winhealth

Plan Well, Live Healthy

Individual Health Plan Evidence of Coverage

Effective January 1, 2014

This Evidence of Coverage includes all comprehensive adult wellness benefits as defined in Wyoming Statute 26-18-103(b). For more information about the comprehensive adult wellness benefits, see *Preventive Services,* Section 6, Part 1, of this Evidence of Coverage.

WINHEALTH PARTNERS
MEMBER RIGHTS AND RESPONSIBILITIES

As a participant in a WINhealth Partners health plan, you have the right to receive certain information and services from both WINhealth and the health care professionals who care for you. In addition, you have certain responsibilities to ensure that you receive prompt, accurate care and maximize your health plan benefits. Below is a summary of your rights and responsibilities as a WINhealth member. Additional details and information may be found in the health plan policy applicable to your current benefit plan.

YOU HAVE A RIGHT TO:

1. **Information**
   - Receive information about the WINhealth organization, its services, and its providers.
   - Obtain current information about services that are covered and are not covered by your plan.
   - Receive a prompt reply to questions or requests you submit to WINhealth.
   - Have your personal health information kept private and secure.
   - Receive information about your rights and responsibilities as a WINhealth member.

2. **Quality Care**
   - Be treated with respect and recognition of your dignity and privacy.
   - Actively participate with your health care providers in making decisions about your care, engaging in open and honest discussions concerning appropriate treatment options, regardless of cost or benefits coverage.
   - Know that WINhealth does not restrict dialogue between you and your health care providers. Network providers are not employed by WINhealth, and WINhealth does not direct or control recommendations for care made by providers or restrict communication regarding treatment options.

3. **Communicate**
   - Contact WINhealth through the online portal, https://winhealth.healthtrioconnect.com, or by calling the Member Services department, 307-773-1330
     - if you do not understand how to use your plan benefits;
     - to receive an explanation about how a claim was processed;
     - for updated information on deductible, copayment, and coinsurance amounts.
   - Share complaints or file appeals with WINhealth regarding decisions made or actions taken affecting your benefits.
   - Make recommendations to WINhealth regarding this Member Rights and Responsibilities policy.

YOU HAVE A RESPONSIBILITY TO:

1. **Provide Information**
   - Notify WINhealth of changes in your telephone number, physical or email addresses, or other contact information in order to ensure timely communication regarding plan benefits and covered care.
   - Contact WINhealth through the online portal, https://winhealth.healthtrioconnect.com, or by calling the Member Services department, 307-773-1330, if you do not understand how to use your plan benefits.
   - Present your WINhealth identification card and all necessary copayments at the time of receiving care.
   - Give accurate and complete information to health care providers and representatives of WINhealth when discussing care.

2. **Follow Instructions**
   - Read your WINhealth Policy and understand your benefits, including applicable deductibles, copayments and coinsurance amounts, covered services, and excluded services.
   - Obtain preauthorization as required for inpatient care and out-of-network treatment prior to receiving those services.
   - Follow your physicians' plans and instructions for care as discussed with your physicians.

3. **Exercise Your Rights**
   - Although WINhealth does not require it, you may select a primary care physician from WINhealth's network and participate in an ongoing patient-physician relationship concerning your care.
   - Understand your health issues and participate with your provider and WINhealth in identifying and developing treatment plans.
   - Follow the directions and advice you have received and agreed upon with your physicians.
   - Promptly follow WINhealth's procedure for complaints and appeals, if you feel they are warranted.
   - Treat all WINhealth staff with courtesy and respect.

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SECTION 1

GENERAL PLAN INFORMATION

The following Individual Health Plan Evidence of Coverage (the "EOC" or "Policy") explains the Covered Services to which you are entitled as a Member of the WINhealth Plan. If you have enrolled your Spouse or any Children for Coverage under the WINhealth Plan, this Evidence of Coverage also explains the Covered Services available to them.

You should read this Evidence of Coverage carefully and give special attention to the descriptions of Covered Services that are available to you, the procedures you must follow to obtain those Covered Services, and the procedures you must follow to make a claim for benefits. You should particularly note the circumstances under which your Plan benefits may be limited or excluded.

Your responsibilities as an enrolled Member under the Plan are carefully described in this document. You should consult this Evidence of Coverage to ensure that you understand your role in obtaining Plan benefits.

PAYMENT FOR COVERED SERVICES

You are responsible for sending to WINhealth the monthly Premium that must be paid for each Enrolled Member (or for each family unit).

PARTICIPATING PROVIDER NETWORK

The Plan utilizes an integrated health care delivery network that includes Physicians, Hospitals, allied health and ancillary service providers. You gain access to the network and its benefits by selecting a contracted network provider from the Participating Provider Directory. You can find a Participating Provider through the WINConnect Portal by clicking the "Find a Provider" button on the home page. This tool allows you to search for a clinician, a facility, or a pharmacy. You may search by the providers name or specialty, or for a provider within a specified distance from an address you provide. The Plan strongly encourages a long-term primary relationship with a Physician or Physicians who understand the particular health needs of each patient and can help coordinate your care within the WINhealth network.

WINhealth's network is Open Access, which means that the Plan does not require that you choose a Primary Care Provider in order to obtain referrals to see Specialist Providers. Using the "Find a Provider" tool on the WINConnect Portal, you can find a Specialist Provider then make an appointment directly with that Specialist. However, as a Health Maintenance Organization (HMO), WINhealth believes that using a Primary Care Provider enhances a Member's ability to receive the best care possible. As such, WINhealth requires a higher copayment when a Member sees a Specialist Provider.

The following criteria will be used to determine if the Primary Care Provider or Specialist Provider copayment applies:
The following providers will be considered Primary Care Providers:

- Family Practice Physicians
- General Practice Physicians
- Pediatricians

OB-GYN
Internal Medicine Physicians
Nurse Practitioners
Physician Assistants

The following providers will be considered Specialist Providers. A nurse practitioner or physician's assistant working in a specialty clinic (such as dermatology, neurology, or cardiology) will be considered a Specialist Provider for copayment purposes. Any Physician, nurse practitioner or physician's assistant not listed above as a Primary Care Provider will be considered a Specialist Provider.

Behavioral Healthcare Providers and Substance Abuse Treatment Providers are Specialist Providers who do not provide traditional primary care. However, in order to ensure parity between coverage of physical and behavioral health issues, the lower, primary care copayment is applied to services provided by these providers.

OUT-OF-NETWORK BENEFITS

Out-of-Network providers are Hospitals, Physicians, and ancillary providers who are not part of the WINhealth network of providers. Out-of-Network providers have no contractual obligation to adhere to WINhealth policies and reimbursement schedules; therefore, you will incur additional costs when you see an Out-of-Network provider. In order to avoid unexpected additional costs associated with Out-of-Network providers, you should verify that all services recommended or ordered by a Participating Provider, such as surgical assistants or anesthesiology, are also provided by Participating Providers. You should keep in mind that your annual deductible and Out-of-Pocket limits are doubled for services rendered by Out-of-Network providers. All services rendered outside of the United States are out-of-network services. Emergency services outside of the United States will be covered. We ask that you notify WINhealth of the emergency healthcare services within forty-eight (48) hours. Non-emergent services provided outside of the United States will be covered as out-of-network benefits and require preauthorization. Such services will include only those benefits that would be covered in-network inside the United States.

OBTAINING COVERED SERVICES

You may generally obtain Covered Services by contacting a Participating Provider. That person will either provide any necessary Covered Services or will refer you to another health care provider who can provide the services. This procedure is described in more detail in Section 5.

In an Emergency situation, you should attempt to contact a Participating Provider or the nurse line by calling WINhealth or the number on your identification card; if that is not reasonably possible, you should call 911 or go directly to the nearest Hospital emergency room or medical facility for treatment. Emergency Healthcare Services are available under the Plan on a 24-hours-per day, 7-days-per week basis. The procedure for obtaining Emergency Healthcare Services or Urgent Healthcare Services is described in more detail in Section 6.

Participating Providers are reimbursed according to the negotiated WINhealth fee schedule. Reimbursement mechanisms may be used to encourage Participating Providers to offer the most medically-appropriate, cost-effective care.

You should always show the health care provider your Plan identification card to ensure that claims for services you receive are submitted in a timely manner. Failure to show your Plan identification card may result in delays in payment. Prior to your appointment, you should also ensure that you have satisfied all requirements for obtaining Covered Services (e.g., a proper referral and/or Preauthorization from WINhealth).

If you are unsure about the procedure for obtaining Covered Services, contact WINhealth at the address or telephone number listed in Section 2.

SECTION 2

CONTACT INFORMATION

Name and Address:

You may obtain information about the procedure for obtaining Healthcare Services or any other aspect of the Plan by writing or calling:

Address:	**WINhealth** **1200 East 20th Street, Suite A** **Cheyenne, Wyoming 82001**
Website:	**www.winhealthplans.com**
Telephone:	**(307) 773-1300 or (800) 868-7670**
Fax:	**(307) 638-7701**

Member Secure Web Portal:

https://WINhealth.healthtrioconnect.com

The secure Member Portal offers 24/7 access to benefits and eligibility information and claims payment information. FAQs may provide answers to your questions outside of our normal business hours.

Member Services Department Contact:

By contacting our Member Services Department, you can get information about benefits, find out who is a Participating Provider, verify that Preauthorization has been obtained or get answers to other questions.

Member Services (telephone):	(307) 773-1330
Member Services (email):	service@winhealthplans.com

Other Department Contacts:

Health Management and Preauthorization: (307) 773-1320

All notices, authorization requests, claims, and other documents should be sent to the address listed above.

Language Services:

For Members who request language assistance, WINhealth will provide translation services in the requested language through bilingual staff or an interpreter.

SECTION 3

DEFINITIONS

The following defined terms shall have the meanings set forth below when used in this Evidence of Coverage unless the context requires otherwise. Defined terms are identified by being capitalized throughout the Evidence of Coverage. Additional terms are defined elsewhere in the Evidence of Coverage where applicable.

1. **Acute Rehabilitation Facility** - means an acute care hospital unit or freestanding facility that provides aggressive rehabilitation. Patients must be able to tolerate three (3) hours of therapy per day, five (5) days per week in at least two (2) different disciplines, such as physical therapy, occupational therapy.

2. **Behavioral Healthcare Providers** – means providers which include but are not limited to psychiatrists (MD, DO), psychologists (PhD/PsyD), professional counselors (LPC), clinical social workers (LCSW), marriage and family therapists (LMFT) addiction therapists (LAT), social workers, addiction practitioners, addiction practitioner assistants, and mental health workers. The provider must hold a current valid license issued in accordance with law in the State in which they practice. You can find a Behavioral Health Provider using the "Find a Provider" tool on the WINConnect Portal. Choose the type of specialist you want to see, then search by name or find the closest provider to an address you specify. The WINhealth network is Open Access, which means that you may contact a Behavioral Healthcare Provider and arrange an appointment directly. You do not need a referral from a Primary Care Provider to see a Behavioral Health Provider.

3. **Behavioral Healthcare Services** - means those Healthcare Services for the diagnosis and treatment of a behavioral disorder that are Covered Services.

4. **Child** - means a person who is the child, stepchild, legally adopted child, or foster Child of a Member, subject to the following:
   - A. A person who is under the age of twenty-six (26) shall be considered a Child.
   - B. A person who has reached age twenty-six (26) is primarily dependent on the Member for support and maintenance, and provides documentation of a determination of disability from the United States Social Security Administration shall be considered a Child.
   - C. For purposes of this definition, the term "foster child" means a person
     - 1) Whose principal place of residence is with the Member;
     - 2) Who is being raised as a Child of the Member;
     - 3) Who is primarily dependent on the Member for support and maintenance, and;
     - 4) For whom the Member has taken full parental responsibility and control.
   - D. A person for whom a Member becomes legally responsible by reason of placement for adoption shall be considered a Child.
   - E. The child of a Domestic Partner, living with the Member and the Member's Domestic Partner is a Child for the purposes of this definition.

5. **Clinical Trial** is an experiment in which a drug is administered to, dispensed to, or used by one or more human subjects to determine its safety and effectiveness in the treatment of disease. A Clinical Trial may also involve the use of medical equipment, appliances, or devices.

6. **Coinsurance** - means the percentage of the fee that you must pay for your care. Coinsurance does not begin until you satisfy any applicable deductible.

7. **Confinement** - means an uninterrupted stay of more than twenty-four (24) hours in a Hospital, Inpatient Substance Abuse Hospital, Long Term Acute Care Hospital (LTACH), Acute Rehabilitation Facility or Skilled Nursing Facility.

8. **Congenital Anomaly** - means a defective development or formation of a part of the body that was present at the time of birth.

9. **Continuous Quality Improvement (CQI)** – means the continual process of ongoing monitoring which leads to repeated program enhancements and performance improvement.

10. **Copayment** - means the fixed amount of money you pay to the provider, facility, pharmacy, or other provider when you receive services. Copayments are to be paid at the time treatment is rendered. Copayments do not begin until you have satisfied any applicable deductible.

11. **Coverage** - means a Member's entitlement to Plan benefits, subject to the limitations and Exclusions applicable to such benefits under this Evidence of Coverage.

12. **Covered Services** - means a Medically Necessary Healthcare Service for which benefits are provided under the provisions of this Evidence of Coverage. A Covered Service must be Medically Necessary and provided under the rules and policies of the Evidence of Coverage to be a benefit. Please see the definition of Medically Necessary.

13. **Credentialing** – means assessing and validating the qualifications of a licensed independent practitioner to provide health services. WINhealth takes the Credentialing of prospective providers very seriously to ensure that our Members have access to the most highly qualified practitioners possible.

14. **Creditable Coverage** - means health coverage of an individual under: a group health plan, (including while on COBRA Continuation Coverage), health insurance Coverage, Medicare, Medicaid, a state health benefits risk pool, a public health plan and certain other health programs.

15. **Custodial Care** - means skilled or unskilled care that does not seek to cure, but is designed primarily to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care also includes rest cures and home care provided by family members. The provision of care by a Physician, licensed nurse, or registered therapist does not preclude the care from being Custodial Care.

16. **Deductible** - means the fixed expense you must pay for certain Services before WINhealth will start paying benefits for them. Copayments and Coinsurance do not count toward any deductible. Deductibles are based on a Plan Year unless otherwise specified.

17. **Dentist** - means any doctor of dental surgery (D.M.D., D.D.S.) who is duly licensed and qualified as such under the law of the state in which the Dentist provides dental services.

18. **Designated Organ Transplant Facility** - means a Hospital named as such by the Evidence of Coverage that has entered into an agreement with WINhealth to provide Covered Services in connection with organ transplant procedures.

19. **Direct Benefits** - means Healthcare Services provided directly to you for which Plan benefits are paid directly to your provider.

20. **Director of Behavioral Health** – means the Physician or Behavioral Health Provider designated by the Plan as the Director of Behavioral Health. The Director of Behavioral Health oversees the Preauthorizations, medical necessity review, and care management programs of the Plan related to Behavioral Health and Substance Abuse issues.

21. **Domestic Partner** –means an unmarried person who is of the same or opposite sex of an unmarried Member, and who shares a common domestic life with the Member for purposes of maintaining a long-term personal relationship with the Member.

22. **Durable Medical Equipment** - (DME) means medical equipment that is all of the following: (1) can withstand repeated use; (2) is not a disposable medical supply; (3) is used to serve a medical purpose; (4) is generally not useful to a person in the absence of Illness or Injury, (5) is not available for purchase over the counter, and (6) is appropriate for use in the home.

23. **Effective Date** – means the date coverage becomes effective under the plan.

24. **Eligible Dependent** - means a Spouse, Domestic Partner, Child, or a disabled Child of a Member.

25. **Emergency** - means the sudden and unexpected onset of a condition or an event that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. It is a condition for which a prudent layperson, acting reasonably, would believe that emergency medical treatment is needed.

26. **Emergency Healthcare Services** - means Covered Services that are provided for the treatment of an Emergency.

27. **Enrolled Dependent** - means an Eligible Dependent who is enrolled for Coverage under the Evidence of Coverage.

28. **Enrolled Eligible Person** - means an Eligible Person who is enrolled for Coverage under the Evidence of Coverage.

29. **Enrollment Date** – is the date on which you are eligible to enroll for coverage under the Plan.

30. **Evidence of Coverage (EOC) or Policy** - means the written description of Coverage under the Health Plan that is provided to Members and is considered to be a contract or agreement between an Enrolled Eligible Person and the Health Plan.

31. **Exclusions** - means the portion of this Evidence of Coverage containing the schedule of Healthcare Services and supplies that are excluded from Coverage under the Evidence of Coverage.

32. **Experimental, Investigational, Unproven, Unusual, Or Not Customary Treatments, Procedures, Devices, and/or Drugs** - Means medical, surgical, or psychiatric procedures, treatments, devices, and pharmacological regimen (including investigational drugs and drug therapies), or supplies where either (a) the service is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question regardless of whether the service is authorized by law or used in testing or other studies, or (b) the service requires approval by a governmental authority and such authority has not been granted prior to the service being rendered.

33. **Family Planning** – A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. WINhealth provides coverage of physician charges for contraception management, medication for birth control, and procedures such as an IUD insertion or vasectomy. Generic medication for birth control, IUD insertion, tubal ligation, and vasectomy are considered essential health benefits and are covered without cost sharing. Hysterectomy solely for sterilization purposes and reversal of vasectomy are specifically excluded.

34. **Genetic Information** – Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

35. **Habilitative Services** – means medically necessary health care services and medical devices that assist an individual in acquiring or improving, partially or fully, skills and functioning due to a medically determinable physical or mental impairment. These services address the skills and abilities needed for function in interaction with their environment as normally as possible, taking into account the health capacity of the individual receiving services.

    Habilitation services do not include respite, day-care, recreational care, residential treatment, social services, custodial care, assistance with activities of daily living or education services of any kind, including but not limited to vocational training or services provided under an individualized education program as defined under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1500, et seq.) and its implementing state and federal regulations, nor devices which are not intended to directly treat the impairment or which are able to be used by persons

without the specific impairment. For a medical device to be covered by this definition, it must be one that requires FDA approval and a prescription to dispense the device.

36. **Healthcare Services** - means the services and supplies that may be ordinarily provided to a Member. Only those Healthcare Services that are delivered consistent with the terms of this Evidence of Coverage are Covered Services. Not all Healthcare Services are Covered Services.

37. **Hospital** - means an institution licensed and operated as such under the laws of the state in which it is located, and that has as its primary function the provision of diagnostic, therapeutic, medical, and surgical services on an inpatient basis to persons with an Illness or Injury. A Hospital must have an organized medical staff of Physicians and must offer 24-hour–a-day nursing service by or under the direction of persons who are qualified as registered nurses in the state in which the Hospital is located. A Hospital is not, other than incidentally, a nursing home, rest home, home for the aged, or facility for the provision of Custodial Care.

38. **Illness** - means physical Illness, sickness or disease.

39. **Infertility Treatment** – means medical and surgical treatment to diagnose and treat infertility.

40. **Inherited Enzymatic Disorders** – means a disorder caused by single gene defects involved in the metabolism of amino, organic and fatty acids. Inherited enzymatic disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic academia and propionic acidemia.

41. **In-Network** – means all providers who have entered into a direct or indirect contractual agreement with WINhealth.

42. **Injury** - means bodily damage other than Illness, including all related Conditions and recurrent symptoms.

43. **Long-Term Acute Care Hospital** – means a specialized health care facility that serves patients with serious medical problems and who will require prolonged periods of acute medical care.

44. **Medical Director** - means the Physician designated by the health plan as the Medical Director or the designee of such person. The Medical Director oversees the Preauthorizations, medical necessity review, and care management programs of the Plan.

45. **Medically Necessary** – means 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 patient'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. A prudent Physician would provide.
E. The omission of which could adversely affect or fail to maintain the Member's condition.
F. Is not primarily for the convenience of the patient, Physician, or other health care provider.
G. A medical service, procedure or supply shall not be excluded from being a medical necessity under this section 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:
   1) 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,
   2) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act; or,
   3) Milliman Care Guidelines
H. A medical service, procedure, or supply provided for the purpose of preventing, diagnosing, or treating an Illness, Injury, disease, or symptom is a medical necessity where such service, procedure, or supply has been approved by Medicare for use in the manner prescribed.

46. **Member** - means an Enrolled Eligible Person.

47. **Non-Participating Provider** - means any Physician, Hospital, Skilled Nursing Facility or other provider of Healthcare Services or supplies that has not entered into a Provider Agreement with WINhealth.

48. **Out-of-Pocket Maximum** - The maximum expenses any Member or family will be responsible for during a plan year as indicated in the Summary of Benefits and Coverage. This would include expenses incurred through a Member's payment of applicable Deductibles, Copayments or Coinsurance. The following amounts will not apply toward the Out-of-Pocket Maximum:
   A. The amount of any reduction in payment for allowable charges due to the Member's failure to obtain Preauthorization.
   B. Expenses incurred for care when a benefit limit, if applicable, has been reached.
   C. Expenses incurred by the Member to the extent that the billed amount exceeds the allowable charges (this amount is not the responsibility of a Member as long as the Covered Services were rendered by a Participating Provider).
   D. Expenses incurred by the Member that are not Covered Services or are subject to Exclusion.

49. **Participating Home Health Agency** - means an organization that provides home Healthcare Services that has entered into a Provider Agreement to provide Covered Services to Members under the health plan.

50. **Participating Hospital** - means a Hospital that has entered into a Provider Agreement to provide Covered Services under the health plan.

51. **Participating Physician** - means a Physician who has entered into a Provider Agreement to provide Covered Services under the health plan.

52. **Participating Provider** - means any Physician, Hospital, Skilled Nursing Facility, or other provider of Healthcare Services or supplies that has entered into a Provider Agreement to provide Covered Services under the health plan.

53. **Participating Skilled Nursing Facility** - means a Skilled Nursing Facility that has entered into a Provider Agreement to provide Covered Services under the health plan.

54. **Physician** - means any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified as such under the law of the state in which the doctor provides Healthcare Services.

55. **Podiatrist** –means any provider who specializes in the care of the feet and who is duly licensed and qualified as such under the law of the state in which the doctor provides Healthcare Services.

56. **Policy or Evidence of Coverage (EOC)**- means the written description of Coverage under the Health Plan that is provided to Members and is considered to be a contract or agreement between an Enrolled Eligible Person and the Health Plan.

57. **Preauthorization** - means the written approval by WINhealth of a service, procedure, equipment, medication or supply based on a request from a Provider prior to the service or procedure being rendered. Preauthorization is based on Medical Necessity, is not a guarantee of benefits and is subject to the Evidence of Coverage provisions in effect at the time of service.

58. **Preferred Drug List** - means the list of brand and generic prescription drugs that have been identified under the Plan to be the best value with regard to clinical effectiveness and cost. A higher level of benefit is paid when prescriptions are selected from the Preferred Drug List. Members are provided with a booklet containing the Preferred Drug List annually. The list is available on WINhealth's Member portal where it is updated quarterly.

59. **Premium** - means the monthly fee that must be paid to WINhealth for each Member Enrolled for Coverage under this Health Plan.

60. **Pre/Postnatal Care** – means care during pregnancy and for six (6) weeks after delivery provided by a Physician specializing in obstetrics/gynecology or family practice, a licensed midwife or a nurse practitioner.

61. **Primary Care Provider** – means one of the following: family practice physician, general practice physician, pediatrician, OB/GYN, internal medicine physician, nurse practitioner or physician assistant who is seeing patients in a primary care capacity.

62. **Prosthetic Device** - means any artificial device, instrument, or object that is intended to replace a limb or body part.

63. **Provider Agreement** - means a contractual agreement between WINhealth and an established provider network, a Physician, Hospital or other provider of HealthCare Services or supplies under which the provider agrees to provide Covered Services or supplies to Members through the Health Plan.

64. **Qualified Health Plan** – means a Health Plan that has been approved for participation in the Healthcare Marketplace by The United States Department of Health and Human Services and The Center for Medicare/Medicaid Services.

65. **Qualified Medical Child Support Order** - means a judgment, decree, or order that has been determined by WINhealth pursuant to Section 609 of the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. § 1169), to be adequate to qualify the Child for Coverage under the Plan.

66. **Quality Assurance (QA)** – means demonstrating that the programs and services meet a defined set of requirements, outcomes, clinical standards, or benchmarks.

67. **Quality Control** – means the use of systematic methods to ensure that a service or program conforms to a desired standard.

68. **Quality Improvement (QI)** – means the betterment or enhancement of programs or services.

69. **Quality of Care (QOC)** – means healthcare and services that respect the individual's needs and choice, improve the likelihood of achievable and desired clinical outcomes, and are consistent with current evidence-based knowledge.

70. **Reasonable And Customary** - means fees for Healthcare Services that WINhealth has determined are fees that regional providers customarily charge for such services.

71. **Reimbursement Benefits** – means the reimbursement of a member for reimbursable costs incurred by the Member for Covered Services.

72. **Reimbursable Costs** - means costs for Covered Services paid by a Member that are eligible for payment under the Plan. Reimbursable Costs provided by a Non-Participating Provider shall be the total Reasonable and Customary expenses for such Covered Service, less any applicable Deductible, Copayment or Coinsurance.

73. **Service Area** - means the geographical area served by the health plan, as approved by the Wyoming Insurance Commissioner or other regulatory agencies, within which WINhealth provides or arranges for the provision of Covered Services to Members.

74. **Skilled Nursing Facility** - means a facility that is licensed and operated under applicable state law to provide care and treatment to persons convalescing from Illness, Injury or behavioral disorder, and which has been certified as a Skilled Nursing Facility under Medicare.

75. **Sole Source healthcare** – means healthcare that is medically necessary to the welfare of the Member; beyond the typical abilities of the Member's primary care provider; and, unavailable from any appropriate in-network medical or surgical specialist or beyond the expertise and capabilities to be administered in-network as declared by an in-network medical or surgical specialist, and; inappropriate for or inaccessible to telemedicine services. A member's request or a primary care provider's preference for an out-of-network referral when an available in-network medical or surgical specialist exists does not meet criteria for Sole Source. Sole Source criteria must be met for out-of-network services to be covered as in-network benefits.

76. **Special Enrollment** - allows certain individuals who are otherwise eligible for coverage to enroll in the Plan, regardless of the Plan's regular enrollment dates. Special Enrollment rights may be triggered upon loss of eligibility for other coverage, including loss of employer contributions toward other coverage, such as: marriage, divorce, death of spouse, birth of a Child, adoption, and placement for adoption.

77. **Specialist Provider** – means any health care provider whose practice is limited to a specific area of medicine..

78. **Spouse** - means a person whose relationship with a Member is recognized as a legal marriage.

79. **Substance Abuse Services** - means Covered Services and supplies provided for the diagnosis and treatment of chemical or drug dependency as those terms are defined in the "International Classification of Diseases" of the United States Department of Health and Human Services.

80. **Summary of Benefits and Coverage (SBC)** – means a concise document detailing, in plain language, simple and consistent information about the health Plan's benefits and Coverage. The Summary of Benefits and Coverage summarizes the key features of your Plan, such as the Covered Services, cost-sharing provisions (Deductible, Copayments and Coinsurance), and Coverage limitations and exceptions.

81. **Telemedicine** – means the electronic real-time synchronous audio-visual contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of the patient. The patient is in one location with specialized equipment including a video camera and monitor and with a referring physician or presenting health care practitioner. The providing consulting health care practitioner is at another location with specialized equipment including a video camera and monitor. The health care practitioner and the patient interact as if they were having a typical, in-person medical encounter.

82. TRANSITIONAL BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CARE - Transitional care is temporary inpatient behavioral health or substance abuse services provided in a non-hospital facility accredited by the Joint Commission or any other accrediting organization with comparable standards recognized by the State of Wyoming in preparation for conversion to intensive outpatient or outpatient behavioral health or substance abuse care.

83. **Temporarily Absent from Service Area** - means circumstances where a Member has temporarily left the Service Area (such as on a vacation) but intends to return to the Service Area within a reasonable period of time.

84. **Urgent Care Facility** - means a health care facility that is not a Hospital and has as its primary purpose the provision of immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

85. **Urgent Healthcare Services** - means Covered Services provided to a Member that are necessary for the treatment of a condition arising from Illness, Injury or behavioral disorder which requires medical or surgical attention within twenty-four (24) to forty-eight (48) hours to prevent a serious deterioration in the Member's health but which do not constitute Emergency Healthcare Services.

86. **WINhealth Individual Health Plan (Plan)** - means the health plan established under this Evidence of Coverage through which Covered Services are provided to Members pursuant to the terms and conditions of the Evidence of Coverage.

SECTION 4

ELIGIBILITY AND ENROLLMENT

Eligibility

1. **Eligibility For Coverage**
   In order to enroll in this health plan, each applicant must meet each of the following requirements whether or not the applicant is a single applicant or there are multiple applicants in a family:
   A. Must be no more than sixty-four and one-half (64-1/2) years of age at the time of the application.
   B. Must submit a completed and signed enrollment application, including all requested information, and payment of applicable Premium.
   C. A Spouse is eligible to enroll as a Dependent even if legally separated.
   D. Children are eligible to enroll as Dependents through the month in which they reach the age of twenty-six (26).
   E. A Dependent Child will continue to be eligible after the above age limits while the Child is and continues to be both incapable of self-sustaining employment by reason of behavioral retardation or physical handicap and is chiefly dependent upon the Member for support and maintenance, provided proof of such incapacity and dependency is furnished within thirty (30) days of the Child's attainment of the limiting age.
   F. A newborn of a Member will be an Eligible Dependent as of the date of birth for the first thirty-one (31) days. The newborn must be formally enrolled within thirty-one (31) days of birth and Premium for the upcoming period must be paid for the coverage to continue pat the initial thirty-one (31) days.
   G. A court has ordered that Coverage be provided under the Member's health Plan.
   H. A person for whom the Member becomes legally responsible by reason of placement for adoption or by foster-child placement.
   I. Coverage is not effective until the applicant is notified in writing by WINhealth of such date of Coverage is to commence. As this is an individual Health Benefit Plan, Members of a family who are approved for Coverage will each be issued his or her own individual Health Benefit Plan.

2. **Effective Date Of Coverage** – Coverage shall become effective at 12:00 am Mountain Standard Time on the Member's Effective Date.

3. **Re-Enrollment After Termination Of Coverage** - A Member whose Coverage has terminated either voluntarily or involuntarily as described in Section 8 may reapply for Coverage as provided in Section 4(1) provided that all requirements for enrollment under Section 4 are satisfied and that any applicable re-enrollment fees are paid.

SECTION 5

OBTAINING PLAN BENEFITS

1. **Overview Of Benefits**
   Each Member is entitled to receive Covered Services as described in Section 6, from Participating Providers. WINhealth reserves the right to reasonably interpret the terms of this Evidence of Coverage and to provide standards of interpretation and review in making the benefit determinations described herein.
   A. Each Member is entitled to receive the following Benefits:
      1) Direct Benefits consisting of the provision of Covered Services by either Participating Providers or Non-Participating Providers.
      2) Reimbursement Benefits for Reimbursable Costs incurred by the Member for Covered Services provided by Non-Providers; and,
      3) Emergency and Urgent Healthcare Services as described in Section 6.
   B. Members are entitled to receive the Covered Services described in Section 6 subject to the following:
      1) Benefits will be provided only during the period that the Member is enrolled.
      2) Benefits will be provided to a person only while that person is a Member and prior to the time Coverage for such Member has terminated under Section 8.
      3) A Member's entitlement to the health Plan benefits described in subsection A is also subject to the terms, conditions, limitations and Exclusions set forth in this Evidence of Coverage.
   C. Preauthorization – Services that require Preauthorization by WINhealth include the following:
      1) Confinement to a Hospital, Skilled Nursing Facility, Rehabilitation Facility or other institution. When WINhealth is the secondary payor, either because the Member has other primary coverage, or because of third-party liability such as a Workers' Compensation case, preauthorization is not required for coordination of benefits;
      2) Confinement to a behavioral health or substance abuse treatment facility;
      3) Durable Medical Equipment (DME)
      4) Covered Services in a Member's home;
      5) Radiological scans, including MRA, MRI, PET, SPECT or CT Scan
      6) Certain prescriptions.
      7) Any organ transplant.
   D. This list is not all inclusive. In an emergency situation, an authorization should be requested within forty-eight (48) hours after the service is rendered. The Member should contact WINhealth to determine benefit Coverage and Preauthorization requirements. The requesting or referring provider must initiate the Preauthorization process prior to the services being rendered. The Member should ensure that Preauthorization has been obtained from WINhealth prior to obtaining services by contacting Member Services at (307) 773-1330. WINhealth will determine whether the requested service can be preauthorized and will provide written notification to the Member and the requesting and performing providers.

E. Emergency Situations – Emergency health care services are Covered Services as long as they fit generally accepted guidelines for Emergency health care services. In the case of an Emergency, a Member should call 911 or proceed directly to the emergency room. Non-emergent services rendered in an emergency room are not Covered Services. WINhealth offers its Members 24-hour/7-day access to a nurse advice line. A Member may call the nurse advice line to obtain help in evaluating the severity of a situation to assist in deciding the urgency of care required. By calling the nurse advice line, a Member may be able to avoid unnecessary and costly emergency room services.

2. **Direct Benefits And Reimbursement Benefits**

A. Members are entitled to receive benefits for Covered Services specified in Section 6 if ALL of the following requirements are satisfied:
   1) The Covered Services are Medically Necessary
   2) The Premium for the Member has been paid pursuant to Section 7(1)
   3) The Member has obtained Preauthorization for the Covered Services, if required. (Member is responsible for verifying that the proper Preauthorization has been granted. If Preauthorization is required for Covered Services or supplies, but is not obtained, the Member may not receive reimbursement for the Covered Services or supplies.)
   4) The Member has paid the applicable Copayment or Coinsurance for the Benefit, if any, in accordance with Section 7(2), of the Benefit Plan
   5) No Exclusion or limitation applies to the Covered Services

B. Direct Benefits - A Member obtains Direct Benefits for Covered Services when a provider submits a claim for Covered Services on behalf of the Member within one-hundred-eighty (180) days of the date of the Covered Services. Such provider is then paid directly based on the applicable benefit. If the Direct Services consist of Emergency health care services or Urgent Healthcare Services, the Member must follow the procedures described in Section 6 in order to receive Covered Services.

C. Reimbursement Benefits – If a Member seeks treatment from an Out-of-Network provider, the Member is required to submit a claim for reimbursement not later than one-hundred-eighty (180) days after the date of the Covered Service.
   1) As part of the written claim for reimbursement, the Member must submit documentation of the Covered Services. WINhealth may establish rules regarding the documentation or other proof required to be submitted, and may determine whether the documentation submitted with any particular claim is satisfactory. WINhealth may require a Member to submit additional proof in support of a claim that WINhealth determines has not been satisfactorily verified.
   2) If a Member fails to file a claim within the time period set forth above or fails to provide proof as required by subsection (1), the Member shall have no Reimbursement Benefits for the Covered Services or supplies that are the subject of the claim.
   3) WINhealth will reimburse the Member for Reimbursable Costs within forty-five (45) days of receiving both the written claim for reimbursement and satisfactory documentation of the claim.

3. **Temporary Absence From Service Area**

A Member who is Temporarily Absent from the Service Area shall be covered only for the following WINhealth Benefits:

A. Emergency Healthcare Services or preauthorized Urgent Healthcare Services.

B. Healthcare Services that have been preauthorized by WINhealth.

4. **Second Opinion**

A. A Member's Coverage under the health Plan is subject to the right of WINhealth to request a second opinion from a Physician as to whether a prescribed Healthcare Service is Medically Necessary or whether an alternative course of treatment for the Member's Illness or Injury may be more medically appropriate. Member's Copayment, Coinsurance and Deductible for the costs of obtaining a second opinion will be waived provided that the second opinion is obtained within thirty-one (31) days of the first opinion, or as soon thereafter as is reasonable possible. The procedures for obtaining a second opinion are as follows:

B. WINhealth shall notify the Member that a second opinion has been requested.

C. WINhealth will provide the Member with a list of Physicians who are authorized to provide a second opinion. The Physician who is to provide the second opinion must not be affiliated with the Physician who provided the initial opinion, unless WINhealth consents to provision of the second opinion by an affiliated Physician.

D. The Member is responsible for arranging a consultation with the Physician who will provide the second opinion. The consultation must take place within thirty-one (31) days after the first opinion was provided, or as soon thereafter as reasonably possible.

E. If the second opinion differs from the first opinion, WINhealth may request a third opinion. Any such third opinion will be obtained in the same manner as provided in this Section.

F. In the event that WINhealth requests a second opinion to confirm the medical necessity of a specific service, but the Member does not obtain the second opinion or fails to comply with the prescribed course of treatment, the service may not be covered.

G. If the second opinion requested by WINhealth is received within thirty-one (31) days after the first opinion was provided, or as soon thereafter as reasonably possible, the Member's Copayment, Coinsurance and Deductible for costs associated with the second opinion shall be waived.

H. If the third opinion requested by WINhealth is received within thirty-one (31) days after the second opinion was provided, or as soon thereafter as reasonably possible, the Member's Copayment, Coinsurance and Deductible for costs associated with the third opinion shall be waived.

5. **Substitution Of Benefits**
Covered Services may be substituted for other Covered Services at the direction of the Medical Director if, in the opinion of the Medical Director, such substituted Covered Services would be medically appropriate and cost effective, and both the Member and the provider of such Covered Services approve of the substitution.

6. **Members Held Harmless**
To the extent that Healthcare Services are Covered Services under the health Plan and are rendered by a Participation Provider pursuant to applicable policies and procedures for obtaining such Healthcare Services, a Member shall be held harmless by WINhealth for the cost of such Covered Services, except for any Copayment, Coinsurance, or Deductible payable with respect to such Covered Services under Section 7(2). Out-of-Network providers may elect to "balance-bill" members for any difference between the amount paid by the plan and the total cost of the services rendered.

SECTION 6

PART 1. COVERED SERVICES

All benefits are subject to Plan limitations and Exclusions as defined in Section 6, Part 2. Services that are not specifically identified in this Section are not Covered Services.

Description of Plan Benefits

1. **<u>Acute Rehabilitation</u>**
   Covered
   Acute Rehabilitation in a contracted facility is a Covered Services for Members who meet admission criteria and are preauthorized for this care by WINhealth. Determinations regarding whether or not criteria has been met will be made by WINhealth.

2. **<u>Ambulance</u>**
   <u>Covered</u>
   Ambulance for Emergency transport to the nearest Hospital or medical facility is a Covered Service when Medically Necessary. Ambulance transport from hospital to home and hospital to nursing home is a Covered Service when ordered by a Provider and preauthorized by WINhealth. Ambulance transport when used for patient or family convenience is not a Covered Service. A Copayment applies for both air and ground transport.

   <u>Air Ambulance</u> - benefits are payable when ground transportation is not available or feasible, or if the Member's medical condition warrants transport by air ambulance.

   <u>Limits</u>
   Ambulance services must be for emergency transportation. Non-emergent ambulance services must be preauthorized by WINhealth or requested by WINhealth.

   <u>Not Covered</u>
   Ambulance service provided due to the absence of another form of transportation or solely for the Member's convenience is not a Covered Service.

   Alternate Transportation – transportation other than by an ambulance that is specifically designed and licensed for transporting patients, and is operated by trained personnel is not a Covered Service.

3. **<u>Anesthesia</u>**
   <u>Covered</u>
   The provision of anesthesia during surgical procedures is a Covered Service when necessary for a covered surgical procedure and when provided by either a Physician or Certified Registered Nurse Anesthetist (CRNA).
   When surgery is performed during a Hospital Confinement, anesthesia services will only be Covered Services when WINhealth has preauthorized the Hospital Confinement. All elective

surgical procedures that are preauthorized (if required) will be Covered Services when the service is provided by a Physician or CRNA.

Limits
Anesthesia services provided at the time of a non-covered procedure are not covered.

4. Bariatric Surgery
Covered
When deemed medically necessary under the following conditions, with Preauthorization.

A. Surgical procedure performed in a facility with a dedicated bariatric team and program designated as a Center of Excellence as defined by the American Society for Metabolic and Bariatric Surgery.
B. Surgeon performing the procedure is board-certified and accredited by the American Society of Metabolic and Bariatric Surgery.
C. Eligible procedures:
D. Gastric restriction procedure with Roux-en-Y ("Gastric bypass")
E. Gastric restriction procedure without bypass ("Gastric band")
F. Vertical gastrectomy ("Gastric sleeve")
G. All of the following criteria must be met:
   1) BMI> 40 kg/m2, or, BMI 35-40 kg/m2 with one or more documented comorbidities including but not limited to diabetes, hypertension, hyperlipidemia, CHF, coronary artery disease, obesity hypoventilation, obstructive sleep apnea, pulmonary hypertension and severe arthropathy.
   2) Documentation of failure to achieve weight loss by nonsurgical means, including low-calorie diet, exercise, and medications.
   3) Correctable causes of obesity have been ruled out.
   4) On-going participation in a physician-supervised, multidisciplinary weight-loss program for at least six (6) months prior to surgery to include dietary/nutritional counseling, monitored exercise program, behavior modification, and regular support group participation.
   5) Psychological evaluation and clearance to undergo surgery.
   6) Full growth completed.
   7) Ongoing post-operative supervision for weight loss by the bariatric surgeon and bariatric program. Prior to surgery, the surgeon will submit to WINhealth a written outline of said post-operative care and weight loss management guidelines.

Limits
Physician referral and Preauthorization by WINhealth is required.
Limit one procedure per lifetime.

5. **Behavioral Health and Substance Abuse**

Covered

- Outpatient benefit - Preauthorization for outpatient physician and counseling services for behavioral health/mental health substance abuse treatment is not required.
- Intensive Outpatient/Inpatient benefit – Intensive outpatient treatment and inpatient mental health or substance abuse care are covered when the treatment and/or admission have been preauthorized by WINhealth.
- Partial Hospitalization benefit. Partial hospitalization days may be substituted in a ratio of one and one-half (1-1/2) partial days equal one (1) inpatient day when preauthorized by WINhealth.
- Transitional Care –Transitional inpatient mental health or substance abuse care is covered when the admission has been preauthorized by WINhealth. The maximum lifetime benefit is one hundred (100) days.

Not Covered

- Court-ordered psychiatric therapy or psychiatric therapy as a condition of parole or probation.
- Psychological testing of a Member that is requested by or for a third party, except as required in Section 6(1)(D) Bariatric Surgery.
- Treatment for autism and Asperger's syndrome.
- Treatment for ADHD, ADD or oppositional defiant disorder except for drug therapy.
- Counseling related to consciousness-raising, for borderline intellectual functioning, for occupational problems, or for activities of an educational nature.
- Vocational or religious counseling.
- Developmental disorders including, but not limited to, reading, arithmetic, language or articulation disorders.
- IQ testing.
- Lifestyle and personal growth counseling.
- Early infant stimulation.
- Counseling for transsexualism.
- Cognitive skills rehabilitation.
- Psychotherapy credited toward earning a degree or required for education purposes.
- Psychosurgery.
- Marital counseling.
- Treatment of learning disabilities, discipline problems, and inpatient Confinement for environmental change.
- Residential/custodial behavioral health or substance abuse treatment.
- Biofeedback.

6. **Cardiac Rehabilitation (Phase II)**

Covered

Phase II cardiac rehabilitation is supervised by a physician and occurs on an outpatient basis. Cardiac Rehabilitation benefits are available to Members following acute cardiac diagnoses and treatment, as long as the rehabilitation takes place no earlier than two (2) months prior to and no later than eight (8) months after the triggering cardiac event.

Limits
Benefit is limited to one course of therapy per incident.

7. **Care Management Program**
Covered
A. Support for a Member living with a chronic disease, including asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and congestive heart failure. The program includes coordination of care with providers and may include visits by a registered nurse. These services are offered with no Copayment or Coinsurance.
B. Nutritional counseling with applicable deductible, copayment or coinsurance.
C. Diabetic education programs.

8. **Chemotherapy**
Covered
A. Outpatient injectable chemotherapy, when oral administration of prescribed medication is not medically appropriate
B. Services and materials for chemotherapy
   1) Participation in a clinical trial must be preauthorized as benefit limits or Exclusions may apply.
   2) Select chemotherapy regimens may be provided on an inpatient basis and will be covered when the hospital confinement has been preauthorized.
   3) One wig, up to $500, per Plan year.

9. **Chiropractic Care**
Covered
Services rendered by a chiropractor are covered. Such services are limited to manipulation and x-ray of the spine.

Not Covered
A. Acupuncture
B. Paraffin therapy
C. Vitamins
D. Exercise equipment
E. Massage therapy

Limits
Chiropractic services are subject to the Deductible, Copayment or Coinsurance per visit, and benefit coverage is limited to 15 visits per plan year.

10. **Cochlear Implants**
Covered
This is a pediatric benefit ONLY for children up to age 18. All preliminary work, implantation of the device, and aftercare including annual testing and reprogramming are Covered Services, with Preauthorization.

11. Dental Services

Covered

Coverage is available for the following dental services only:

A. Treatment for an accidental Injury to the mouth, teeth or jaw in which the initial service is performed within ninety (90) days of the accident. The accidental Injury cannot be a result of biting or chewing. Treatment must be for restorative services and supplies necessary to promptly repair or replace sound natural teeth.

B. Incision and drainage of a cyst or cellulitis.

C. Surgical removal of tumors and cysts.

D. Anesthesia and facility charges are covered for dental procedures when preauthorized, whether performed in a Hospital, outpatient facility or other free-standing surgery center and when one of the following criteria is met:

1) Individual age seven years or younger
2) Individual who is severely psychologically impaired or developmentally disabled
3) Individual who has one or more significant medical comorbidities which require additional monitoring during and immediately following the procedure
4) Individuals in whom the complexity of the proposed dental procedure would preclude the use of local anesthesia or conscious sedation

E. All dental services must be preauthorized

Limits

Restoration of the mouth, teeth, or jaw due to an accidental Injury is limited to those services that are Medically Necessary.

Facility charges for hospitalization for dental procedures are only covered when a medical condition exists that makes hospitalization necessary to safeguard the health of the Member. WINhealth will not cover the dental procedure unless it is described as a Covered Service in this Section 6 and has been preauthorized.

Not Covered

A. Services provided for the treatment of conditions or complications related to teeth, including but not limited to a tooth abscess are not Covered Services unless the complication is life-threatening.

B. Coverage is not available for cosmetic replacement of serviceable restorations, materials that are more expensive than necessary for restoration of damaged teeth, and personalized restorations.

C. Coverage is not available for Physician or Dentist services related to dental care except as noted in limits above.

D. Shortening of the mandible or maxilla for cosmetic purposes

E. Hospitalization, including anesthesia, solely for extraction of teeth in the absence of a qualifying medical condition.

F. All dental services or supplies for preventive treatment of disease of the teeth, alveolar processes, supportive tissues (gums) and dental x-rays.

G. Dentures

12. Dermatology Services

Covered

A. Surgical or chemical treatment of genital or plantar warts.
B. Medical treatment of acne and rosacea.
C. Phototherapy is a Covered Service for select conditions and requires Preauthorization.

Not Covered

A. Surgical or chemical treatment of skin tags or common warts.
B. Dermabrasion or peel
C. Purchase or use of tanning bed.

13. Diabetes Care

Covered

Coverage under this Evidence of Coverage includes benefits for equipment, supplies and outpatient self-management training and education, including nutritional counseling for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items. Some equipment, including but not limited to diabetic shoes, requires Preauthorization.

14. Emergency Care

Covered

A medical Emergency is the sudden and unexpected onset of a condition or an event that you believe endangers your life or could result in serious Injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. Follow-up care, if covered, will be paid based on the network status of the provider.

If the Member does not comply with the following rules and the applicable rules stated in Section 5, Emergency Healthcare Services may not be Covered Services under the Plan:

Obtaining Emergency Healthcare Services - In a life- or limb-threatening Emergency, a Member should call 911 or go directly to the nearest Hospital emergency room or medical facility for treatment.

Transfer to Participating Facility Following an Out-of-Area Emergency - If a Member is in Confinement in a Hospital that is a Non-Participating facility, WINhealth may elect to transfer the Member to a facility that is a Participating Provider, if the Member's attending Physician approves the transfer as medically appropriate. The Plan will pay for such transfer. If, after the attending Physician has approved the transfer, the Member chooses to remain in the Non-Participating Provider facility, further services will be covered at the appropriate benefit level, if any.

Determination that Healthcare Services Are Not Emergency Healthcare Services- If WINhealth determines, based on generally accepted medical criteria, Healthcare Services or supplies are not Emergency Healthcare Services such Healthcare Services or supplies will not be Covered services.

Limits

Emergency Healthcare Services do not require Preauthorization. However, non-emergent Healthcare Services obtained in an emergency room are not Covered Services.

Calling the nurse line – WINhealth offers its Members 24-hour/7-day access to a nurse advice line. If a Member is unsure if symptoms require Emergency room services, the Member can access the nurse line by calling WINhealth or the number on the Member's identification card. The nurse line personnel will review the symptoms and help the Member decide if a visit to the Emergency room is necessary. By calling the nurse advice line, a Member may be able to avoid unnecessary and costly emergency room services.

If a Member is admitted to the Hospital, the emergency room Copayment is waived.
WINhealth may review use of emergency facilities. Payment of claims may be denied and charges may be the Member's responsibility if WINhealth determines that the claim was for non-emergent services.
In a life- or limb-threatening Emergency, the Member should call 911 or the local equivalent.

If the Member is hospitalized at a Non-Participating Provider facility, WINhealth may elect to transfer the Member to a Participating Provider Hospital if it is medically appropriate. WINhealth requests notification within forty-eight (48) hours of Emergency Healthcare Services or inpatient hospitalization.

Not Covered

Non-emergent services and services that are found to not be Medically Necessary
Follow-up care in the emergency facility

Emergency Healthcare Services do not require Preauthorization. Therefore, the Member must be responsible for using emergency facilities appropriately. Non-Emergency Healthcare Services are not Covered Services when rendered in an emergency facility.

15. Genetic Testing / Genetic Counseling

Covered

A. Amniocentesis for chromosome determination.
B. BRCA testing with Preauthorization
C. Counseling regarding BRCA genetic testing for women at high risk will be provided without cost sharing.
D. Genetic tests which have therapeutic implications may be covered services when preauthorized by WINhealth.

Not Covered

All testing including genetic screenings, for Genetic Information except as listed above

16. <u>Habilitative Services</u>

<u>Covered</u>

Habilitative Services are Covered Services when ordered by a Provider.

Limits

Benefit is limited to eighty (80) visits per plan year and is subject to applicable Deductible, Copayment and/or Coinsurance.

17. <u>Hemodialysis</u>

<u>Covered</u>

All necessary services for hemodialysis for chronic renal disease and for kidney transplants

18. <u>Home HealthCare</u>

<u>Covered</u>

Skilled home Healthcare Services are covered if such services are Medically Necessary and ordered by a Provider and preauthorized by WINhealth.

<u>Limits</u>

A. For services to be covered, the home health care agency must provide a treatment program that includes the estimated time that home care is needed and the frequency and duration of all services to be provided.
B. Benefit is limited to sixty (60) visits per incident inclusive of all services.
C. Provider must periodically review the progress and, as necessary, change or alter the treatment program. Home Healthcare Services are covered as long as they remain Medically Necessary, subject to the sixty (60) visits per incident limitation.

<u>Not Covered</u>

A. Care by a nurse's aide, family member or person residing with Member
B. Laundry services
C. Housecleaning services
D. Home companion
E. Assisted daily living services
F. Custodial care
G. Private duty nursing
H. Transportation
I. Items available over the counter

19. <u>Hospice</u>

<u>Covered</u>

Hospice care is covered with preauthorization when the member is in the final stages of a terminal Illness condition.

<u>Limits</u>

Benefits will apply when services are provided under the direction of the Member's physician, who certifies that the member is in the terminal stages of an Illness, with a life expectancy of approximately six (6) months or less.

The Member must choose to receive hospice care instead of standard benefits for the terminal illness. Hospice care is for terminal conditions and is based upon the concept that those Members receiving hospice care choose not to avail themselves of Healthcare Services related to seeking a cure for the terminal condition. While receiving hospice care in the Member's home or in a hospice facility, if a Member requires treatment for a condition not related to the terminal Illness, the Plan will pay for such Healthcare Services to the extent that they are Covered Services.

Bereavement services are covered for the immediate family of a deceased Member provided that the surviving spouse and/or other dependents continue to have coverage under the Plan.

Not Covered

Voluntary services or supplies

Counseling by clergy or voluntary groups

Services performed on the Member's remains.

Curative services and supplies related to the terminal conditions that are not part of Hospice Care

Services of a caregiver other than provided by the hospice agency, including but not limited to, someone who lives in the Member's home or someone who is a relative of the member.

Services that provide a protective environment where no professional skill is required, such as companionship or sitter services.

Services not related to the medical care of the Member, including but not limited to legal services, estate planning, funeral costs, food services such as Meals-on-Wheels, transportation services except covered Medically Necessary professional ambulance services.

20. Hospital Care

Covered

Inpatient Hospital services are Covered Services if the Confinement has been preauthorized.

A. Room and board expenses including the cost of the room, meal services for the patient, nursing services and laundry services

B. Ancillary –services, which are rendered during an inpatient stay, include drugs and pharmaceuticals, medical supplies, blood administration, diagnostic and therapeutic services.

C. Coordinated discharge planning services.

D. Private duty nursing limited to professional services of a registered nurse in an inpatient acute-care setting when ordered by a physician. Preauthorization by WINhealth is required.

Not Covered

A. Prescription drugs issued by the Hospital for use after Confinement ends.

B. Convenience items: Those services and supplies provided for personal convenience that are not Medically Necessary, such as grooming items, guest meals, television, telephone expenses, etc.

21. Infertility Diagnosis And Treatment

Covered

A. Diagnostic and therapeutic laparoscopy
B. Prescription drugs

Not Covered

A. Artificial insemination, including the donation or storage of sperm
B. Maternal surrogacy or the artificial insemination of a gestational carrier
C. Gamete intrafallopian transfer
D. Peritoneal oocyte and sperm transfer

22. Inherited enzymatic disorders

Covered- requires Preauthorization by WINhealth

A. A one-time evaluation and training program when medically necessary, within one year of diagnosis.
B. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition or treatment.
C. Equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy

Limits

Self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in inherited enzymatic disorders.

23. Laboratory Services

Covered

Medically Necessary laboratory services are Covered Services when requested by a Provider.

Not Covered

Laboratory tests that are not related to a specific Illness or Injury, such as feared exposure to a disease/condition are not Covered Services unless provided according to the schedule of preventive services.
Laboratory services provided in conjunction with health fairs.

24. Maternity Care

Covered

A. Provider Services - Charges for prenatal, postnatal and delivery are covered.
B. Hospital Services - Inpatient services including room expense and ancillary services provided by a Hospital are covered under the inpatient Hospital benefit. Pursuant to the Newborns' and Mothers' Health Protection Act, (NMPHA), inpatient benefits may not be restricted to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery if delivery occurs in a hospital. If the birth occurs outside the hospital and the Member is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. Any decision made regarding the early discharge of either the mother or the

newborn child prior to the 48-hour (or 96-hour) period shall be made by the attending physician in consultation with the mother or authorized representative.

C. Newborn Care - Hospital nursery charges for newborn babies and Physician newborn care are Covered Services as part of covered maternity care. A separate Deductible, Copayment or Coinsurance for the newborn will not apply unless the number of days of hospitalization exceeds that of the mother. When the mother is not covered under this Plan, the child's newborn care may be covered separately from maternity care if the father is covered under this Plan; however, Deductibles, Copayments or Coinsurances may apply.

D. When delivery of a newborn Child is a Covered Service, benefits are not restricted for any Hospital length of stay in connection with childbirth for the mother or newborn Child when the services are Medically Necessary.

E. Postnatal Care – charges for lactation counseling and one (1) breast pump are covered.

F. Provider and Hospital Services for prenatal/postnatal care and delivery are Covered Services for a Members dependent child. The newborn child of a dependent child will not be covered following delivery unless the child is otherwise eligible for coverage under the Plan.

Maternity and Pregnancy-Related Services Covered With No Cost-Share

A. Laboratory screenings for pregnant women:
  1) Iron-deficiency anemia
  1) Bacteria in urine
  2) Hepatitis B virus
  3) RH incompatibility

B. Syphilis

C. Breastfeeding supplies, including manual and small electric (AC and/or DC) breast pumps, support, and counseling for pregnant and nursing women

D. Gestational diabetes screening for women 24 to 28 weeks' pregnant and those at high risk of developing gestational diabetes

E. Tobacco use screening, intervention, and expanded counseling for pregnant tobacco users

F. Folic acid supplements for women who may become pregnant

Limits

All maternity care must be coordinated by a Provider.

Not Covered

Home delivery
Any procedure intended solely for gender determination
Birthing classes
Nursing bras, pads, lotions, creams, etc.
Hospital-grade electric breast pumps

25. Nutritional Therapy

Covered

Food/formula that is specially formulated for specific medical conditions, that is not available over-the-counter and is not normally consumed by generally healthy individuals.

Limits

A. Must be prescribed by a provider.
B. Must account for at least half of the patient's diet.
C. Preauthorization is required.

Not Covered

A. Nutritional ***supplements***.
B. Nutritional ***products*** are considered supplements when they are non-essential or convenience additions or substitutions to a regular formula or adult solid or blenderized (liquefied) food diet.
C. Banked breast milk.
D. Standard cow's milk or soy-based formula.

26. Pediatric Dental Health Risk Assessment

Covered

One (1) routine dental health risk assessment by a Primary Care Provider or pediatrician (does not include a dentist) every six (6) months for children up to age 19.

Limits

Some plans offer dental benefits for children. Review your Summary of Benefits and Coverage for information about benefits offered under your plan.

27. Pediatric Vision

Covered

A. One (1) routine vision examination by an optometrist or ophthalmologist annually for children up to age 19.
B. One set of frames and/or lenses every twelve (12) months.

Not Covered

A. Special coatings such as anti-scratch, or UV screening
B. Transition lenses
C. Designer frames
D. Designer lenses

28. Physician Services

Covered

A. Physician services including visits and examinations, consultation, and personal attendance with the Member in the Physician's office or in a Hospital or Skilled Nursing Facility.
B. Physician's visits to the Member's home when medically appropriate.
C. Medical consultation services, including charges made by a Physician for a second opinion.
D. Telemedicine as defined in Section 3.

Not Covered

A. Examination for employment, licensing, insurance, adoption, travel, school or sports purposes; or court-ordered examination or treatment.
B. Expenses for medical reports, including preparation and presentation.
C. Expenses for examinations and treatment conducted for the purpose of medical research.
D. Expenses related to missed appointments and rescheduling fees.
E. Expenses for Physician waiting or standby time, after-hours services and other additional charges, except for neonatal, transplant and trauma standby.
F. Exams or evaluations for the purpose of allowing a Member to return to work.

29. Podiatric Care

Covered

Services rendered by a Podiatrist, including routine office visits and standard x-rays are covered. All podiatric procedures including injections and surgeries must be preauthorized by WINhealth.

Not Covered

A. Treatment of weak, strained or flat feet.
B. Shoe-insert foot orthotics.
C. Cutting, removal or treatment of corns or calluses or trimming the free edge of toenails in the absence of active treatment of a metabolic or peripheral vascular disease.

30. Prescription Drugs

Benefits for prescription drugs are determined using the Preferred Drug List. All covered generic drugs are subject to the lowest copayment. Covered brand name drugs are subject to the second level copayment. Brand name prescription drugs that are not listed on the Preferred Drug List are subject to the highest Copayment.

Covered

A description of your prescription drug Coverage can be found in your Summary of Benefits and Coverage. To fill a prescription, present your Plan identification card to the pharmacy.

Preferred Drugs - Covered generic and brand name prescription drugs that are included on the Preferred Drug List are covered at the lower Copayment or Coinsurance level.

Non-Preferred Drugs - Covered brand name drugs, some of which are not listed on the Plan's Preferred Drug List, are subject to a higher Copayment or Coinsurance amount.

Over-the-Counter Drugs - Over-the-counter drugs for the following preventive indications: Low-dose aspirin for prevention of heart disease in men age 45-79 and women age 55-79, low-dose aspirin as part of the treatment regimen in adult patients with documented coronary artery disease, and folic acid supplements for women who may become pregnant. A prescription from your provider is required.

Diabetic Supplies - Diabetic supplies (test strips, alcohol swabs, lancets and syringes) are covered. Copayment and Coinsurance may be waived on diabetic supplies. Contact Member Services at (307) 773-1330 for more information.

Fluoride supplements - Fluoride supplements for appropriate children (preschool children older than age six (6) months whose primary water source is deficient in fluoride) are covered.

Limits

A. Quantity for a maintenance prescription drug purchased through either a mail service or retail pharmacy cannot exceed a ninety (90) day supply.

B. For maintenance drugs, as defined by standard lists, a ninety (90) day supply may be dispensed if two months' Copayments are paid.

C. Prescriptions are covered with varying Copayments for brand and generic medications.

D. If a brand name medication is dispensed when the generic equivalent is available, the Member will be responsible for the brand Copayment plus the difference in price between the generic and brand medications. If the Member's provider can document Medical Necessity as to why the Member cannot tolerate the generic equivalent, the difference in price may be waived; however, the Copayment will still apply.

E. Some prescription drugs have a Step Therapy requirement. For specific categories of drugs, a trial and failure of an approved generic version must be documented before any brand name versions are eligible for coverage. These categories include but are not limited to:
   1) Diabetes drugs
   2) Cholesterol-lowering agents
   3) Nonsteroidal anti-inflammatories
   4) Proton pump inhibitors for reflux
   5) Serotonin-based antidepressants
   6) Triptans for migraine treatment

F. The most recently updated list may be accessed on the WINhealth website.

G. Some prescription drugs require preauthorization. A drug may be preauthorized for up to a one (1) year period of time. Drugs requiring Preauthorization by WINhealth include:
   1) Injectable medications
   2) Interferon/Intron/Avonex
   3) Growth hormones
   4) Accutane
   5) Retin A or equivalent for adult acne
   6) Drugs exceeding $500 per month
   7) Prescription drugs for help with smoking cessation.
   8) Other drugs, not listed here, may be added to those requiring Preauthorization. Call WINhealth with any question as to whether a drug requires Preauthorization.

Not Covered

Excluded Drugs: Not all prescription drugs are covered. Members can contact the WINhealth Member Services department with questions about Coverage for the specific drug prescribed. Some examples of drugs excluded from Coverage include but are not limited to:
   1) Weight-loss drugs
   2) Medications available without a prescription except as described above under Over-the-Counter Drugs.
   3) Experimental or investigational drugs

4) Drugs for cosmetic purposes

31. Preventive Services Covered

The list of preventive services covers a full range of immunizations and diagnostic tests and screenings for members of all ages. The services below are recommended by the following agencies: Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the State of Wyoming. There will be no member cost sharing for the preventive services listed below as long as the services are provided by a Participating Provider and are offered in accordance with the following schedule, unless otherwise indicated. ** If at any point, any of the below preventive services ceases to be a preventative service recommended by the above agencies, Copayments and Deductibles may apply.

Schedule of Preventive Benefits

Under One Year of Age

- One newborn genetic screen within twenty-four (24) to seventy-two (72) hours of birth, and a second genetic screening at age 7 to 10 days.
- One-time newborn test for hearing loss
- Six (6) well-child exams*
- Immunizations per Centers for Disease Control and Prevention Guidelines

One Year but Less Than Six Years

- Three (3) well-child exams between ages 1 and 2 years*
- Annual well-child exam between the ages 2 and 6 (but no more than one (1) exam in any (twelve) 12 continuous-month period)*
- Immunizations as per Centers for Disease Control and Prevention Guidelines
- Annual hematocrit/hemoglobin
- One (1) annual eye exam between ages 3 and 6 by a pediatrician, an ophthalmologist, or an optometrist
- Hearing screening and testing recommended and performed by a participating Provider
- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months

Six Years but Less Than Twelve Years

- Annual Well-child exams*
- One (1) routine eye exam every two (2) years by an ophthalmologist or optometrist
- One (1) tuberculosis skin test annually
- One (1) dipstick urine annually
- One (1) hematocrit/hemoglobin annually
- Immunizations, including influenza, per Centers for Disease Control and Prevention Guidelines
- Hearing screening and testing as recommended and performed by a participating Provider

- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months

Twelve Years but Less than Eighteen Years

- Annual health maintenance visits*
- One (1) routine eye exam every two (2) years by an ophthalmologist or optometrist
- Diphtheria/tetanus booster, if appropriate
- Tuberculosis skin test annually
- Dipstick urine annually
- Hepatitis B vaccine series
- Pelvic examination and cervical cancer screening (including Pap smear) annually for females
- Reflex HPV testing for sexually active females and males annually
- Immunizations, including influenza per Centers for Disease Control and Prevention Guidelines
- Hearing screening and testing as recommended and performed by a Participating Provider (ages 12-16)
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, vasectomy, and contraceptive counseling as deemed appropriate by your provider
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider.
- Domestic violence screening and counseling for women, as deemed appropriate by your provider.
- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months

Eighteen Years but Less Than Forty Years
Men:

- Annual health maintenance visit*
- EKG every five (5) years
- Prostate examination for cancer, annually
- Measles, mumps and rubella if recommended by your provider
- Influenza vaccine annually
- Pneumococcal vaccine
- Hepatitis B vaccine
- Reflex HPV testing annually
- Tuberculosis skin test annually
- Dipstick urine annually
- Complete blood count (CBC) annually
- Basic metabolic panel lab test annually
- Lipid screening every five (5) years
- Diabetes screening with either fasting glucose or two-hour postprandial glucose, or glucose tolerance test every five (5) years
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually

- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider.
- Vasectomy

Women:

- Annual health maintenance visit*
- EKG every five (5) years
- Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually
- Clinical breast examination, annually
- Measles, mumps, rubella under age 20
- Influenza vaccine annually
- Pneumococcal vaccine
- Hepatitis B vaccine
- Dipstick urine annually
- Tuberculosis skin test annually
- Complete blood count (CBC) annually
- Lipid screen every five (5) years
- Basic metabolic panel lab annually
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every five (5) years
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by your provider
- Domestic violence screening and counseling, as deemed appropriate by your provider
- Breast cancer chemoprevention counseling for women at high risk

Forty Years but Less Than Sixty-five Years
Men:

- Annual health maintenance visit*
- EKG
- Prostate examination and laboratory tests for cancer, annually
- Reflex HPV testing annually
- Dipstick urine annually
- Complete blood count (CBC) annually
- Lipid screen every annually
- Basic metabolic panel lab test
- Tuberculosis skin test annually
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three (3) years
- Thyroid Stimulating Hormone Test (TSH) every three (3) years
- Tetanus/Diphtheria booster

- Influenza vaccine annually
- Pneumococcal vaccine
- Hepatitis B vaccine
- Zostavax vaccine for men age 60 and older
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
- Colonoscopy for colorectal cancer screening for men age 50 to 75 is a covered benefit
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Vasectomy

Women:
- Annual health maintenance visit*
- EKG
- Pelvic examination, and cervical cancer screening (including Pap smear), and reflex HPV testing, annually
- Clinical breast examination, annually
- Screening mammogram, annually
- Dipstick urine annually
- Complete blood count (CBC) annually
- Lipid screen every three (3) years
- Basic metabolic panel lab annually
- Tuberculosis skin test annually
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three (3) years
- Tetanus/diphtheria booster
- Pneumococcal vaccine
- Influenza vaccine annually
- Hepatitis B vaccine
- Zostavax vaccine for women age 60 and older
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
- Colonoscopy for colorectal cancer screening for women age 50 to 75 is a covered benefit
- Screening for osteoporosis by DEXA scan three (3) years after age 50 with identifiable risk factors for osteoporosis as deemed appropriate by your provider
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by your provider
- Domestic violence screening and counseling, as deemed appropriate by your provider
- Breast cancer chemoprevention counseling for women at high risk

Sixty-five Years and Over
Men:
- Annual health maintenance visit *
- EKG annually

- Prostate examination and laboratory tests for cancer, annually
- Reflex HPV testing annually
- Lipid screen annually
- Dipstick urine annually
- Tuberculosis skin test annually
- Thyroid Stimulating Hormone (TSH) test
- Tetanus/Diphtheria booster every ten (10) years
- Complete blood count (CBC) annually
- Basic metabolic panel lab test annually
- Influenza vaccine annually
- Pneumococcal vaccine
- Zostavax vaccine
- Hepatitis B vaccine series
- Colorectal cancer examination, including colonoscopy, and laboratory tests for cancer annually
- Diabetes screening with either fasting glucose and two-hour postprandial glucose or glucose tolerance test annually
- One-time screening with ultrasound for abdominal aortic aneurysm for men with a history of smoking
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider

<u>Women:</u>

- Annual health maintenance visit *
- EKG annually
- Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually
- Clinical breast examination, annually
- Screening mammogram, annually
- Lipid screen annually
- Dipstick urine annually
- Tuberculosis skin test annually
- Thyroid function test
- Tetanus/diphtheria booster every ten (10) years
- Complete blood count (CBC) annually
- Basic metabolic panel lab annually
- Influenza vaccine annually
- Pneumococcal vaccine
- Zostavax vaccine
- Hepatitis B vaccine series
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test annually
- Screening for osteoporosis with DEXA scan every two (2) years as deemed appropriate by your provider

- Colorectal cancer examination, including colonoscopy and laboratory tests for cancer, annually
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Breast cancer chemoprevention counseling for women at high risk
- Domestic violence screening and counseling as deemed appropriate by your provider

*Well-child examinations and adult health maintenance visits include but are not limited to provider counseling regarding diet and exercise, provider screening for obesity, depression and alcohol misuse, screening and intervention for tobacco use, provider screening for sexually transmitted diseases, and blood pressure screening.

**Pursuant to Wyoming Statute § 26-18-103(b),testing procedures and the examination of adult policyholders and their spouses for breast cancer, prostate cancer, cervical cancer and diabetes will be covered at eighty percent (80%) of allowable charges up to a total annual benefit of one-hundred and fifty dollars ($150.00).

This shall not apply to high deductible policies where the deductible equals or exceeds five thousand dollars ($5,000.00) per person or per family per year or policies qualifying as federal medical savings accounts.

Limits

These recommendations are subject to change. All preventive services should be rendered upon the advice of a health care provider. Unless specifically indicated herein, other routine screening is not a covered benefit. Preauthorization is not required for screening or diagnostic colonoscopy. This includes proctosigmoidoscopy, sigmoidoscopy, colonoscopy, anoscopy, endoscopy, small-intestine and stomal, and surgical endoscopy. Preauthorization IS required for Virtual colonoscopy, CT colonoscopy and Capsule endoscopy of the esophagus, small bowel or colon.

32. Radiation Therapy

Covered

Radiation Therapy

33. Radiology Services

Covered

A. Medically Necessary radiology services are covered when they are ordered by your provider.

B. Radiology services ordered by a Non-Participating Provider or performed in a non-participating facility will be covered at a lower benefit level unless preauthorized by WINhealth.

Limits

The following procedures require Preauthorization and must be referred by a Provider. This list is not all inclusive. Please call Member Services at (307) 773-1330 for more information.

A. Magnetic Resonance Angiography (MRA)

B. Positron Emission Tomography (PET and PET-CT)
C. Computerized Tomography Scans (CT)
D. Single Photon Emission Computed Tomography (SPECT)

34. Reconstructive Surgery
Covered
A. Repair of congenital defect(s) with Preauthorization.
B. All stages of breast reconstruction surgery following a mastectomy, such as:
   1) Surgery to produce a symmetrical appearance on the other breast after cancer surgery;
   2) Treatment of any physical complications, such as lymphedemas;
   3) One (1) breast prosthesis every two (2) years and two (2) surgical bras per year;
C. Preauthorization is required for these and other reconstructive surgeries.

Not Covered
A. Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental Injury. Examples include, but are not limited to:
   1) Penile prosthesis (any type)
   2) Breast augmentation and breast implants
   3) Breast reduction and reduction mammoplasty
B. To determine benefit coverage and Preauthorization requirements regarding a particular surgery, please contact Member Services.

35. Rehabilitative Care
Covered

A. Physical Therapy
Physical Therapy is a Covered Service when ordered by a provider.

Limits
Benefit is limited to forty (40) visits per incident per plan year and is subject to applicable Deductible, Copayment and/or Coinsurance. The benefit maximum per incident for physical therapy is offered in combination with the benefit maximum per incident for occupational therapy. An incident is medical procedure, an Illness, or an Injury where the therapy is being offered to regain previous level of function. Physical therapy is only offered to regain a previous level of function after the Member has experienced an incident.

Not Covered
Massage therapy
Myofascial release therapy
Paraffin bath

Occupational Therapy
Covered
Occupational therapy is covered when ordered by a Provider.

Limits
Benefit is limited to forty (40) visits per incident per plan year and is subject to applicable Deductible, Copayment, and or Coinsurance. The benefit maximum per incident for occupational therapy is offered in combination with the benefit maximum per incident for physical therapy. An incident is medical procedure, an Illness, or an Injury where the therapy is being offered to regain previous level of function. Occupational therapy is only offered to regain a previous level of function after the Member has experienced an incident.

B. Speech Therapy
Speech therapy is covered when ordered by a Provider.

Not Covered
Developmental speech therapy for children

Limits
Preauthorization by WINhealth is required.
Coverage is only available when service is provided for treatment of head injury, stroke/CVA (Cerebral Vascular Accidents); cancer of the mouth, removal of the tongue or Injury to the structures and mechanism of phonation to restore previously existing speech. Benefit is limited to twenty (20) visits per incident per Plan Year.

C. Excluded from Rehabilitative Care Coverage

1) Special evaluation and therapies including, but not limited to, the following are not Covered Services:
2) Acupuncture
3) Communication delay
4) Learning disability
5) Mental retardation and related Conditions
6) Multiple handicaps
7) Perceptual disorders
8) Sensory deficit
9) Sex addiction
10) Vision therapy
11) Behavioral training
12) Biofeedback
13) Coma stimulation
14) Developmental and neuroeducational testing or treatment
15) Educational services or studies
16) Hearing therapies
17) Hypnotherapy
18) Myofunctional therapy
19) Vocational rehabilitation
20) Chelation therapy, except for heavy metal toxicity
21) Maintenance Therapy

36. Skilled Nursing Facility

Covered

Skilled Nursing Facilities provide inpatient skilled nursing care and related services to members who require medical, nursing, or rehabilitation services but who do not require the level of care provided in a Hospital.

Limits

Preauthorization by WINhealth is required. Lifetime limit of one-hundred (100) covered days.

Not Covered

Facility and service charges that are maintenance or custodial in nature

37. Supplies and Equipment

Covered

Durable Medical Equipment (DME) - The purchase or rental of DME is covered when prescribed by a Provider and Preauthorized by WINhealth. Benefits paid for the rental of equipment may apply to the purchase price as determined by the Participating Provider's contract. The decision to purchase or rent the equipment will be made by WINhealth.

Prostheses and Orthopedic Appliances - Devices used to support, eliminate, or restrict motion in a part of the body that is diseased or injured are Covered Services when Medically Necessary and preauthorized by WINhealth. Covered prostheses and orthopedic appliances include, but are not limited to:
Artificial limbs
Leg braces
Arm and back braces
Orthopedic shoes for diabetes and peripheral vascular disease only. Requires Preauthorization.

Medical Supplies - Including but not limited to:
Colostomy bags and other supplies for their use
Needles for administering insulin
Oxygen services and supplies

Medical Equipment - Including but not limited to:
Manually operated wheelchairs
Crutches
Infusion pump

Limits

DME must be obtained from a Provider and requires Preauthorization by WINhealth.
Repair of DME when properly maintained and verified by service records-requires Preauthorization.
Replacement costs will be covered when an item is no longer repairable.

Not Covered

Some of the items not covered include, but are not limited to:

1) Convenience items
2) Consumable supplies and equipment
3) Deluxe items
4) Maintenance of equipment
5) Devices not medical in nature
6) Customization of rental equipment that is not Medically Necessary
7) Special braces or equipment not specifically listed above
8) Braces used as aids in sports and activities
9) Corsets and other non-rigid appliances
10) Prostheses for cosmetic purposes
11) Repair, maintenance or replacement due to loss or for duplication
12) Shoe-insert foot orthotics for podiatric use and arch support including wrapping
13) Medical supplies used for comfort, convenience, personal hygiene or first aid that do not require special fabrication, fitting, or a physician's prescription (examples: support hose, bandages, adhesive tape, gauze, antiseptics.)
14) Surgical trays
15) Non-prescription food items
16) Hot tubs
17) Exercise equipment
18) Air Conditioners
19) Humidifiers
20) Motorized wheelchairs
21) Robotic limbs and organs (except for LVAD)

38. Surgical Assistants

Covered

Assistant surgeon services will be Covered Services when Medically Necessary using Medicare guidelines, and when elected by a qualified Provider.

39. Transplants

Covered

Solid human organ and bone marrow transplant services are Covered Services if not considered experimental or investigational, and when performed at a Designated Organ Transplant Facility. Services are covered based on established criteria by the medical community and WINhealth and are provided only upon referral by the Member's provider. Covered Services include the directly related, reasonable medical and Hospital expenses of the donor and transportation if applicable.

Recipient Expenses - Recipient expenses directly related to the transplant procedure are Covered Services, including pre-operative and post-operative care, surgical, storage and transportation costs directly related to the donation of an organ used in a covered organ transplant procedure.
Hospital Services - Hospital services directly related to the covered transplant procedure, including pre-operative and post-operative care.
Physician Services - Recipient medical expenses directly related to the covered transplant procedure, including pre-operative and post-operative care.
Donor Expenses – Reasonable surgical costs, including pre-operative services up to thirty (30) days prior to and post-operative services up to sixty (60) days following a procedure directly

related to the donation of an organ for an eligible Member are covered if all of the following conditions are met:

A. Donor suitability donor evaluation and guideline criteria, when applicable (i.e., living kidney transplant, living liver transplant).
B. The organ to be donated is appropriate for the proposed transplant.
C. For a bone-marrow, peripheral-blood or umbilical-cord blood stem-cell transplant, there is an identified, appropriate, allogeneic match between the donor and the recipient.
D. The charges are not covered by the donor's benefit plan.
E. Claims for the donor are submitted under the name of the WINhealth Member who is the transplant recipient.

Not Covered

A. Transportation and lodging expenses.
B. Expenses for a Member who is a donor when the recipient is not a WINhealth member.

Limits

A. All services related to a solid human organ or bone marrow transplants must be preauthorized by WINhealth and must be provided in a Designated Organ Transplant Facility.
B. Coverage for transplants will not be provided when resulting from a condition that is not a Covered Service by WINhealth.
C. Post transplant prescription drugs are subject to the regular prescription Copayments and/or Coinsurance.
D. Repeat pre-transplant evaluations at the same or another transplant center may not be Covered Services if the Member has previously been determined to not be a candidate by a WINhealth's Designated Organ Transplant Facility.

40. Urgent Healthcare Services

Covered

Urgent Healthcare Services are for Conditions that are not emergencies but need medical attention within twenty-four (24) to forty-eight (48) hours when a Member does not have ready access to a Physician. Services rendered by a Participating Urgent Care Facility do not require Preauthorization. Participating Urgent Care Facilities are listed in the provider directory. If a Member is unsure if symptoms require Urgent Healthcare Services, the Member can access the nurse line by calling WINhealth or the number on the Member's identification card. The nurse line personnel will review the symptoms and help the Member decide if a visit to the Urgent Care Facility is necessary.

Obtaining Urgent Healthcare Services - In a situation that is not an Emergency, if a Member requires Urgent Healthcare Services, the Member should go to the nearest Urgent Care Facility for treatment. If the Urgent Healthcare Services Facility is a Non-Participating Provider the Member must first notify WINhealth. Urgent Healthcare Services rendered by a Non-Participating Provider must be preauthorized by WINhealth. Your provider may request Preauthorization by calling WINhealth Medical Management at (307) 773-1330.

Limits

Urgent Healthcare Services that are rendered by Non-Participating Providers are Covered Services only when Medically Necessary and preauthorized by WINhealth. If Urgent Healthcare Services are required after hours or over the weekend, the Member should contact Member Services and leave a message to ensure that the correct benefit is applied to the visit.
Out of area follow-up care at an Urgent Care Facility is not a Covered Service.

PART 2. BENEFIT PLAN EXCLUSIONS AND LIMITATIONS

Limitations and Exclusions, including but not limited to, the following apply to services as indicated.

1. Experimental, investigational, unproven, unusual, or not customary treatments, procedures, devices, and/or drugs are excluded. Treatments, procedures, devices and/or medications/drugs shall be deemed excluded (not Covered Services) as Experimental, Investigational, Unproven, Unusual or Not Customary if:
   - A. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
   - B. It is the subject of a current Investigational new drug or new device application on file with the FDA; or
   - C. It is being provided pursuant to a Phase I, II, III, or IV as the Experimental or research arm of a Clinical Trial (except routine patient care costs and drugs approved by the FDA for the treatment of cancer or other life-threatening disease s provided in conjunction with a phase I, II, III, or IV study or clinical trial as required by Wyoming Statute § 26-20-301); or
   - D. It is being provided pursuant to a written protocol that describes among its objectives, determinations of safety, toxicity, effectiveness in comparison to conventional alternatives; or
   - E. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by Federal Regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
   - F. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; or
   - G. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
   - H. It is Experimental, Investigational, Unproven, Unusual or not a generally acceptable medical practice in the predominant opinion of independent experts; or
   - I. A majority of a representative sample of not less than three (3) health insurance or benefit providers or administrators consider the requested treatment, procedure, device or drugs to be Experimental, Investigational, Unproven, Unusual, or Not Customary based upon criteria and standards regularly applied by the industry; or it is not Experimental or Investigational in itself pursuant to the above, and would not be Medically Necessary, but for being provided in conjunction with the provision of a treatment, procedure, device or drug which is Experimental, Investigational, Unproven, Unusual or Not Customary.
   - J. A nationally recognized resource including, but not limited to Hayes Inc. or Milliman, has deemed the Healthcare Services to be Experimental, or Investigational.

   New technology or treatment must have Food and Drug Administration (FDA) approval at minimum to be considered as a covered benefit. Without FDA approval, the technology or treatment is considered investigational or experimental and is not a covered benefit. The

Medical Director investigates and researches new treatments and technologies or new applications of pre-existing treatment and technology. After deliberation by physician-led committees and with input by local physician experts as well as consultation with the health plan actuaries and legal evaluation of current health plan structure for specific exclusions, WINhealth Partners will consider recommendations regarding the new technology. Decisions are based upon safety, efficacy, cost, currently available options, and availability of information in published scientific literature regarding controlled trials.

2. Services for the care or treatment of an Injury incurred in connection with war or any act of war, whether declared or undeclared; any act of terrorism; sickness or treatment of a medical condition arising out of service in the armed forces or units auxiliary thereto; or participation in a felony with a conviction, assault, riot, or insurrection are excluded.

3. Services for any condition, (disease, Illness, or bodily Injury) resulting from employment—if the Member or Enrolled Dependent is eligible to be covered under a Workers' Compensation Act or other similar law—are excluded. Exclusions will not apply to partners, proprietors, or corporate officers of the employer who are not covered by a Workers' Compensation Act or other similar law.

4. Non-surgical treatment of TMJ is excluded. Invasive/incisional surgical treatment of TMJ is covered when preauthorized by WINhealth.

5. Charges or services for dental work or treatment which includes: Hospital or professional care in connection with an operation or treatment for the fitting or wearing of dentures, orthodontic care or dental treatment of malocclusion; and operations on or treatment to the teeth or supporting tissues of teeth are excluded, except for: a) removal of cysts or suspected malignant tumors, or b) treatment of an Injury to natural teeth not caused by chewing if the injury occurs while the patient is insured. Refer to Section 6, Part 1, *Dental Services* for more information.

6. Services for any condition for which an insured would have no legal obligation to pay in the absence of this or any similar coverage or that is rendered by a provider who is a member of the insured's immediate family are excluded.

7. Surgery and any related services intended solely to improve appearance but not restore bodily function are excluded. Surgical correction of a deformity resulting from disease, trauma, developmental or congenital anomalies is covered when preauthorized by WINhealth.

8. Services for the correction of, or complications arising from, treatment or an operation to improve appearance if the original treatment or operation either was not a Covered Service under this health Plan or would not have been a Covered Service if the patient had been insured. However, if (a) the treatment or operation was covered under a Member's prior insurance carrier during the ninety (90)-day period immediately preceding the end of such coverage and immediate transfer to the Plan's coverage, and (b) complications or corrective treatment is required within the first ninety (90) days of the Plan's coverage, then such treatment shall be covered and this exclusion shall not apply.

9. Services for cosmetic purposes including the appearance of skin, restoration of hair, wigs, cranial prostheses, or any form of hair replacement, topical application or treatment are excluded, unless otherwise indicated in this document.

10. Service for orthomolecular therapy including nutrients, vitamins, and food supplements are excluded unless otherwise indicated in the Summary of Benefits and Coverage and preauthorized by WINhealth.

11. Charges or services incurred after the date of termination of the Member's Coverage are excluded.

12. Charges or services for personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, physical fitness equipment, beds or hot tubs are excluded.

13. Charges for failure to keep a scheduled visit, charges for completion of any form, or charges for medical information are excluded.

14. Services provided for school, aviation, camp, employment, sports and travel physicals, immunizations or prescription drugs required for travel are excluded.

15. Charges or services for Custodial Care, domiciliary care or rest cures or treatment in a facility or part of a facility that is mainly a place for rest or convalescence are excluded. Custodial Care for the care or treatment of alcoholism or drug addiction, training, schooling, or occupational therapy is excluded.

16. Services for the reversal of sterilization or treatment of sexual dysfunction not related to organic disease or Injury are excluded.

17. Elective termination of unwanted pregnancy

18. Charges or services for any treatment leading to or in connection with transsexualism, sex changes, or modifications including, but not limited to, surgery are excluded.

19. Charges or services for treatment of weak, strained, or flat feet; Shoe-insert foot orthotics or strapping; cutting, trimming or, removal of corns, calluses; and trimming of the free edge of toenails, nails are excluded. Orthopedic shoes are excluded except for diabetes and peripheral vascular disease with Preauthorization.

20. Charges or services for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses are not covered unless otherwise stated in your Summary of Benefits and Coverage.

21. Charges or services for radial keratotomy, myopic keratomileusis, vision therapy and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia and stigmatic error are excluded

22. Charges or services for hearing aids and supplies, tinnitus maskers, or examinations for the fitting of hearing aids.

23. Counseling or inpatient treatment for ADD/ADHD or oppositional defiant disorder is excluded.

24. Charges for services and supplies for, or related to, conception by artificial means, including but not limited to artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques are excluded.

25. Charges or services for travel whether or not recommended by a Physician are excluded.

26. Charges or services for lifestyle improvements including physical fitness programs.

27. Non-emergent or pre-operative days of Confinement unless preauthorized as Medically Necessary by WINhealth are excluded.

28. Court-ordered treatment is excluded.

29. Emergency room services for non-emergent conditions are excluded.

30. Complimentary therapies including, but not limited to: acupuncture, massage therapy, reflexology and paraffin baths are excluded unless otherwise covered herein.

31. Services rendered at health fairs are excluded, unless otherwise stated in your Summary of Benefits and Coverage.

32. Lithotripsy of plantar fascia for plantar fasciitis is excluded.

33. Intradiscal Electrothermic Therapy (IDET) procedure is excluded.

34. Heathcare Services that are not Covered Services, regardless of the recommendation or order by a Participating or Non-Participating Provider, are excluded.

35. Breast augmentation and breast implants are excluded.

36. Breast reduction and reduction mammoplasty are excluded.

37. Labial reduction is excluded.

38. Penile prostheses of any type, including any mechanical device used to treat erectile dysfunction, are excluded.

39. Surgical or chemical treatment of skin tags or common warts is excluded.

<u>NOTE:</u> This list is not all inclusive. To determine coverage and benefits for specific services, please contact WINhealth Member Services. See Section 2 for contact information.

SECTION 7

Premiums and Copayments

1. Premium Payments

A. **Payment of Premiums**. Under the benefit Plan, the Subscriber is required to make a payment on behalf of each Enrolled Member. Each Member may also be required to make applicable Deductible, Copayments or Coinsurance payments for Healthcare Services received under the health Plan.

B. **Responsibility for Payment** - The Subscriber is responsible for the payment of monthly Premiums for each Member enrolled for Coverage under the health Plan. The Subscriber shall pay in advance the aggregate amount of Premiums for all Enrolled Members no later than the monthly due date specified in this Evidence of Coverage.

C. **Amount of Premiums -** The total amount of Premiums that the Subscriber must pay for each monthly payment period shall be the sum of the individual Premiums for each Member, calculated on the basis of each Member's enrollment classification and rate.

D. **Grace Period** - The Subscriber shall be entitled to a grace period of thirty-one (31) days following each monthly due date for the payment of Premiums. If the Subscriber pays the aggregate amount of Premiums due for a monthly payment period within the applicable grace period, the Subscriber shall be deemed to have made the required payment on the monthly due date. If the Subscriber does not pay the aggregate amount of Premiums due by the end of the grace period, the health benefit Plan will terminate on the last day of the last month for which the Subscriber has made the required Premium payment in full.

2. Copayments

Payment Of Copayments

A. **Member's Responsibility for Copayments: Direct Benefits** - Each Member who receives Direct Benefits under the health Plan shall pay any applicable Copayment for such Direct Benefits directly to the provider who provides the Direct Benefits.

B. **Member's Responsibility for Copayments: Reimbursement Benefits** – When a Member seeks treatment from an Out-of-Network Provider, the Member may be responsible for 100% of the billed charges less any amount paid to the Provider by WINhealth.

C. **Amount of Copayment** - Copayments are defined in your SBC.

D. **More than One Copayment** - The Member is responsible for paying all applicable Copayments if more than one Copayment applies to a particular Healthcare Service.

3. Provider Reimbursement

E. Payment To Providers

1) Except for any applicable Copayment or other payment specified in the Schedule of Benefits, a Member shall not be required to pay any amounts to any Participating Provider who provides Covered Healthcare Services to the Member. All charges for such Healthcare Services in excess of the Copayment or other payment specified in the Schedule of Benefits will be paid by WINhealth directly to the Participating Provider under the terms of the applicable Provider Agreement. If a Member is erroneously charged a fee by a Participating Provider in excess of any applicable Copayment or other payment specified in the Schedule of Benefits, the Member should immediately contact WINhealth for correction of the erroneous charge.
2) A Member is liable for the entire expense charged for Healthcare Services provided by Non-Participating Providers, except for Emergency Healthcare Services, Urgent Healthcare Services, Direct Benefits arranged by the Health Plan under Section 5(2), or Reimbursement Benefits described in Section 5(3).

4. Adjustments To Premium Rates and Copayments

The Premium rates for each eligibility classification, as specified in this Evidence of Coverage and the Copayments applicable to specific Healthcare Services, as specified in the Schedule of Benefits and in any Schedule of Supplemental Coverage, may be adjusted by WINhealth effective as of any due date for the payment of Premiums that is more than one (1) year after the Effective Date. The Premium rates and Copayments may also be changed at any time by amendment of this Evidence of Coverage. WINhealth shall give written notice to the Member of any such change in Premium rates or Copayments at least thirty-one (31) days prior to the effective date of such change.

SECTION 8

TERMINATION OF MEMBER'S COVERAGE

1. **Termination Of Coverage**
   A. A Member's Coverage under the Health Plan shall end on either (1) the date upon which one of the events below occurs; or (2) the last day of the monthly payment period during which one of the events below occurs.
      1) The day after the last day of the grace period for a specified monthly payment period, as described in Section 7(1)(A)(6), if the Premium for the Member for such monthly payment period has not been paid. If the required Premium is accepted by WINhealth after the expiration of the grace period the Member's Coverage will be reinstated retroactively.
      2) Member ceases to be an Eligible Person or Eligible Dependent.
      3) Member requests termination of Coverage in a written notice to the WINhealth.
      4) WINhealth provides written notice to the ember that Coverage is being terminated for one of the following reasons:
      5) The Member knowingly provided materially false information to WINhealth with regard to any person's eligibility for Coverage.
      6) The Member knowingly and without authorization from WINhealth used another Member's WINhealth identification card or permitted another person to use his or her WINhealth identification card.
      7) The Member failed to pay Premium when due and/or within required time frame.
      8) The Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the Plan.
   B. Any termination of Coverage under this Section 8 shall be effective as of 11:59 p.m. Mountain Time on the specified date.
   C. A Member's Coverage may not be terminated retroactively except in cases of fraud or intentional misrepresentation, or failure to timely pay required premiums. WINhealth will provide the Member with thirty (30)-days advance written notice of its intent to retroactively terminate coverage.
   D. A Certificate of Creditable Coverage shall be issued within fourteen (14) days after notification to WINhealth of termination of Coverage. Certificates of Creditable Coverage may be requested for up to twenty-four (24) months after the date Coverage is terminated.

2. **Notification Of Termination Events**
   A. The Member shall notify WINhealth if any of the following events occurs:
      1) The Member ceases to have his or her principal residence in the Service Area
      2) The Member has requested termination of Coverage under Section 8(1) (D)
   B. The notification shall be made as soon as possible after the occurrence of the applicable event. Any termination of Coverage under Section 8(1), however, shall be effective even if notice is not given to WINhealth under this Section 8(2).

3. **Renewability**

A. All health benefit policies are renewable including all Eligible Members or Dependents, except:

1) For nonpayment of the required Premiums by the Member
2) For fraud or material misrepresentation by the Member under the terms of the Coverage
3) For noncompliance with material plan provisions that have been approved by the Commissioner
4) If WINhealth stops writing new individual Evidence of Coverage business as long as:
5) WINhealth provides notice to the Commissioner and contract holder of its decision to stop writing new individual Evidence of Coverage business; and,
6) No policies are cancelled for at least one-hundred-eighty (180) days after the date of the notice of WINhealth decision to stop writing new individual Evidence of Coverage business

SECTION 9

CLAIMS PROCEDURE AND RESOLUTION OF APPEAL OR QUALITY OF CARE ISSUE

1. **Claims For Benefits**
   A Member's claim for benefits under the health Plan is processed as a Direct Benefits claim in accordance with Section 5(2), a Reimbursement Benefits claim in accordance with Section 5(3), or a second opinion in accordance with Section 5(5).
2. **Initial Benefits Determinations**
   A. After written notice of a claim for benefits or Preauthorization request is received by WINhealth, WINhealth shall review and provide a benefits determination to the Member as follows:
      1) Preauthorized Services – WINhealth shall notify a Member within fifteen (15) days after receipt of the Preauthorization request whether a service is covered under the Plan. If an extension of this period is necessary due to the failure of the Member to submit the necessary information for WINhealth to evaluate the request for benefits, WINhealth shall contact the Member and/or provider and specifically describe the required information and allow the Member and/or provider thirty (30) days from receipt of the original authorization request to provide the specified information. If the requested information is not provided within thirty (30) days of the original authorization request, the request will be cancelled.
      2) Urgent Healthcare Services Out-of-Network – WINhealth shall notify a Member as to whether an Urgent Healthcare Service is covered under the Plan as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the authorization request, provided that the Plan defers to the attending provider with respect to the decision of whether the claim constitutes "urgent care." If a Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, WINhealth shall notify the Member as soon as possible and not later than twenty-four (24) hours after receipt of the authorization request by the Plan. The Member shall be afforded a reasonable amount of time under the circumstances, and not less than forty-eight (48) hours, to provide the information necessary for WINhealth to make a benefit determination.
      3) Notice Provided to Member of Benefit Determination – In the event of an adverse benefit determination, the Plan shall provide a notice of the determination containing the following information:
         a) date of service;
         b) provider of service;
         c) claim amount (if applicable);
         d) information regarding availability of diagnosis and treatment codes and corresponding meanings upon request;
         e) the specific reason(s) for the adverse determination, including the denial code and corresponding meaning;
         f) a description of the Plan provision or standard (if any) on which the determination is based;

g) a description of the Plan's review procedures and time limits applicable to such procedures;

h) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of cost upon request;

i) if the adverse benefit determination is based on a medical necessity or experimental treatment or other similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

j) In the case of an adverse benefit determination involving urgent care, a description of the expedited review process applicable to such claims, except that notice of the determination may be provided orally, with a written confirmation within three (3) days.

B. Payment of Covered Benefits Claims – All covered benefits claims shall be paid by WINhealth within forty-five (45) days of written proof of the service(s) and sufficient supporting evidence.

3. Complaint Procedure

A. Oral Complaint – A Member may issue an oral complaint by calling Member Services at (307) 773-1330 or visiting WINhealth's Cheyenne office and asking to meet with a Member Services representative. The WINhealth staff member who receives the oral complaint shall complete a Notice of Complaint/Appeals form and submit it to the Appeals Coordinator for processing.

B. Written Complaint – A Member may issue a written complaint by mailing it to WINhealth's Cheyenne office; emailing it to Member Services at service@winhealthplans.com; sending it via facsimile to (307) 638-7701; transmitting it through our member portal at https://WINhealth.healthtrioconnect.com; or by hand delivering it to the Cheyenne office.. Written complaints shall immediately be forwarded to the Appeals Coordinator for review and assignment to the appropriate department manager.

C. Processing and Appeal of Complaint – WINhealth will investigate and respond to a Member's complaint as expeditiously as possible. Within thirty (30) days of receipt of the complaint, WINhealth will provide the Member with a written response describing the investigation of the complaint, the results of that investigation, and any action taken by WINhealth to respond to and/or resolve the complaint. The letter will also include a description of the Member's right, if any, to appeal the response. In the event that the issue is urgent and delay in reviewing the issue could seriously jeopardize the life and/or health of a Member, a Member's ability to regain maximum functioning, or the ongoing immediate treatment of a Member, investigation of the issue will be expedited and a response provided within seventy-two (72) hours.

If a Member is dissatisfied with the response to the complaint, and the resolution is an adverse decision affecting the Member's ability to receive benefit coverage, access to care, access to services or payment for care of services, the Member may seek review of the complaint through the Appeal process.

D. **Language Services** – For Members who request language assistance to issue a complaint, WINhealth will provide translation services in the requested language through bilingual staff or an interpreter and utilize similar services to communicate the results of the complaint investigation to the Member.

4. **Appeal Procedure**

A. The Member or the Member's authorized representative has the right to appeal an adverse benefit determination pursuant to the following procedure.

B. **Informal Resolution:** - WINhealth's Member Services department shall contact the Member or the Member’s authorized representative to attempt to resolve the issue through informal discussions. Informal resolution is not required prior to initiation of an internal appeal.

C. **Internal Appeal** – A Member may appeal an adverse benefit determination and obtain a full independent review of the determination by submitting a request I writing to WINhealth. An Appeal may be requested for an adverse determination involving a service already provided (e.g. an emergency room visit) or a service for which the Member and his/her provider are requesting Preauthorization (e.g. referral to a Non-Participating Provider).

D. **Timing**: WINhealth must receive a request for appeal within one-hundred-eighty (180) days of the initial determination by WINhealth. An Appeal of a service already provided will be decided within forty-five (45) calendar days of WINhealth's receipt of the appeal request. An Appeal regarding a service not yet provided will be decided within thirty (30) calendar days of WINhealth's receiving the appeal request. Medical Necessity: If the adverse benefit determination on appeal involves medical judgment, a qualified, independent health professional will be consulted in reviewing the determination and and identified in the decision on appeal provided to the Member. At the Member's election, a signed opinion will be obtained from a medical consultant not employed by WINhealth.

E. **Language Services** – For Members who request language assistance to appeal an adverse benefit determination, WINhealth will provide translation services in the requested language through bilingual staff or an interpreter and utilize similar services to communicate the results of the Appeal investigation to the Member.

F. **Expedited Appeal**: If the adverse benefit determination involves urgent care and/or a Member and his/her provider believe a standard appeal may delay medical treatment in such a way that endangers the Member's life, health or ability to regain maximum function, the Member and his/her provider may request an expedited appeal. A request for an expedited appeal may be submitted orally or in writing, and all information, including the Plan's determination on review, shall be transmitted between the Plan and the Member by telephone, facsimile, or other similarly expeditious method. An expedited appeal shall be decided as soon as possible but not later than seventy-two (72) hours after the Plan's receipt of the request for review.

G. **Concurrent Request for Expedited External Review**: If the expedited appeal involves a determination based on medical necessity, the Member may request an expedited external review (using the procedure described below) at the same time the Member requests the expedited internal appeal.

H. **External Review**: If a Member's claim is denied for Medical Necessity and the Member has exhausted the internal appeal process outlined above, the Member has the right to request an external review of the adverse benefit determination by an Independent Review Organization ("IRO") approved by the State of Wyoming Department of Insurance ("DOI").

I. Timing**:** Member must submit the request for external review to WINhealth on a form approved by the DOI within sixty (60) days of receiving the Internal Appeal determination. WINhealth will immediately provide a copy of the request to the DOI and assign the request to an IRO approved by the DOI. The IRO will be provided with all documents and other information upon which WINhealth relied in making the adverse benefit determination.

J. **IRO review:** The IRO shall determine whether the Member is or was covered under the Plan at the time the medical services were requested or provided; whether such services appear to be Covered Services under the Plan; whether the Member has exhausted the internal appeal process under the Plan; and whether the Member has provided WINhealth with all information required to process an external review, including an authorization for release of protected health information related to the external review, a health care professional's certification as to medical necessity, and the required fifteen dollar ($15) filing fee. WINhealth shall be responsible for the cost of the IRO's review. Within five (5) days, the IRO will notify WINhealth and the Member whether the documentation is complete. The Member is permitted to submit in writing to the IRO any additional supporting documentation to be considered by the IRO in reviewing the adverse benefit determination. The IRO will share all such information with WINhealth.

K. **Determination:** Within forty-five (45) days of the date the request for external review is received, the IRO shall provide written notice to the Member, WINhealth, and the DOI of its decision to uphold or reverse WINhealth' determination that the services requested by the Member are not medically necessary. In the event that the IRO determines that the claim(s) should be allowed, WINhealth will authorize the services and/or approve the claim(s) for payment and notify the Member of such approval within five (5) days.

L. **Expedited external review:** A Member may request an expedited review by the IRO if the timeframe for completing a normal external review would seriously jeopardize the life and health of the Member or the Member's ability to regain maximum function, or the Member's claim concerns a request for admission, availability of care, continued stay or health care service for which the Member received emergency services but has not been discharged from a health care facility. Such review will be completed as soon as possible but in no event more than seventy-two (72) hours after the date the request for expedited external review is received.

5. Quality Assurance Procedure

If a Member has a concern or complaint about the quality of the Healthcare Services rendered by a Participating Provider, the Member may report the matter in writing to the Medical Director at WINhealth. The Medical Director will respond to the Member to confirm receipt of the question

or issue and proceed investigate the matter pursuant to WINhealth's Quality Assurance Program and the Healthcare Quality Improvement Act of 1986, as applicable.

6. **Department Of Insurance**
If a Member has a concern or complaint about the Plan, the Member may submit a consumer complaint to the Wyoming Department of Insurance using the form and instructions provided on the DOI website.

SECTION 10

COORDINATION OF BENEFITS

1. **Applicability Of Coordination Of Benefits Provision**
   A. **In General** – This "Coordination of Benefits" " ("COB") Provision is intended to avoid delays in claims payment and duplication of benefits when a Member is covered by two (2) or more coverage plans providing benefits or services for medical care or treatment.
   B. **Application** - This COB Provision applies to WINhealth when a Member has health care coverage under more than one plan. If this COB Provision applies, the order of benefit determination rules listed herein determine whether the benefits of WINhealth are applied before or after those of another Coverage plan. The benefits of WINhealth:
      1) Shall not be reduced when, under the order of benefit determination rules, WINhealth applies the Plan benefits before another plan; but
      2) May be reduced when, under the order of benefits determination rules, another plan applies its benefits first. The effect of any such reduction is described in Section 12(4).

2. **COB Provision Definitions**
   For purposes of Section 10, the following defined terms shall have the meanings set forth below:
   A. **Coverage plan** means any of the following plans that provides benefits or services for, or because of, medical or dental care or treatment:
      1) Group insurance or group-type Coverage plans, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage Plans. It also includes coverage other than school accident-type Coverage
      2) Coverage under a governmental plan or Coverage required or provided by law. This does not include a state plan under Medicaid.

      Each contract or other arrangement for Coverage under subsections (1) or (2) above is a separate Coverage plan. Also, if an arrangement has two parts and the COB Provision rules apply only to one of the two parts, each of the parts is a separate Coverage plan.
   B. **Primary Plan** means the plan whose benefits must be determined without taking into account the existence of any other plan. When WINhealth is a Primary Plan, its benefits are determined before those of the other Coverage plan without considering the other Coverage plan's benefits. When WINhealth is a Secondary Plan, its benefits are determined after those of the Primary Coverage plan and may be reduced because of the Primary Coverage plan's benefits. When there are more than two (2) Coverage plans covering the insured person, WINhealth may be a Primary Plan as to one or more other Coverage plans, and may be a Secondary Plan as to a different Coverage plan or plans.
   C. **Secondary Plan** means a Coverage plan that is not a Primary Plan.
   D. **Allowable Expense** means a necessary, Reasonable and Customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more Coverage plans covering the person for whom the claim is made.
   E. **Claim Determination Period** means a plan year. However, it does not include any part of a year during which a person has no Coverage under WINhealth or any part of a year before the date this COB Provision or a similar provision takes effect.

3. **Order of Benefit Determination Rules**
WINhealth determines whether the Plan is a Primary Plan or Secondary Plan with respect to another Coverage plan by using the first of the following rules that applies:

A. **Employee/Non-Employee** - The Coverage plan that covers the person as a Member or Subscriber is the Primary Plan.

B. **Dependent Child/Parents not Separated or Divorced** - Except as stated in subsection (C) below, when the Plan and another Coverage plan cover the same Child as a Dependent, and the parents are not separated or divorced:
1) The Coverage plan of the parent whose birthday falls earlier in a year is the Primary.
2) If both parents have the same birthday, the Coverage plan that covered one parent for the longer period of time is the Primary Plan.

C. **Dependent Child/Parents Separated or Divorced** - If two or more Coverage plans cover a person as a Dependent Child of divorced or separated parents, the Coverage plan described in the first of the following subsections is the Primary Plan:
1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and the entity obligated to pay or provide the benefits under that parent's Coverage Plan has actual knowledge of those terms, that Coverage Plan is the Primary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
2) The Coverage plan of the parent with custody of the Child;
3) The Coverage plan of the Spouse of the parent with custody of the Child.
4) The Coverage plan of the parent not having custody of the Child.

D. **Active/Inactive Employees** - The Coverage plan that covers a person as an Employee who is neither laid off nor retired (or as a Dependent of such an Employee) is the Primary Plan.

E. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Coverage plan that has covered an Employee, Member or Subscriber for the longer period is the Primary Plan.

4. **Effect On WINhealth Benefits**

A. **Application of this Section** - When the Plan is a Secondary Plan, the benefits of the Plan may be reduced as provided under this section. Such other Coverage plan or Coverage plans are referred to as "the Primary Plan" in subsection (B) below.

B. **Reduction in WINhealth Benefits** - The benefits of the Plan will be reduced when the benefits that would be payable for the Allowable Expenses in a Claim Determination Period under the Plan in the absence of this COB Provision are less than or equal to the benefits that would be payable for the Allowable Expenses in the same Claim Determination Period under the Primary Plan. In that case, the benefits of the Plan will be reduced so that the benefits under the Plan, when added to the benefits exceed the Allowable Expenses in the Claim Determination Period.

5. **Right To Receive And Release Needed Information**
WINhealth shall have the right to obtain or provide such information that it determines to be necessary to administer this COB Provision. The Plan may obtain or provide such information without notice to, or consent from, any person. Each Member who receives WINhealth Benefits must provide any reasonable information requested by WINhealth under this Section 10(5).

6. **Payments Made Under The Other Coverage Plan**
A payment made by Medicaid or Medicare may include an amount that should have been paid under the Plan. If it does, WINhealth may pay that amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Plan. WINhealth will not have to pay that amount again.

7. **WINhealth Right Of Recovery**
If the amount of the payments made by WINhealth exceeds the amount the Plan should have paid under this COB Provision, then WINhealth shall have the right to recover the excess from one or more of the persons to whom or for whom it has paid benefits, or from insurance companies or other organizations who have an obligation to pay such benefits.

SECTION 11

SUBROGATION

As a condition of eligibility to receive benefits under the Health Plan, each Member agrees that WINhealth shall be subrogated to his or her Rights of Recovery of damages, to the extent benefits are provided under the Plan for Illness or Injury for which any third person is (or may be) legally responsible, and the Member hereby assigns to WINhealth such cause of action.

The Member shall cooperate with WINhealth and do whatever is reasonably necessary to secure those Rights of Recovery. The Member shall do nothing that would prejudice those Rights.

If the Member fails to take the necessary legal action to recover from a responsible party, the Member agrees (as a condition of eligibility to receive benefits under the Plan) that WINhealth may proceed in the name of the Member against the responsible party and will be entitled to recovery of the amount of benefits paid and the expenses for that recovery.

In the event that WINhealth recovers an amount greater than the benefit paid, the excess, reduced by the expenses of recovery, will be paid to the Member. WINhealth reserves the right to compromise the amount of the claim if, in the opinion of WINhealth, it is appropriate to do so.

The Plan has the Rights of first recovery against any third party allegedly responsible for the Member's Injury or Illness for which benefits were paid by WINhealth. WINhealth shall be reimbursed in full prior to the payment of any damages or settlement proceeds to the Member even if the damages or proceeds available to satisfy any judgment against the third party are not sufficient to fully compensate the Member for his or her Injury or Illness.

SECTION 12

SERVICE AREA

The Service Area for the Health Plan is the state of Wyoming.

SECTION 13

AMENDMENT AND TERMINATION OF CONTRACT

1. **Amendment Of Contract**
   The Contract may be amended at any time upon the written agreement of WINhealth and the Member. No amendment of the Contract shall impair any Member's right to Reimbursement Benefits for Reimbursable Services incurred by the Member prior to the effective date of the amendment. Any amendment to the Contract or to this Evidence of Coverage shall be stated in a separate document that is issued to each Member.

2. **Termination Of Contract**
   The Contract shall continue in effect until terminated. The Contract shall terminate on the earliest of the following dates:

   A. The day after the last day of the last month for which the Member has made the required Premium payment in full, if the Member has not paid the total amount of Premiums due by the end of the grace period defined in Section 7(1)(6)
   B. The date specified by either WINhealth or the Member in a written notice of termination given to the other party at least thirty-one (31) days prior to the specified date of termination

   The termination of the Contract shall not impair any Member's right to Reimbursement Benefits for Reimbursable Services incurred by the Member prior to the date of termination, nor shall the termination relieve the Member of its obligation to pay any Premiums due for periods prior to the date of termination.

SECTION 14

MISCELLANEOUS PROVISIONS

1. Notices

Notice given by the Plan to Members shall constitute notice.

2. Entire Agreement

The Contract constitutes the entire agreement between WINhealth and the Member regarding the Coverage to be provided to Members under the Health Plan. All statements made by the Member shall, in the absence of fraud, be deemed to be representations and not warranties. No such statement shall void or reduce Coverage under the Health Plan or be used in defense of a legal action unless it is contained in a written application.

3. Relationship Between Parties

The relationships between the various parties under the Health Plan are as follows:

A. **Independent Contractors** - The relationship between WINhealth and Participating Providers (except for the position of Medical Director) and between WINhealth and the Member are contractual relationships between independent contractors. Participating Providers are not agents or employees of WINhealth, and WINhealth and its employees are not agents or employees of Participating Providers.

B. **Provider and Patient** - The relationship between a Participating Provider and any Member is that of provider and patient. A Physician who provides medical services to a Member is solely responsible for those medical services. A Hospital that provides Hospital services to a Member is solely responsible for those services.

4. Records And Information

A. The All documents furnished to the Plan by a person in connection with that person's Coverage, and all records of the Plan that are pertinent to a Member's Coverage may be inspected by WINhealth at any reasonable time..

B. As a condition of eligibility for Coverage under the Health Plan, each Member authorizes and directs any person or facility that has, examined or treated the Member to furnish to WINhealth at any reasonable time, upon its request, any and all information and records or copies of records relating to, examination or treatment rendered to the Member. WINhealth agrees that such information and records will be considered confidential.

C. WINhealth shall have the right to submit to appropriate medical or other review bodies or individuals all information regarding Healthcare Services provided to Members.

5. **Examinations**
In the event of a question or dispute concerning the provision of WINhealth Benefits, WINhealth may reasonably require that a Member be examined, at the Health Plan's expense, by a Physician acceptable to WINhealth.

6. **Misstatement of Age.**
If the insured's age is misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

7. **Limitation Of Actions**
No action in law or equity may be brought against the Health Plan, WINhealth, or any officer, director, or employee of WINhealth, by any Member with respect to any matter arising under the Health Plan or the relationship between that Member and WINhealth until the Member has fully complied with claims and complaint procedures set forth in Section 9 of this Evidence of Coverage. No action at law or in equity shall be brought to recover under the Evidence of Coverage prior to the expiration of sixty (60) days after written proof of loss is furnished in accordance with the requirements of the Evidence of Coverage and no action shall be brought upon the expiration of three (3) years after the time written proof of loss is required to be furnished..

8. **Time Limit On Certain Defenses**
Except for a fraudulent statement, no statement made by the Member shall be used to void the Contract after it has been in force for a period of two (2) years.

9. **Commencement And Termination Of Coverage**
All Coverage under the Health Plan shall begin and end at 12:01 a.m. Mountain Time on the date as of which the Coverage begins or ends.

10. **Assignment Of Policy**
This policy is not assignable.

11. **Governing Law**
The Contract is delivered in and shall be governed by the laws of the State of Wyoming.

12. **Conformity With Statutes**
Any provision of the Health Plan, which, on its effective date, is not in conformity with applicable federal statutes and regulations, or with Wyoming statutes and applicable Wyoming regulations, shall not be rendered invalid, but shall be construed and applied as if it is in full conformity and compliance with such provisions and applicable regulations, and the Health Plan is hereby amended to conform to the minimum requirements of such statutes and regulations.

13. **Workers' Compensation Not Affected**
The Coverage provided under the Health Plan is not in lieu of and does not affect any requirements for Coverage by Workers' Compensation Insurance. Benefits will not be denied to a Member whose Employer has not complied with law and regulations governing Workers'

Compensation Insurance, provided that such Member has received Healthcare Services in accordance with the requirements of the Health Plan.

14. **Exemption of Proceeds; Disability Insurance**
Except as otherwise provided herein, the proceeds of all contracts of disability insurance and of provisions specifying benefits because of the insured's disability, which are supplemental to any life insurance or annuity contracts executed, are exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his use.

15. **Nondiscrimination**
In compliance with federal and state law, WINhealth shall not discriminate on the basis of age, gender, color, race, creed, national origin, ancestry, disability, marital status, sexual preference, religious affiliation or public assistance status.

16. **Headings**
The subject headings used in the Evidence of Coverage are included for purposes of reference only and shall not affect the construction or interpretation of any of its provisions.

17. **Construction**
Throughout the Evidence of Coverage, the singular shall include the plural, the plural shall include the singular, and all genders shall be deemed to include other genders, whenever the context so requires.

SECTION 16

Privacy Practices

Privacy Practices

Members' protected health information (PHI) is confidential. PHI is information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present or future payment for the provision of health care to a Member; and that identifies the Member or for which there is a reasonable basis to believe the information can be used to identify the Member. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations limit the Plan's use and disclosure of Member PHI, as further described in the **Notice of Privacy Practices** included at the end of this document as Appendix A.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Wyoming who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Wyoming Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep Coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The Wyoming Life and Health Insurance Guaranty Association may not provide Coverage for this policy. If Coverage is provided, it may be subject to substantial limitations or Exclusions, and require continued residency in Wyoming. You should not rely on Coverage by the Wyoming Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales or to induce you to purchase any kind of insurance policy.*

The Wyoming Life and Health Insurance Guaranty Association
P. O. Box 36009
Denver, CO 80236-0009
(888) 959-4091
(303) 292-5022

State of Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, Wyoming 82002
(800) 438-5768 (in Wyoming)
(307) 777-7401
Fax: (307) 777-2446

The state law that provides for this safety net Coverage is called the Wyoming Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Coverage

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are **not** protected by this Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside of that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also **does not** provide Coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy by a group contract-holder;
- Annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

Limits on Amount of Coverage

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values for life insurance policies, $300,000 for basic hospital, medical and surgical insurance or major medical insurance, $300,000 for disability insurance, disability income insurance and long-term care insurance, $100,000 for coverages not defined as disability insurance or disability income insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance, including any net cash surrender and net cash withdrawal values, $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or $300,000 in life insurance death benefits – - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of Coverages.

APPENDIX A

NOTICE OF PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

The WINhealth Partners Health Plan (the "Plan") is referred to as "we," "us," and "our" in this Notice. Persons insured as participants in the Plan are referred to as "you" and "your" in this Notice.

The Plan is required by law to maintain the privacy of protected health information (PHI). PHI is information that is created or received by the Plan that relates to the past, present or future physical or mental health or condition of a Plan member; the provision of health care to a Plan member; or the past, present or future payment for the provision of health care to a Plan member; and that identifies the Plan member or for which there is a reasonable basis to believe the information can be used to identify the Plan member. This Notice includes information about our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice, but we may need to revise our privacy practices from time to time. Thus, we reserve the right to change the terms of the Notice and make the new provisions effective for all PHI that we maintain. If we revise the Notice, we will either (i) post the revised Notice on our website (www.winhealthplans.com) by the effective date of any material change and provide information on how to obtain the revised Notice in our next annual mailing to Plan members, or (ii) if we do not post the revised Notice on our website, we will provide you with a revised Notice within 60 days of any material change.

We are required by law to:

- Maintain the privacy of your PHI.
- Give you this Notice of our legal duties, privacy practices, and your rights with respect to your PHI.
- Follow the terms of this Notice.
- Notify you following a breach of unsecured PHI.

Permitted Uses and Disclosures of Your Protected Health Information

We may use and/or disclose your PHI for the following purposes:

- **Treatment** – We may discuss your PHI with heath care providers in order to facilitate medical treatment. For example, Our Medical Management department may discuss your PHI with your doctor in order to authorize coverage for medical services requested by your doctor.

- **Payment** – We may use and disclose your PHI in order to pay for medical services or equipment you receive that are covered under your benefit plan. In addition, we may disclose your PHI in order to coordinate benefits with other insurance companies. For example, if you receive medical treatment following a motor vehicle accident, we may disclose your PHI to your automobile insurance company in order to coordinate benefits for medical treatment paid under your car insurance policy with those provided under your health benefit plan.

- **Health Care Operations** – We may use and disclose your PHI in order to operate our business and ensure that you receive quality care. For example, we may disclose your PHI to contracted health care providers tasked with evaluating the quality of treatment and services delivered by participating providers.

- **Care Management – We may also use your PHI to identify and contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you suffer from a chronic disease such as asthma or diabetes, we may contact you to discuss your participation in our Disease Management program, which assists members in managing treatment of such illnesses. We may also send you newsletters that contain general health information.**

- **Plan Sponsor** – We may disclose your PHI to the Plan Sponsor for use in administering the Plan.

- **Health Oversight Activities –** We may disclose your PHI to health oversight agencies for oversight activities authorized by law, including audits, investigations, inspections, and licensure or disciplinary actions related to health care programs and entities.

- **Disclosure Required by Law –** We may use or disclose your PHI when required by law.

- **Public Health –** We may disclose your PHI to public health authorities tasked with collecting information about public health and monitoring the quality and safety of FDA-regulated products and activities. We may also disclose your PHI to the extent authorized by law in order to notify other persons of potential exposure to a communicable disease and/or risk of contracting or spreading such a disease.

- **Workers' Compensation** – We may disclose your PHI as required by workers' compensation laws or other programs that provide benefits for work-related injuries or illnesses.

- **Abuse or Neglect –** We may disclose your PHI to the appropriate governmental authorities if we reasonably believe that you have been a victim of abuse, neglect, or domestic violence.

- **Legal Proceedings** – We may disclose your PHI in response to a court order, subpoena, discovery request or other lawful process related to a judicial or administrative proceeding.

- **Business Associates** – We may disclose your PHI to third parties we contract with to provide various services. For example, we may disclose your PHI to a third-party consultant hired to review and evaluate the quality of care you received from a Plan provider. These third parties ("business associates") are also required to maintain the privacy of your PHI.

- **Law Enforcement** – We may disclose your PHI to law enforcement officials in order to aid in the investigation of a crime.

- **Imminent threat to health or safety** – We may disclose your PHI as necessary to avoid an imminent threat to your health and safety or that of the public.

- **Those Involved in Your Care** – We may disclose your PHI to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of

your location and condition. If you are not present, our disclosure will be limited to the PHI that directly relates to the individual's involvement in your medical care.

- **Fundraising** – We may use or disclose your PHI to contact you for fundraising purposes. However, you have the right to opt-out of receiving such fundraising communications. If you opt-out, we will not contact you for fundraising purposes.

- **Other** – We may disclose PHI of deceased members to coroners or funeral directors. We may disclose PHI to organ donation and transplant associations to facilitate organ transplants. We may disclose your PHI, if you are in the Armed Forces for activities deemed necessary by appropriate military command authorities. We may disclose PHI to authorized federal officials for conducting national security and intelligence activities or to the Department of State to make medical suitability determinations. If you are an inmate at a correctional institution, then under certain circumstances, we may disclose your PHI to the correctional institution.

Uses and Disclosures of Your Protected Health Information that Require Your Authorization

We must obtain your written permission ("Authorization") to use or disclose your PHI to any person and for any purpose not referenced above. Specifically, most uses and disclosures of psychotherapy notes will require your authorization. Uses and disclosures of PHI which result in our receipt of financial payment from a third party whose product or service is being marketed will require your authorization. Additionally, disclosures that constitute a sale of PHI will also require an authorization. You have the right to revoke an Authorization at any time, except in cases in which we have already acted based on your permission.

Your Rights with Respect to Your Protected Health Information

- You and/or your personal representative are entitled to see and get a copy of your PHI held by the Plan. However, you do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies.
- You have the right to request restrictions on certain uses and disclosures of your PHI. However, we are not required to agree to all requested restrictions. We will honor requests to restrict disclosures to your health plan where (i) the disclosure is for payment or health care operations purposes and is not required by law, and (ii) the information relates to medical services paid in full by you or someone other than your health plan.
- You may request that we communicate with you in a different manner or at a different place. For example, you may request that we send correspondence to a post office box instead of your home address.
- You have the right to request that we amend your PHI; however, we may deny a request to amend PHI if it was not created by us or we believe the PHI is accurate and complete. If your amendment request is denied, you may submit a statement of your disagreement to be included with subsequent disclosures of your PHI.
- You may request a list of disclosures we have made of your PHI. Your request may be for disclosures made up to 6 years prior to the date of your request. If the PHI disclosed is an electronic health record, the accounting will include disclosures up to 3 years before the date of your request. The list will include the date of each disclosure, the name of the person or entity to whom we made the disclosure, a description of the PHI disclosed, and the reason for such

disclosure. The list will not include disclosures made for treatment, payment, or health care operations; disclosures authorized by you or your personal representative; or disclosures required by law.

- You may receive a paper copy of this Notice upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan and/or with the Secretary of the Department of Health and Human Services. There will be no retaliation of any kind against any person making a complaint. Complaints may be made in writing to the addresses below:

WINhealth Partners
Attn: Compliance Officer
1200 East 20th Street
Cheyenne, WY 82001
Phone: (307) 773-1300
Toll Free: (800) 868-7670
Fax: (307) 638-7701

Region VIII - Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
Phone: (303) 844-2024
Fax: (303) 844-2025
TDD: (303) 844-3439