of mentally ill patients. IMDs in Wyoming include the Wyoming State Hospital and the Wyoming Training School.

- X. *Kid Care CHIP PPO (Preferred Provider Organization) Physician, Hospital, or Provider*
A physician, hospital, or other provider who has entered into a PPO agreement with us or another Blue Cross Blue Shield plan to bill us directly for covered services.

NOTE: A physician, hospital, or other provider who has not entered into a PPO agreement with us or another Blue Cross Blue Shield plan is not eligible for payment and may bill you directly for services performed.

- Y. *Managed Care*
Managed Care is a health care system that manages cost, utilization and quality of healthcare service. The key objectives of Kid Care managed care include improvement in health plan performance, healthcare quality, and health outcomes for children.

- Z. *Medical Care*
Professional services rendered by a physician or a professional other provider for the treatment of an illness or injury.

- AA. *Medical Emergency*
A medical emergency is a sudden and unexpected condition which requires immediate professional or hospital care or both 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.

- BB. *Medical Necessity*
1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
 - a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
 - b. Provides for the diagnosis, direct care and treatment of the Participant's condition, illness, disease or injury;
 - c. Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care;
 - d. Is not primarily for the convenience of the Participant, Physician or other Healthcare 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.

3. If the participant's request for coverage for a health care service or treatment is denied by Blue Cross Blue Shield of Wyoming as not being a medical necessity or on another similar basis, the participant has the right to have its decision reviewed by following the procedure outlined below. The participant also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her:

- a. **Internal Appeals:** All internal appeals for claim denials may be made by sending a letter requesting an internal review to Blue Cross Blue Shield of Wyoming, 4000 House Avenue, Cheyenne, WY 82003-2266 within thirty (30) days of the date the participant received the denial. The participant may provide Blue Cross Blue Shield of Wyoming with additional information that relates to his or her claim and may request copies of information that Blue Cross Blue Shield of Wyoming has that pertains to his or her claim. The participant may request that at least one (1) accredited medical consultant who is not an Employee of Blue Cross Blue Shield of Wyoming review his or her appeal if the claim was denied as not being medically necessary or on a similar basis.

Blue Cross Blue Shield of Wyoming will notify the participant of its decision in writing within thirty (30) days of receiving the appeal. If the participant does not receive the decision within the thirty (30) days allowed, the participant may be entitled to file a request for external review. The participant also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her. After having completed an internal review, the participant may have a right to an external review.

- b. **External Review:** If Blue Cross Blue Shield of Wyoming denies the participant's request for the provision of or payment for a health care service or course of treatment on the basis that it is not medically necessary or on another similar basis, the participant may have a right to have the decision reviewed by health care professionals who have no association with Blue Cross Blue Shield of Wyoming and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice. The participant also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her. The participant must submit a request for external review within sixty (60) days after receipt of this notice to Blue Cross Blue Shield of Wyoming's appeals office. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.
- c. **Expedited Review:** The participant may be entitled to an expedited review when his or her medical condition or circumstances require, and in any event within seventy-two (72) hours, where:
 - (1) The timeframe for the completion of a normal review would seriously jeopardize the participant's life or health or would jeopardize his or her ability to regain maximum function; or
 - (2) The participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

To request an external review or an expedited review, the participant must complete the REQUEST FORM and RELEASE OF RECORDS that accompanied his or her claims denial, together with the documents requested, including a health care professional's statement of medical necessity. The required fee must accompany the request. The participant's request must be received at Blue Cross Blue Shield of Wyoming, 4000 House Avenue, Cheyenne, WY 82003-2266 within sixty (60) days of the date on the Notice of Appeal Rights. The cost of the external review shall be the responsibility of Blue Cross Blue Shield of Wyoming.

CC. Mental Illness

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

DD. Other Provider

An entity other than a hospital or physician which is licensed where required, to render covered services. Other providers include, but are not limited to:

1. Alcoholism Treatment Center is a detoxification and/or rehabilitation facility licensed by Wyoming or another state to treat alcoholism.
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. Drug Abuse Treatment Facility is a facility other provider which is primarily engaged in providing detoxification and rehabilitation treatment for drug abuse.
4. 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.
5. 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.
6. 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.
7. 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.
8. Hospice is a facility that offers a coordinated program of home care for a terminally ill patient and the patient's family.
 9. Other medical facilities not specifically listed above.

EE. Outpatient

An enrolled child who receives services or supplies while not an inpatient.

FF. Pharmacy

Pharmacy means any licensed establishment where prescription legend drugs are dispensed by a licensed pharmacist. NOTE: A participating pharmacy is one which has entered into an agreement with Blue Cross Blue Shield of Wyoming.

GG. 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.

HH. PPO

A preferred provider organization.

II. 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 only as listed:

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 Assistants or Nurse Practitioners: Blue Cross Blue Shield of Wyoming will pay for covered patient care, as rendered by a physician assistant (including nurse practitioners) when the sponsoring physician does not see the patient or become directly involved in the medical service being provided.

A sponsoring physician is a licensed physician approved to sponsor a physician assistant by the State Board of Medical Examiners.

A 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.

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 an enrolled child that:

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

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

JJ. Public Institution

A public institution is a facility that incarcerates individuals who are involuntarily serving time for a criminal offense. Public institutions include state or federal prisons, jails, detention facilities, or other penal facilities. Public institutions in Wyoming include:

1. Wyoming State Penitentiary,
2. Wyoming Honor Conservation Camp or Wyoming Boot Camp
3. Wyoming Honor Farm
4. Wyoming Women's Center
5. Wyoming Boy's and Girl's School
6. Frontier Correctional Systems
7. Pioneer Home
8. City/County Jail Facilities

A facility is a public institution when it is under the responsibility of a governmental unit or when a governmental unit exercises administrative control.

KK. Rehabilitative Admissions

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

LL. Single Membership

A membership which covers one person (the enrolled child).

MM. Surgery

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

NN. Therapy Service

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

1. Radiation Therapy is the treatment of disease by X-ray, radium, or radioactive isotopes.
2. Chemotherapy is the treatment of malignant disease by chemical or biological antineoplastic agents.
3. Dialysis Treatments are the treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
4. Physical therapy is the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devised to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
5. Respiratory Therapy is the introduction of dry or moist gases into the lungs for treatment purposes.
6. Occupational Therapy is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
7. Speech Therapy is the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and development anomalies, or previous therapeutic processes.

Section III. Eligibility Regulations

Eligibility will be determined only by the Wyoming Department of Health, Kid Care CHIP. Please call the following phone number if you have questions regarding eligibility:

1-855-294-2127

Insurance through Kid Care CHIP is available to a child or adolescent who:

1. Is a United States citizen or a qualified alien and has lived in the United States for a minimum of five (5) consecutive years,
2. Is a Wyoming resident,
3. Is less than 19 years of age,
4. Is not eligible for EqualityCare (Medicaid),
5. Is not covered by health insurance and has not been covered by health insurance for one (1) month prior to Kid Care CHIP eligibility, except as provided in the NOTE section below,
6. Is not eligible to receive health insurance benefits under Wyoming's state employee benefit plan as a state employee or as the dependent of a state employee,
7. Is not residing in an institution for mental disease at the time of application to Kid Care CHIP,
8. Is not residing in a public correctional institution,
9. Has countable family income within the Kid Care CHIP income guidelines, and
10. Household composition is determined by how it will benefit the child or adolescent to be eligible for Kid Care CHIP.

NOTE: The following are not considered health insurance coverage under Kid Care CHIP guidelines when determining eligibility for #5 as listed above:

1. Accident-only insurance policies,
2. Indian Health Services (IHS),
3. EqualityCare (Medicaid),
4. School insurance purchased so children can participate in school-related activities,
5. Children's Special Health Services (CSH), and
6. Insurance for a specific illness (e.g. cancer) or a specific part of the body (e.g. vision or dental),

Once the child or adolescent has been determined eligible for Kid Care CHIP, eligibility will continue for twelve (12) months. The eligible child or adolescent may be taken off before the twelve (12) months of eligibility has been fulfilled if the individual either turns age 19, moves out of the state of Wyoming, is placed in a public institution, fails the quality control process or becomes eligible for certain EqualityCare (Medicaid) programs.

Section IV. Effective and Ending Dates

- A. *The Effective Date*
The effective date of coverage will be assigned by the Wyoming Department of Health.

- B. *When Coverage Under this Agreement Ends*
Coverage will be terminated according to guidelines determined by the Wyoming Department of Health. Should the enrolled child wish to maintain coverage beyond the termination date, special arrangements must be made in advance with Blue Cross Blue Shield of Wyoming.

- C. *Certificate of Creditable Coverage*
When coverage under this Agreement is terminated, Blue Cross Blue Shield of Wyoming will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the affected enrolled child. Certificates of Creditable Coverage may also be obtained from Blue Cross Blue Shield of Wyoming upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through Blue Cross Blue Shield of Wyoming.

Section V. How We Will Pay

Blue Cross Blue Shield of Wyoming will process claims and shall determine the payment and/or denial of those claims.

Your coverage pays benefits for allowable charges (subject to possible copayment provisions) as indicated on the Schedule of Benefits page, for service and supplies as shown in SECTION VI.

A. *Hospital*

Benefits for inpatient rooms, services, and supplies provided by Kid Care CHIP PPO hospitals are subject to Allowable Charges.

Pre-Admission Review

If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition), services must be submitted in advance to Blue Cross Blue Shield of Wyoming's Pre-Admission Review program.

A decision regarding hospitalization shall be reached in accordance with your medical needs no later than fourteen (14) days after the receipt of both the request for services and all additional documentation necessary to complete the review.

If pre-admission review of services with Blue Cross Blue Shield of Wyoming is obtained and an inpatient admission is determined to be necessary, the room allowance and ancillary services provided by the hospital or alcoholism treatment center are covered subject to the limitations and exclusions of this Agreement.

B. *Physician*

Benefits for services and supplies provided by Kid Care CHIP PPO physicians are subject to Allowable Charges.

Blue Cross Blue Shield of Wyoming Kid Care CHIP PPO providers have entered into an agreement with us to accept our Allowable Charge as the full allowance for individual covered procedures. Payment for services provided by Kid Care CHIP PPO providers will be made directly to the provider. If you choose a provider who does not take part in the Kid Care CHIP PPO network, no benefits are available under this Agreement and you will be responsible for all charges except in the case of a medical emergency.

Any specific service listed in Blue Cross Blue Shield of Wyoming's Allowable Charge fee schedules shall not be construed to extend coverage to any service not specified as a covered service.

If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming. See PRE-ADMISSION REVIEW under HOSPITAL above.

C. Payment Allowances Under This Coverage

As explained in SECTION VI. BENEFITS, a copayment may be required before some covered services can be provided. After you make any required copayment, we will then pay 100% of the allowable charge for covered services.

The total copayments for an individual family are limited to a maximum of 5% of your household's gross yearly income per enrollment year. Once this family maximum has been reached, no additional copayments will be required for any family member covered under Kid Care CHIP for the remainder of the enrollment year.

NOTE: American Indians and Alaskan Natives are exempt from all copayments of any type.

*See cost sharing information on page 1.

The total amount payable to or for an enrolled child, for covered medical expenses incurred by each enrolled child during his or her lifetime, will not exceed \$1,000,000. However, if an enrolled child is removed from Kid Care CHIP because the child no longer meets the eligibility requirements described in the section on ELIGIBILITY REGULATIONS, and then at a later date reapplies and is found eligible again, the total amount of benefits previously paid will be added to any additional benefits provided in determining whether the lifetime maximum has been met. If a child reaches their lifetime maximum, the child will be removed from the program at the end of that month. If the child reapplies at a later date, the child will not be eligible since he or she has met the lifetime maximum on benefits.

D. Calculation Of Out Of Area Payments

When an enrolled child obtains health care services through BlueCard® outside the geographic area that BCBSWY serves, the amount that Kid Care CHIP will pay for covered services is calculated on the lower of:

1. The billed charges for the covered services, or
2. The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Blue Cross Blue Shield of Wyoming.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the

actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount that Kid Care CHIP pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating the Participant's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard® method noted above in paragraph one of this section or require a surcharge, Blue Cross Blue Shield of Wyoming would then calculate the Kid Care CHIP liability for any covered health care services in accordance with the applicable state statute in effect at the time the child received the care.

E. Your Payment Responsibilities To Kid Care CHIP PPO Providers and Non-Kid Care CHIP PPO Providers

1. Kid Care CHIP PPO Providers - If you choose a Kid Care CHIP PPO professional, other provider or facility provider, we will pay them directly for covered services under all portions of your Subscription Agreement.
2. Non-Kid Care CHIP PPO Providers - If you choose a provider who does not take part in the Kid Care CHIP PPO, no benefits are available under this Agreement and you will be responsible to the provider of services for all charges except in the case of a medical emergency.

Section VI. Benefits

The following pages describe the various services and supplies that Blue Cross Blue Shield of Wyoming pays and to what extent these benefits are covered on an inpatient or outpatient basis by different types of providers.

BCBSWY complies with federal guidelines for Managed Care. Managed Care is a health care system that manages cost, utilization and quality of healthcare services. The goals of managed care include keeping children healthier and improving the quality of healthcare they receive. The services are provided to help keep your child healthy, not only to treat illnesses. Services like Early and Periodic, Screening, Treatment and Development (EPSDT) make sure any health problems are identified and treated as early as possible so that children live their healthiest lives.

Blue Cross Blue Shield of Wyoming pays only for services and supplies related to and required for the treatment of a specific illness or injury. All benefits are subject to “Section VII. What We Will Not Pay For – General Limitations and Exclusions,” in this Agreement, and “Section V. How We Will Pay.”

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

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

A. *Accidents*

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

BENEFITS -

Inpatient: See “Room Expenses and Ancillary Services.”

Outpatient: Covered when services are provided by a physician, hospital, or other facility.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

B. Ambulance Services

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

BENEFITS - The following professional ambulance services are covered only in the event of a medical emergency. 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 enrolled child’s home, nursing home, or skilled nursing facility in the same locale.

LIMITATIONS AND EXCLUSIONS -

1. Air Ambulance: In most cases, ground ambulance is the normally approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the enrolled child’s condition warrants air ambulance services under the terms of the Plan.
2. Other Transportation Services: We will not pay for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.
3. Patient Safety Requirement: If you could have been transported by automobile or public transportation without danger to your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

NOTE: We will not pay for ambulance charges for the convenience of the family or enrolled child. (Example: Transportation of an infant to be closer to the family's home.)

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

C. *Anesthesia Services*

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

BENEFITS -

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

Outpatient: Blue Cross Blue Shield of Wyoming will provide benefits if an enrolled child undergoes a surgical procedure as an outpatient.

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

LIMITATIONS AND EXCLUSIONS -

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

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

D. Blood Expenses

DEFINITION – “Blood” expenses include the following:

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

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

LIMITATIONS AND EXCLUSIONS -

General: The “limitations and exclusions” that apply to “Surgery” benefits also apply to blood expense.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

E. Consultations

DEFINITION - When requested by the physician in charge of your case, 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: We will pay for physician consultations.

Outpatient: We will pay for physician consultations.

Second Surgical Opinion: Blue Cross Blue Shield of Wyoming will pay for the physician’s services as well as for any charges for tests necessary for you to receive a second surgical opinion before undergoing any surgery. If possible, you should provide any test results taken by your physician when you obtain the second surgical opinion.

If the first and second opinions differ, Blue Cross Blue Shield of Wyoming will also provide for payment of covered expenses incurred if you seek a third opinion.

LIMITATIONS AND EXCLUSIONS -

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

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

F. Dental Services (Medical Benefits only)

DEFINITION – “Dental services” are those which are performed for treatment of conditions related to the teeth or structures supporting the teeth.

BENEFITS – In addition to the medical benefits described below, benefits for preventive dental care, dental fillings, and related services may be covered through the Delta Dental Plan of Wyoming. Please see benefit information furnished to you by Delta Dental for details.

Hospital:

Inpatient: If you are hospitalized for one of the following reasons, we will pay the Allowable Charges for the room and for covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES) provided by a hospital:

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

We will also pay the Allowable Charges for the room and for covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES) in a hospital if you have a hazardous medical condition (such as a heart condition) which makes it necessary for you to have an otherwise non-covered dental procedure performed in the hospital. (See “limitation” number 2 below.)

Outpatient: We will pay for services provided by a hospital or other facility for any one of the seven procedures listed above under “inpatient” benefits.

Physician:

Inpatient: We will pay for the seven procedures listed above under “inpatient” benefits when provided by a physician, dentist, or oral surgeon. The benefit allowance for surgery includes payment for pre-operative visits, local infiltration of anesthesia, and follow-up care.

Outpatient: We will pay for the seven procedures listed above under “inpatient” benefits when provided by a physician, dentist, or oral surgeon. The benefit allowance for surgery includes payment for pre-operative visits, local infiltration of anesthesia, and follow-up care.

LIMITATIONS AND EXCLUSIONS -

1. **Accidental Injury Benefits:** We will not pay for restoring the mouth, tooth, or jaw because of injuries from biting or chewing.

We will pay 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 enrolled child's effective date of membership.
 - 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. Related services must be performed within one year from the date of the accident.
 - f. All services must be performed while your coverage is in effect.
2. **Hazardous Medical Conditions:** If, due to a hazardous medical condition (e.g. a heart condition), you must be hospitalized for a non-covered dental procedure, you may receive benefits for inpatient hospital charges. Even if you do, however, benefits for the services provided by your dentist or oral surgeon will still be limited to those described above under "Dental Services."
 3. **Pre-Authorization:** Before inpatient benefits will be allowed for hazardous medical conditions, we must give written authorization of such benefits in advance of the date you are 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 admission will not be considered hazardous medical conditions. If your physician, dentist or oral surgeon needs to perform a dental procedure for non-dental reasons, benefits will be allowed only if written authorization is given by us in advance of the date services are performed.
 4. **Restorative Services:** Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances determined by us to be appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
 5. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
 6. No physician services are provided for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.

See "Section VII. What We Will Not Pay For – General Limitations and Exclusions."

G. *Diabetes Services*

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

BENEFITS -

Inpatient: Benefits include Allowable Charges for the room and covered ancillary services (see “Room Expenses and Ancillary Services”).

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

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

1. A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis, and
2. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition, or treatment. This additional training shall be limited to three (3) hours per year.

LIMITATIONS AND EXCLUSIONS -

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

H. Hearing Care

DEFINITION – “Hearing care” covers hearing exams, including newborn hearing screens in a hospital or outpatient setting.

BENEFITS –

We will pay for the assessment and diagnosis of hearing problems.

LIMITATIONS AND EXCLUSIONS –

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

I. Hemodialysis And Peritoneal Dialysis

DEFINITION – “Hemodialysis” is the treatment of a kidney disorder by removal of blood impurities with dialysis equipment.

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

BENEFITS –

Inpatient: Hemodialysis and peritoneal dialysis are covered when a physician treats you as an inpatient.

Outpatient: Hemodialysis and peritoneal dialysis are covered in the outpatient department of a hospital or other facility, or in your home. We will also pay for rental (but not to exceed the total cost of purchase) or at our option, the purchase of equipment when prescribed by a physician and required for therapeutic use.

LIMITATIONS AND EXCLUSIONS -

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

J. Home Health Care

DEFINITION – “Home health care” is medical care provided in the patient’s home in lieu of inpatient hospitalization.

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

1. You would have to be admitted to a hospital or skilled nursing facility if you did not receive home health care.
2. A plan for your home care must be sent in 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.
5. The program must begin within fourteen (14) days of discharge from the hospital or skilled nursing facility.
6. Prior approval by Blue Cross Blue Shield of Wyoming is required before benefits are payable.

BENEFITS -

Inpatient: Not covered.

Outpatient: We will pay only for the following services:

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

Benefits will NOT be 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 “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

K. Hospice Benefits

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

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

1. You must experience an illness for which the attending physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate, although curative care may continue during the hospice period.
3. The attending physician must refer you to the program and must be in agreement with the plan for treatment of your condition.
4. Prior approval by Blue Cross Blue Shield of Wyoming is required before benefits are payable.

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. Bereavement counseling sessions for covered family members during the twelve (12) months following the death of the terminally ill patient.

These hospice benefits are in place of all other benefits provided under any other part of the Agreement for the same services with the exception of curative care services.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

L. *Laboratory, Pathology, X-Ray, Radiology & MRI 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 “MRI” 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 - Blue Cross Blue Shield of Wyoming will pay for services provided by a hospital or other facility or by a physician, independent pathology laboratory, or independent radiology laboratory.

Pre-Admission Testing: Blue Cross Blue Shield of Wyoming will pay for pre-admission testing ordered by your surgeon leading up to surgery, if:

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

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

LIMITATIONS AND EXCLUSIONS -

1. Unrelated services: Services which are not related to a specific illness or injury are not covered.
2. Routine Examinations: Please see WELL CHILD AND ADOLESCENT CARE.
3. Weight Loss Programs: We will not pay for laboratory or X-ray services related to weight loss programs.
4. Venipuncture/Handling Fee: Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.

See SECTION VII., WHAT WE WILL NOT PAY FOR - GENERAL LIMITATIONS AND EXCLUSIONS

M. Maternity Care

DEFINITIONS –“Maternity” services are those required by female enrolled children for the diagnosis and care of a pregnancy, delivery of a child, pre-natal care, and family planning.

Delivery services include the following:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Termination of pregnancy when it is necessary to save the life of the mother or when the pregnancy itself is the result of rape or incest.
5. Ectopic pregnancies.

Pre-natal care includes obstetrical services provided prior to the delivery of a newborn.

Family planning is the regulation, by birth control methods, of the number of children that a woman will have.

NOTE: Under provisions of federal law, Blue Cross Blue Shield of Wyoming may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending physician and the mother.

BENEFITS -

Hospital:

Inpatient: Benefits include Allowable Charges for the room and covered ancillary services for the female enrolled child. See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: The following charges are covered for the female enrolled child:

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 a female enrolled child 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).

Pre-natal Care:

Inpatient and Outpatient: Approved pre-natal care is covered.

Family Planning:

Inpatient: Pre-pregnancy family planning services and prescribed supplies are covered.

Outpatient: Pre-pregnancy family planning services and prescribed supplies are covered. Birth control contraceptives are covered as described under PRESCRIPTION DRUGS AND MEDICINES.

NOTE: Please remember the baby is not covered at birth under Kid Care CHIP, only the eligible mother is covered. If you want coverage for the baby, you must apply immediately after the baby is born. Please call 1-855-294-2127 to request that an application be mailed to you. You do not have to wait until the baby is born to request an application.

EqualityCare has a Pregnant Woman's Program that covers an eligible pregnant mother during her pregnancy and her baby as soon as the child is born. Coverage for the baby continues for the child's first year of life. To learn more about the program or to see if you may be eligible, please call 1-855-294-2127.

LIMITATIONS AND EXCLUSIONS -

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

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

See "Section VII. What We Will Not Pay For – General Limitations and Exclusions."

N. *Medical Care For General Conditions*

DEFINITIONS – “Inpatient medical care” expenses are those billed by a physician for services provided while you are 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 facility for services provided in the physician’s office, the outpatient department of a hospital or other facility, or your home, for a condition which does not require surgery.

BENEFITS -

Hospital:

Inpatient: Benefits include Allowable Charges for the room and covered ancillary services (see “Room Expenses and Ancillary Services”).

If your physician recommends that you be hospitalized (for a non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's Pre-admission Review program. See Pre-Admission Review under “Section V. How We Will Pay.”

Outpatient: We will pay for medical care provided at a hospital or other facility when medically necessary.

Physician:

Inpatient: We will pay for care by a physician in a hospital for:

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

Inpatient medical care benefits will be payable for one physician per covered hospitalization. (See “Consultations” if more than one physician is involved.)

NOTE: If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's Pre-admission Review program. See Pre-Admission Review under “Section V. How We Will Pay.”

Outpatient: We will pay for medical care by a physician when required for the treatment of a specific illness or injury.

Spinal manipulations are covered to a maximum of \$250.00 per benefit year.

LIMITATIONS AND EXCLUSIONS -

1. Private Room Expenses: If you have a private room in a hospital, covered charges under your Agreement are limited to the Allowable Charges, 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 “Well Child and Adolescent Care” or when needed for sports, employment, or as required by a government authority.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

O. Medical Emergencies

DEFINITION – A “medical emergency” is a sudden and unexpected condition which requires immediate professional or hospital care or both 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 –

Inpatient and Outpatient: We will pay for medically necessary care received from both Kid Care CHIP providers and Non-Kid Care CHIP providers if the following rules are followed:

1. When in need of emergency care, the enrolled child should go to the nearest doctor or hospital.
2. Emergency care may be needed if the enrolled child’s condition is severe, if there is severe pain, or if there is immediate need of medical attention to prevent any of the following:
 - a. Serious jeopardy to health,
 - b. Serious damage to bodily functions, or
 - c. Serious damage to a bodily organ or part.
3. The above rules should also be followed if the enrolled child is out of state.

There is a copayment for emergency room visits (see information on pages 1-2) unless the visit results in an admission as an inpatient.

LIMITATIONS AND EXCLUSIONS

See “Section VII. What We Will Not Pay For – General Limitations And Exclusions.”

P. Mental Health or Substance Use Disorder Care

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

“Mental health benefits” means benefits with respect to services for mental health conditions as defined under the terms of this Subscription Agreement 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 Subscription Agreement 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 Participant 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 Participant’s home.

BENEFITS -

Inpatient:

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

Intensive Outpatient:

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

Other Outpatient or Office:

Benefits will be based on the Allowable Charges.

NOTE: Blue Cross Blue Shield of Wyoming Kid Care CHIP PPO Providers have agreed to accept Blue Cross Blue Shield of Wyoming’s Allowable Charges as payment in full and will not bill you for amounts that exceed Blue Cross Blue Shield of Wyoming’s Allowable Charges. If you choose a provider who does not take part in the Kid Care CHIP PPO network, no benefits are available under this Agreement and you will be responsible for all charges

LIMITATIONS AND EXCLUSIONS –

1. Institute for Mental Disease: Federal law prohibits coverage of a child in a facility which would be termed an institute for mental disease (IMD) under Medicaid regulations (42 CFR 435.1009). Upon entry into such a facility, the enrolled child will be terminated from coverage.
2. 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.
3. 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.
4. Educational Credits: Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Participant's education or training regardless of the diagnosis or symptoms that may be present.
5. Marital Counseling: Benefits will not be paid for marital counseling or related services.
6. Tobacco Dependency: Benefits will not be paid for services, supplies or drugs related to tobacco dependency.
7. 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 "Section VII. What We Will Not Pay For – General Limitations and Exclusions."

Q. Prescription Drugs And Medicines

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

Blue Cross Blue Shield of Wyoming may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain covered prescription drugs. Such discounts are the sole property of Blue Cross Blue Shield of Wyoming and will not be considered in calculating any enrolled child’s copayment or benefit maximums. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the plan.

BENEFITS

Prescription drugs and medicines are covered by RxCare Wyoming™ when purchased from a participating pharmacy. When you need a prescription filled, you should go to a participating pharmacy and present your membership card with the RxCare Wyoming™ logo. The participating pharmacy will only charge for your copayment as shown below. The pharmacy will be reimbursed for the remaining balance.

Benefits for prescription drugs and medicines purchased through a participating pharmacy are as follows:

1. Plan A: Exempt from all co-payments. Non-preferred brand drugs are not a benefit.
2. Plan B: The pharmacy out of pocket maximum per benefit year is \$100 per child. The copayment for generic prescriptions is \$3. The copayment for brand name prescriptions is \$5. Non-preferred brand prescriptions are not a benefit.
3. Plan C: The pharmacy out of pocket maximum per benefit year is \$200 per child. The copayment for generic prescriptions is \$5. The copayment for brand name prescriptions is \$10. Non-preferred brand prescriptions are not a benefit.
4. Insulin and diabetic supplies are considered to be covered under RxCare Wyoming™ benefits, as are medical foods for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exists.
5. The maximum amount or quantity of prescription drugs that will be considered as eligible charges may not exceed a thirty (30) day supply when taken in accordance with the direction of the prescriber.

Special Situations

If you must purchase drugs from a non-participating pharmacy or if you forget to present your membership card with the RxCare Wyoming™ logo, Blue Cross Blue Shield of Wyoming can provide you with special claim forms to obtain benefits under this section of your Agreement. The claim forms must be sent to the address indicated on the form. In these situations, you will be responsible for the difference between RxCare Wyoming's™ reimbursement to you and the actual charge made by the pharmacy. The claim forms can also be found on the Blue Cross Blue Shield of Wyoming website at <https://www.bcbswy.com/members/forms.html/>.

LIMITATIONS AND EXCLUSIONS -

1. Non-Preferred Drugs: There is no coverage for non-preferred brand drugs.
2. Non-Prescription Items: We will not cover drugs and medicines that can be purchased without a written prescription, even if the physician has prescribed such “over-the-counter” medications.
3. Take-Home Drugs: Drugs and medicines which are provided as “take-home supply” by the hospital are covered only under your Major Medical coverage.
4. Weight loss: Prescription drugs and medicines related to weight loss programs are not covered.
5. Hair Loss: Prescription drugs and medications related to hair loss are not covered.
6. Tobacco Dependency: Prescription drugs and medications related to tobacco dependency are not covered.
7. Cosmetic Drugs: Prescription drugs and medicines used for cosmetic purposes are not covered.
8. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins (except pre-natal vitamins) and food supplements (except as stated under BENEFITS item 1 above), is not covered.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

R. Rehabilitation

DEFINITION – “Rehabilitation” includes services for the purpose of restoring the child’s ability to live as normally as possible after a disabling injury or illness. A disabling injury or illness is defined as a cerebral vascular accident (stroke), head injury, spinal cord injury, or as required as the result of post-operative brain surgery.

BENEFITS -

Inpatient and Outpatient: A lifetime maximum of \$25,000 per enrolled child is covered. (See “Room Expenses And Ancillary Services”).

LIMITATIONS AND EXCLUSIONS –

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

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

S. *Room Expenses And Ancillary Services*

DEFINITION – “Room expenses” include such items as the cost of your room, general nursing services, meal services for yourself, 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 enrolled children when such services are provided for the treatment of the condition for which the enrolled child requires care. Such services include, but are not limited to:

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

BENEFITS -

Inpatient:

Pre-Admission Review: If your physician recommends that you be hospitalized (for any non-maternity or non-accidental condition), services must be submitted in advance to Blue Cross Blue Shield of Wyoming’s Pre-admission Review program. See Pre-admission Review under “Section V. How We Will Pay.”

For additional cost sharing information see pages 1-2.

Outpatient: Ancillary services billed by a hospital or other facility are covered. For additional outpatient benefits under your 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. Mental Health, Alcoholism, or Drug Abuse Care: All benefits for room expenses and ancillary services related to these special conditions are paid according to the section of this Agreement titled “Mental Health, Alcoholism, Or Drug Abuse Care.”
3. Personal or Convenience Items: We will not pay for services and supplies provided for personal convenience which are not related to the treatment of your condition. (Examples:

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

4. Skilled Nursing Facilities: Services or supplies provided by skilled nursing facilities, extended care facilities, or similar institutions are not covered except as described under Prudent Business Judgment in the “General Provisions” section of this Agreement.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

T. *Supplies, Equipment And Appliances*

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

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

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

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

BENEFITS -

1. Durable medical equipment - We will pay Allowable Charges for the rental or purchase of durable medical equipment, whichever is less expensive. When a purchase is authorized, we will also pay 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.
3. The following prosthesis and orthopedic appliances are covered, as well as fitting, adjusting, repairing, and replacement due to wear or a change in your condition that 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 your physician recommends a change in prescription.
5. Oxygen - We will pay for oxygen and the equipment needed to administer it.

LIMITATIONS AND EXCLUSIONS -

1. **Deluxe or Luxury Items:** If the supply, equipment, or appliance you order includes more features than you need for your condition, we will allow only up to the Allowable Charges for the item that would have met your medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair “sidecars.”)

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

2. **Durable Medical Equipment:** Items such as air conditioners, purifiers, humidifiers, dehumidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical condition.
3. **Hospital Beds:** We will not pay for hospital beds (including waterbeds or other floatation mattresses).
4. **Medical Supplies:** Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics.)
5. **Allowable Charges:** Benefits for all supplies, equipment, and appliances are limited to the Allowable Charges.
6. **Special Braces:** We will not pay for special braces or special equipment.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

U. Surgery

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

BENEFITS -

Hospital:

Inpatient: Benefits include Allowable Charges for the room and covered ancillary services (see “Room Expenses And Ancillary Services”).

If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming’s Pre-admission Review program. See Pre-admission Review under “Section V. How We Will Pay.”

Outpatient: Blue Cross Blue Shield of Wyoming will provide benefits for services performed in a physician’s office, ambulatory surgical facility, or outpatient department of a hospital.

Physician:

Inpatient: The benefit allowance for surgery performed by a physician includes payment for pre-operative visits, local administration of anesthesia, follow-up care and recasting.

If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition), services must be submitted in advance to Blue Cross Blue Shield of Wyoming’s Pre-admission Review Program. See Pre-admission Review under “Section V. How We Will Pay.”

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

Outpatient: Blue Cross Blue Shield of Wyoming will provide benefits for services performed in a physician’s office, ambulatory surgical facility, or outpatient department of a hospital.

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 as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic surgery must have occurred after the enrolled child's original membership effective date, and continuous coverage must be maintained from the date of birth, accident or disease treatment. We 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 enrolled child 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. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.
3. Dental Surgery: For a complete description of benefits allowed for dental services, see "Dental Services."
 4. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the main surgery. Additional benefits are not allowed for these procedures.
 5. Obesity and Weight Loss: We will not pay for the treatment of obesity or for weight loss programs.
 6. Organ Transplants: We will not pay for organ or tissue transplants.
 7. Private Room Expenses: If you have a private room in a hospital, covered charges are limited to the semi-private room allowance, whether or not a semi-private room is available.
 8. Sex-Change Operations: We will not pay for sex change operations, or related expenses.
 9. Sterilization Procedures: Such surgeries and related expenses will be covered. Reversals of sterilization procedures are not covered.

See "Section VII. What We Will Not Pay For – General Limitations and Exclusions."

V. *Surgical Assistants*

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

BENEFITS -

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

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

NOTE: Benefits for surgical assistant services performed by another physician will be based on 20% of the Allowable Charge. Benefits for services performed by a physician's assistant or registered nurse will be based on 10% of the Allowable Charge.

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 “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

W. Therapies

DEFINITIONS – “Chemotherapy” is drug therapy administered as treatment for malignant conditions of certain body systems.

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

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

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

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

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

BENEFITS -

Hospital:

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

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

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

1. Chemotherapy (drug and administration charges) 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

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 for malignant conditions.
2. Radiation therapy.
3. Respiratory therapy.

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

1. Chemotherapy (drug and administration charges) for malignant conditions.
2. Radiation therapy.
3. Physical therapy provided by a physician or by a registered physical therapist
4. Respiratory therapy.
5. Occupational therapy
6. Speech therapy

LIMITATIONS AND EXCLUSIONS -

1. Prior Authorization: No benefits are available for speech therapy or occupational therapy without prior written authorization from Blue Cross Blue Shield of Wyoming.
2. Physical, Speech, and Occupational therapy: The combined annual benefits for physical, speech, and occupational therapy are limited to a maximum of \$750 per enrolled child.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

X. *Vision Care*

DEFINITIONS – “Vision Care” expenses are those billed by a physician or other professional provider for the routine care of the eye and the prescribing of corrective lenses.

BENEFITS

1. Vision Examinations: We will pay for one vision exam for each enrolled child during each benefit year.
2. Frames: We will pay for one frame for each enrolled child up to a maximum of \$100 during each benefit year. Includes directly related provider services for use (e.g. facial measurements, determination of interpupillary distances, assistance in frame selection, fitting and adjustment). If the cost of the frame is more than \$100, the subscriber will be responsible for the additional cost.
3. Lenses: We will pay for one pair of lenses (except in the case of a change in prescription) for each subscriber during each benefit year.
4. Contact Lenses: We will pay up to a maximum of \$100 during each benefit year for each enrolled child for a contact lens exam (fitting and evaluation) and the contact lenses. If the cost of these services is more than \$100, the subscriber will be responsible for the additional cost. NOTE: Children may have only glasses OR contacts. Kid Care CHIP will not pay for both.

LIMITATIONS AND EXCLUSIONS

1. EYE CARE - Services for the conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia, and presbyopia will be covered only as described under BENEFITS above. In addition, benefits for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, the servicing of corrective lenses, and consultations related to such services will also be limited only to those benefits, if any, described above.
2. Prescription Sunglasses, Oversized, Photosensitive or Anti-Reflective Lenses: Will not be covered if the charge exceeds the Schedule of Benefits for lenses as defined.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

Y. *Well Child and Adolescent Care*

DEFINITION – “Well Child and Adolescent Care” services are physician-delivered or physician-supervised outpatient services for the enrolled child.

BENEFITS - We will pay for the following services only at 100% of the Allowable Charges without regard to any copayment

1. Periodic examinations which include a history, physical examination, developmental assessment, and anticipated guidance necessary to monitor the normal growth and development of the child.
2. Oral and/or intramuscular injections for the purpose of immunizations.
3. Laboratory tests.

The above services must conform with the recommendations of the American Academy of Pediatrics and Bright Futures as shown in the most current publication. Services will be available when the child exceeds the following ages:

1 month	12 months	48 months
2 months	15 months	60 months
4 months	18 months	72 months
6 months	24 months	
9 months	36 months	

LIMITATIONS AND EXCLUSIONS

1. Eye Care and Dental Services: Please see section in this Agreement on VISION CARE. In addition, certain dental benefits are provided in this Agreement under DENTAL SERVICES and other benefits may be covered through the Delta Dental Plan of Wyoming.

See “Section VII. What We Will Not Pay For – General Limitations and Exclusions.”

Section VII. What We Will Not Pay For – General Limitations And Exclusions

The general limitations and exclusions listed in this section apply to all benefits described in this Agreement. In accordance with the provisions of this Agreement, we will not pay for any of the following services, supplies, situations, hospitalizations or related expenses. These are the responsibility of the parent to pay for.

- A. *Acupuncture*
Services related to acupuncture, whether for medical or anesthesia purposes are not covered.
- B. *Alternative Medicine*
Treatments and services for alternative medicine are not covered benefits under this Agreement. Alternative medical therapies include, but are not limited to: interventions, services or procedures not commonly accepted as part of allopathic or osteopathic curriculums and practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, massage therapy, and aromatherapy.
- C. *Artificial Conception*
Artificial insemination, “test tube” fertilization or other artificial methods of conception are not covered.
- D. *Autopsies*
Services related to autopsies are not covered.
- E. *Biofeedback*
Services related to biofeedback are not covered.
- F. *Cardiac Rehabilitation*
Services designed to assist enrolled children recovering from recent heart problems are not covered.
- G. *Complications Of Non-benefit Services*
Services or supplies that you receive for complications resulting from services that are not allowed (such as non-covered cosmetic surgery and experimental procedures) are not covered.
- H. *Convalescent Care*
Convalescent care is that care provided during the period of recovery from illness or the effects of injury and surgery. Benefits for convalescent care are limited to those normally received for a specific condition.
- I. *Cosmetic Surgery*
Cosmetic Surgery: “Cosmetic surgery” is beautification or aesthetic surgery to improve an individual’s appearance by surgical alteration of a physical characteristic. Cosmetic

surgery does not become reconstructive surgery because of psychiatric or psychological reasons.

Benefits for a cosmetic surgery procedure and related expenses are allowed only when reconstructive surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive surgery will only be provided for the diseased body part except as noted below. The situation requiring cosmetic surgery must have occurred after the enrolled child's original membership effective date, and continuous coverage must be maintained from the date of birth, accident or disease treatment. We 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 enrolled child who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

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

J. Custodial Care

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

K. Diagnostic Admissions

If you are admitted as an inpatient to a hospital for diagnostic procedures, and could have received these services as an outpatient without danger to your health, we will not pay for hospital room charges or other charges that would not be paid if you have received diagnostic services as an outpatient.

L. Domiciliary Care

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

M. Educational Programs

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

N. Environmental Medicine

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

O. Experimental Or Investigational Procedures

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

P. Eye Care

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

Q. 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.

R. Genetic And Chromosomal Testing/Counseling

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

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

S. 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, 2003, or comparable peer review programs, and the operation of the institution is subject to review according to Federal and State laws.

- T. *Hair Loss*
Wigs or artificial hairpieces, or hair transplants or implants, regardless of whether there is a medical reason for hair loss, are not covered.
- U. *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.
- V. *Hypnosis*
Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.
- W. *Learning Disabilities*
Treatment for the reduction or elimination of learning disabilities is not covered.
- X. *Legal Payment Obligations*
Services for which legally you do not have to pay, or charges that are made only because benefits are available under this Agreement are not covered except as required by the federal, state, or local government. This includes services provided by any person related to you or residing in your household.
- Y. *Managed Care Provisions*
Coverage is subject to all pre-admission review, precertification and medical management policies of Blue Cross Blue Shield of Wyoming. Failure by either the provider of services or the participant to comply with such provisions may reduce or eliminate coverage in whole or in part.
- Z. *Medical Services Received As A Result Of Contractual Obligations Or A Third Party's Guarantee To Pay*
Benefits will not be paid for any claims related to medical services or supplies that an enrolled child 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 enrolled child 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 enrolled child 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 enrolled child's agreement to seek or receive such medical services or supplies.
- AA. *Medically Necessary Services Or Supplies*
No benefits will be provided for services or supplies that are not medically necessary as defined by Blue Cross Blue Shield of Wyoming and/or our consultants. (See SECTION II. DEFINITIONS.)

BB. *Military Boot Camps and Recreational Facilities*

Coverage is not provided for military boot camps or recreational facilities, even if therapy is included.

CC. *Obesity And Weight Loss*

Obesity in itself is not considered an illness or disease, and benefits are not allowed for the evaluation and treatment of obesity.

DD. *Orthognathic Surgery*

The following types of procedures are not covered:

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

Whether caused by birth defect, facial deformities, cleft palate, cleft palate disease or otherwise, except in the case of an infant covered by us from birth or restoration due to accidental injury occurring while continuously covered. We must give written authorization for orthognathic surgery benefits in advance of the date of service.

EE. *Personal Comfort Or Convenience*

Services and supplies that are primarily for your personal comfort or convenience are not covered.

FF. *Pre-admission Review*

If your physician recommends that you be hospitalized (for any non-maternity or non-emergency condition) services MUST be submitted in advance to Blue Cross Blue Shield of Wyoming's Pre-admission Review program.

A decision regarding hospitalization shall be reached in accordance with your medical needs, but in no event more than fourteen (14) days after the receipt of the request for services and all additional documentation necessary to complete the review.

GG. *Pre-certification*

The following services must be authorized for payment in advance before benefits will be paid:

1. Cosmetic surgery.
2. Dental-related services.
3. Home Health Care.
4. Hospice Care.
5. Breast reconstruction surgery.
6. Occupational therapy.
7. Speech therapy.

HH. Private Duty Nursing

We will not pay for private duty nursing.

II. 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 enrolled children selected to take part are randomized, with some enrolled children receiving the prescribed drugs, treatment, technologies, services, or procedures, and other enrolled children 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.

JJ. Prophylaxis/Prophylactic Medicine

Except as explicitly described elsewhere in this Agreement, medical benefits and treatment that are of a preventive or prophylactic nature are not covered services under this Agreement. 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.

KK. Radial Keratotomy And Related Procedures

We will not pay for radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

LL. Report Preparation

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

MM. Routine Physicals

Services connected with routine physical or screening exams and immunizations are not covered except as described in "Well Child and Adolescent Care" or when needed for sports, employment, or as required by a government authority. (Examples of services not covered: yearly physicals, screening examinations for school, camp, or other activities.)

- NN. Services After Coverage Ends*
No benefits are provided after the coverage is cancelled. (EXAMPLE: If the enrolled child is taken ill and hospitalized on July 30th and the enrolled child cancelled coverage effective August 1st, no benefits are provided for any services received on or after August 1st.)
- OO. Services Not Identified*
Any service or supply not specifically identified as a benefit in this Agreement are not covered.
- PP. Services Prior To The Effective Date*
Charges incurred for supplies and services received prior to the effective date of coverage are not covered.
- QQ. Services While Incarcerated*
We will not provide benefits for an enrolled child incarcerated in any public institution. The enrolled child is excluded from coverage only if he/she meets the definition of an inmate of a public institution as defined at 42 CFR 435.1009.
- RR. Sex Change Operations*
Services related to sex change operations and reversals of such procedures are not covered.
- SS. 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.
- TT. Taxes*
Sales, service, mailing charges or other taxes imposed by law that apply to benefits covered under this Agreement are not covered.
- UU. Temporomandibular Joint Dysfunction (TMJ)*
Benefits are not provided for the treatment of temporomandibular joint disorders and myofascial pain-dysfunction syndrome.
- VV. Therapies*
Special therapies not specifically covered in this Agreement. 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.
- WW. Tobacco Dependency*
We will not pay for services, supplies or drugs related to tobacco dependency.

- XX. Transplants*
We will not pay for organ and tissue transplants.
- YY. Travel Expenses*
Except where specifically indicated, travel expenses for you or your physician are not covered.
- ZZ. Unrelated Services*
Services which are not related to a specific illness or injury are not covered.
- AAA. War*
Services or supplies required as the result of disease or injuries due to war, civil war, insurrection, rebellion, or revolution are not covered.
- BBB. Weight Loss Programs*
Services and supplies related to weight loss programs are not covered.
- CCC. Workers' Compensation*
Services or supplies resulting from a work-related illness or injury, compensation for which is available, in whole or in part, under the provisions of any legislation of any governmental unit, are not covered. See SECTION VIII. for further information.

Section VIII. General Provisions

The following general provisions apply to all benefits described in this Agreement:

A. *Acceptance of This Agreement*

1. Acceptance of the application for membership and payment for the first month's dues shall constitute acceptance of the Agreement, and all of its provisions, terms and conditions by the Plan and the applicant.
2. This Agreement supersedes and renders null and void any and all previous agreements between the Plan and the subscriber to which this Agreement is issued.

B. *Change to the Agreement*

We cannot change this Agreement except through a written endorsement signed by an officer of Blue Cross Blue Shield of Wyoming fifteen (15) days before an endorsement becomes effective. After this, the endorsement becomes part of the Agreement.

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

C. *Claim Forms*

The Plan, upon receipt of a notice of claim, shall furnish to the claimant such forms as are usually furnished by it for filing evidence of loss. If such forms are not furnished within fifteen (15) days of the filing of such notice, the claimant shall be deemed to have complied with the requirements of the Agreement as to notice of loss upon submitting, within the time fixed in the Agreement for filing notice of claim, written proof covering the occurrence, the character and extent of this loss for which claim is made.

D. *Coordination of Benefits*

Coverage under this Agreement will always be secondary to any other coverage that may apply.

E. *Contesting Agreement Validity*

No misstatements, except fraudulent misstatements made by the applicant in the application for the policy, shall be used to void the policy, or to deny a claim for loss incurred or disability, as defined in the Agreement.

F. *Disclaimer of Liability*

We have no control over any diagnosis, treatment, care, or other service provided to an enrolled child by any facility or professional provider, and are not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

G. *Disclosure of Your Medical Information*

All Protected Health Information (PHI) maintained by Blue Cross Blue Shield of Wyoming under this Agreement is confidential. Any PHI about an enrolled child under the

Agreement obtained by Blue Cross Blue Shield of Wyoming from that enrolled child or from a Health Care Provider may not be disclosed to any person except:

1. Upon a written, dated, and signed authorization by the enrolled child 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 enrolled child 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 enrolled child and Blue Cross Blue Shield of Wyoming in which the PHI is pertinent.

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

H. Execution of Papers

On behalf of the enrolled child, he must, upon request, execute and deliver any instruments and papers to us that are necessary to carry out the provisions of this Agreement.

I. Independent Corporation

The Wyoming Department of Health hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Department and Blue Cross Blue Shield of Wyoming, that Blue Cross Blue Shield of Wyoming is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the Association permitting Blue Cross Blue Shield of Wyoming to use the Blue Cross Blue Shield of Wyoming Service Mark in the State of Wyoming, and that Blue Cross Blue Shield of Wyoming is not contracting as the agent of the Association.

The Wyoming Department of Health further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross Blue Shield of Wyoming and that no person, entity, or organization other than Blue Cross Blue Shield of Wyoming shall be held accountable or liable to the Department for any of Blue Cross Blue Shield of Wyoming's obligations to the Department of Health created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross Blue Shield of Wyoming other than those obligations created under other provisions of this agreement.

J. Issuance, Assignment of Benefit

The Plan will issue to the applicant an Agreement and Schedule of Benefits. All benefits

stated in this Agreement are personal to the enrolled child. Neither those benefits nor our payments to the enrolled child may be assigned to any person, corporation, or entity. Any attempted assignment shall be void.

K. Limitation of Actions

No legal action may be taken to recover benefits until the appeals procedure has been exhausted within sixty (60) days after notice of claims has been given as specified above, and no such action may be taken later than three years after the expiration of the time within notice of claim is required by this Agreement.

L. Notice of Claim

1. The Plan will not be liable under this Agreement unless proper notice is furnished to the Plan that covered services have been rendered to an enrolled child. Written notice must be given sixty (60) days after completion of the covered services. The notice must include the data necessary for the Plan to determine benefits. An expense will be considered incurred on the date the service or supply was rendered.
2. Failure to give notice to the Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible.

M. Payment in Error

If we make a payment in error, we may require the provider of services, the applicant, or the ineligible person to refund the amount paid in error. We reserve the right to correct payments made in error by deducting against subsequent claims or by taking legal action, if necessary.

N. Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably be required during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

O. Proofs of Claim

Proof of claim must be furnished to the Plan at its offices at 4000 House Avenue, Cheyenne, Wyoming 82003-2266, in case of claim for loss which the Agreement provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Plan is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

P. Prudent Business Judgment

We may, in a responsible manner, use prudent business judgment which from time to time results in the administration of limited exceptions to the contractual provisions of this Agreement. Such decisions will be made only after establishing the cost-effectiveness of medically necessary services performed on behalf of an enrolled child, and with the

agreement of the affected enrolled child.

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

Q. Reserve Funds

No enrolled child is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by our Board of Directors.

R. Selection of Doctor

Any enrolled child shall be free to select his doctor and his hospital from the approved list of Kid Care CHIP PPO providers. We make no guarantee as to the availability of a doctor or hospital. Our responsibility shall be solely to make payment for the benefits described in this Agreement.

S. Sending Notices

All notices to the enrolled child are considered to be sent to and received by the enrolled child when deposited in the United States Mail with postage prepaid and addressed to the enrolled child at the latest address appearing on our membership records.

T. Statements and Representations

All statements contained in a written application or other written document or instrument made by the applicant to obtain this Agreement, shall be considered representations and not warranties. No such statement shall be used in defense of a claim under this Agreement, unless such statement is a misrepresentation, omission, concealment of facts or otherwise incorrect statement, which is either fraudulent or pertains to the acceptance or issuance of the Agreement. If the true facts had been known to the Plan, the Plan would not have in good faith:

1. Entered in the Agreement or issued the membership, or
2. Have provided coverage with respect to the condition resulting in the loss that is the basis for a claim under this Agreement.

U. Subrogation

For all benefits provided or paid under this Agreement, the Plan shall be subrogated and succeed to any rights of recovery of an enrolled child for expenses incurred against any person or organization. The enrolled child shall take action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interests of the Plan under this Agreement. The enrolled child shall pay the Plan all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of benefits provided or paid under this Agreement.

V. Enrolled Child's Legal Obligations

The applicant is liable for any actions which may prejudice our rights under this

Agreement. If we must take legal action to uphold our rights, then we can require the enrolled child to pay our 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.

W. *Term*

The term of this Agreement shall be one (1) year from its effective date. All services shall be completed during this term. There is no right or expectation of renewal and any renewal will be determined by the Wyoming Department of Health.

X. *Time of Payment of Claim*

Benefits payable under this Agreement for any loss, other than loss for which this Agreement provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss.

Y. *Workers' Compensation*

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

Z. *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. Blue Cross Blue Shield of Wyoming will not be liable under this Agreement unless proper notice (proof) is furnished to Blue Cross Blue Shield of Wyoming that covered services have been rendered to a participant. Written notice must be given within one (1) year after completion of service that is a covered benefit of this Agreement. 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.

Section IX. How To File A Claim Or Appeal

A. How to File a Claim

Insurance Card

The enrolled child's Blue Cross Blue Shield of Wyoming insurance card indicates the type of coverage the enrolled child has. The enrolled child should:

1. Always carry the insurance card and present it to the hospital or physician whenever the enrolled child receives treatment.
2. If the enrolled child changes coverage, we will send a new card, at which time the old card should be destroyed.
3. If the card is lost, a replacement card can be obtained by calling Blue Cross Blue Shield of Wyoming at 1-800-209-9720 or Delta Dental at 1-800-735-3379.

B. When The Enrolled Child Enters A Kid Care CHIP PPO Hospital As A Bed Patient

The enrolled child should present the insurance card when admitted. Kid Care CHIP PPO hospitals will bill Blue Cross Blue Shield of Wyoming for services provided to the enrolled child. The hospital will notify this office of the admission. Payment for covered services will be made directly to the hospital and the enrolled child will receive an explanation of benefits that will indicate which services we paid for and which services were not paid for in accordance with this health insurance agreement. For services that were not paid for because of the limitations or conditions of the agreement, the reason(s) for not paying for these services will be given on the explanation of benefits.

C. Special Situations

If the enrolled child is hospitalized in a PPO hospital outside the State of Wyoming, all charges for services that are covered by the terms of the health insurance agreement will be paid directly to the hospital by the local Blue Cross plan in the state where medical services were provided.

If the enrolled child receives treatment on an outpatient basis outside of the State of Wyoming, or the United States, benefits will be provided for services received that are covered by the terms of the health insurance agreement. It may be necessary for the enrolled child to pay for the treatment and submit the billing to Blue Cross Blue Shield of Wyoming for reimbursement. Itemized bills from the provider of services must be forwarded to us in a timely manner and must include the patient's name, date of birth, date(s) of service, type of service, diagnosis and group and agreement numbers that are found on the enrolled child's insurance card.

If the enrolled child is not certain of which services are covered by the terms of the health insurance agreement, it is important to refer to and read carefully this Agreement.

D. When the Enrolled Child Sees a Physician

A Kid Care CHIP PPO physician submits claims directly to us and payment for services that are covered by the terms of the health insurance agreement are made directly to the physician.

No benefits are available for services received from a physician who does not take part in the Kid Care CHIP PPO network except in the case of a medical emergency.

E. Claims Review Procedure

If you do not agree with a decision made by BCBSWY, you may contact them to ask questions or ask for a review of a decision. You may file a written appeal by sending your request to:

BLUE CROSS BLUE SHIELD OF WYOMING
Member Services Department
P. O. Box 2266
Cheyenne, Wyoming 82003

You will receive a response to your internal appeal within thirty (30) days of receipt.

If, within forty-five (45) days of receiving a letter about a decision and you are not satisfied with the response you receive, you may appeal the decision in writing by sending your complaint to the address below:

Kid Care CHIP
Fair Hearings
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002

If you are not satisfied with Blue Cross Blue Shield of Wyoming's decision, you may appeal the decision. Within forty-five (45) days of receiving a letter about Blue Cross Blue Shield of Wyoming's decision, you may write your grievance and mail it to the address below:

Wyoming Insurance Department
106 E 6th Ave
Cheyenne, WY 82002

F. Answers to Questions or Complaints

If there are questions or if you have a complaint about any of the benefits associated with the health insurance agreement or about rights under the Agreement, Blue Cross Blue Shield of Wyoming should be contacted at 1-800-209-9720.

IN WITNESS WHEREOF, this Agreement is executed by the Plan through its duly authorized officer, undersigned, to take effect 12:01 a.m. Mountain Time on the date of issue set forth on the face of this Agreement.

A handwritten signature in black ink, appearing to read "R Schum". The signature is fluid and cursive, with the first letter "R" being particularly large and stylized.

Rick Schum, President