Medical and Prescription Drug Plan Summary Plan Description

Effective January 1, 2015

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APPENDIX A

SECTION 1

General Information about Healthcare Services

The following Summary Plan Description explains the Covered Services to which you are entitled as a Member of the BestLife Health Plan ("the Plan) offered by your employer, Cheyenne Regional Medical Center ("Cheyenne Regional"). If you have enrolled your Spouse or any Children for Coverage under the Plan, this Summary Plan Description also explains the Covered Services available to them. Defined terms are identified by being capitalized throughout the Summary Plan Description and definitions can be found in Section 3.

You should read this Summary Plan Description 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 Summary Plan Description to ensure that you understand your role in obtaining Plan benefits.

General Plan Information

The Plan is a self-funded Plan administered by WINhealth Partners ("WIN"). The Plan year is January through December. All benefits and deductibles reset every January 1st. Your employer has the right to amend or terminate the Plan at any time during the Plan year. Members of the Plan are responsible to verify benefits to ensure the rules of the Plan have been followed for payment of covered services.

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 healthcare 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 WIN or the number on your identification card; if that is not reasonably possible, you should either 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 WIN fee schedule. Reimbursement mechanisms may be used to encourage providers to offer the most medically appropriate, cost effective care. Such incentive payments may also be based on the level of satisfaction reported by patients related to their care from Participating Providers.

You should always show the healthcare provider your Plan identification card. Prior to your appointment, you should also ensure that you have satisfied all requirements for obtaining Covered Services (for example, by getting a proper referral or by getting the Preauthorization from WIN).

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

Participating Provider Network

The Plan utilizes an integrated healthcare 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 Physician from the list of participating physicians. Your local Physician will help coordinate your care within the WIN network.

Our Participating Provider Directory lists those select Physicians, facilities and ancillary service providers who participate. The Plan strongly encourages a long-term primary relationship with a Physician or Physicians who understand the particular health needs of each patient.

The Plan does not require that you choose a Primary Care Provider in order to obtain referrals to see Specialist Providers. However, the Plan believes that using a Primary Care Provider enhances a Member's ability to receive the best care possible. As such, the Plan 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*:

- Primary Care Physicians
- Family Practice Physicians
- General Practice Physicians
- Pediatricians
- OB-GYN
- Internal Medicine Physicians
- Nurse Practitioners
- Physician Assistants

The following providers will be considered Specialist Providers: Any provider not listed above and whose practice is limited to a specific area of medicine.

*The listed providers must be practicing within their Primary Care capacity for the lower copayment to apply, for example, guiding a woman through a pregnancy or seeing a toddler for a well-child visit. If the provider is seeing patients in a Specialist Provider capacity, the higher copayment will apply. For example, a nurse practitioner or a general practitioner who is working in a specialty clinic (such as dermatology, neurology, or cardiology) or who has limited their practice to a specific area of medicine other than Primary Care will be considered a Specialist Provider for copayment purposes.

Tier 1 Level Benefits

The Plan encourages you to receive care from a Participating Provider ("In-Network"). You may receive Covered Services from any Physician who is a Participating Provider in the network of participating physicians. Some Non-Physician Healthcare Services require a referral from a Participating Physician and Preauthorization by WIN. If care cannot be delivered locally because of the need for specialized services, the request from a Network Physician and Preauthorization by WIN enables you to seek care from an approved Participating Provider outside the Service Area (usually a Tier 2 benefit) and receive Tier 1 level benefits. It is important to remember that these Tier 2 benefits will be reimbursed at the Tier 1 level ONLY when the services are not available from an In-Network provider. Emergent services obtained outside the Service Area will be Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare services will be covered outside the Service Area only when WIN is notified in advance and the services are preauthorized. If it is after hours or on the weekend, please call Member Services to leave a message so that the correct Tier level can be applied to your benefit. If you are unsure whether your symptoms require Urgent Healthcare services, you can access the nurse line by calling WIN or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent Healthcare services.

Tier 2 Level Benefits

Members may choose to obtain services from our extended network by receiving care from a MultiPlan Provider. MultiPlan providers can be accessed without a referral for the Tier 2 benefit. Multiplan providers may bill the member for the difference between the allowable Tier 2 benefit paid by WIN and the total cost of services provided when preauthorization is required but not obtained. For a listing of MultiPlan providers, please follow the MultiPlan link on the Cheyenne Regional website. Members are still responsible for verifying whether a service requires an authorization. Services that require an authorization In-Network will still require an authorization Out-of-Network for any coverage to apply. Emergent services obtained outside the Service Area will be Tier 1 Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare services will be covered outside the Service Area at Tier 1 only when WIN is notified in advance and the services are preauthorized. If it is after hours or on

the weekend, please call member services to leave a message so that the correct Tier level can be applied to your visit. If you are unsure whether your symptoms require Urgent Healthcare services, you can access the nurse line by calling WIN or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent Healthcare services.

Tier 3 Level Benefits

Members may choose to obtain services from physicians/facilities that are not contracted directly with the network or with MultiPlan. Services rendered by these physicians/facilities will be considered Out-of-Network and the Tier 3 benefit will apply. Out-of-Network providers may bill the member for the difference between the allowable Tier 3 benefit paid by WIN and the total cost of services provided. Members are still responsible for verifying whether a service requires an authorization. Services that require an authorization In-Network will still require an authorization Out-of-Network for any coverage to apply. Emergent services obtained outside the Service Area will be Tier 1 Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare services will be covered outside the Service Area at Tier 1 only when WIN is notified in advance and the services are preauthorized. If it is after hours or on the weekend, please call member services to leave a message so that the correct Tier level can be applied to your visit. If you are unsure whether your symptoms require Urgent Healthcare services, you can access the nurse line by calling WIN or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent Healthcare services.

Plan Information

Plan Name: BestLife Medical and Prescription Drug Plan ("the Plan")

Plan Sponsor and Employer: Cheyenne Regional Medical Center ("Cheyenne Regional")

Third Party Administrator: WINhealth Partners ("WIN")

Plan Effective Date: January 1, 2013

Type of Administration: The Plan is an employer-sponsored, self-funded health benefit plan which provides medical and prescription drug benefits, and administrative service is provided through a third party claims administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.
Cheyenne Regional has maintained for its eligible employees a Plan of benefits, which includes medical and prescription drug coverage.

This document contains certain definitions and general administrative provisions which govern the Plan.

The provisions on the following pages are a part of this Plan. Such provisions alone, including any attachments, constitute the arrangement under which payments will be made.

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 Partners**
	1200 East 20th Street, Suite B
	Cheyenne, Wyoming 82001
Telephone:	**(307) 773-1305 or (800) 868-7670**
Fax:	**(307) 638-7701**

Member Services Department Contact:

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

Member Services (telephone).....(307) 773-1305

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

SECTION 3

Definitions

The following defined terms shall have the meanings set forth below when used in this Summary Plan Description unless the context requires otherwise. Defined terms are identified by being capitalized throughout the Summary Plan Description. Additional terms are defined elsewhere in the Summary Plan Description 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 SERVICES** - means those Healthcare Services for the diagnosis and treatment of a behavioral disorder that are Covered Services.

3. **BENEFIT PLAN** - The defined set of benefits provided to members under the Plan. The Benefit Plan also specifies the copayment, if any, and special limitations and Exclusions applicable to each specific Covered Service.

4. **CHILD** - means a person who is the Child, Stepchild, legally adopted Child, or Foster Child of an Eligible Person, 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) and is considered disabled and primarily dependant on the Eligible Person for support and maintenance 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 Eligible Person
      2) Who is being raised as a Child of the Eligible Person
      3) Who is primarily dependent on the Eligible Person for support and maintenance
      4) For whom the Eligible Person has taken full parental responsibility and control.
   D. A person for whom an Eligible Person becomes legally responsible by reason of placement for adoption shall be considered a Child.

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. **COBRA CONTINUATION COVERAGE** - means the continuation of Coverage provided to an electing Member under the health Plan in accordance

with the Employee Retirement Income Security Act of 1974, as amended, or in accordance with Title XXI of the Public Health Service Act, as amended. COBRA allows Members to continue to pay for and receive Covered Services after they may no longer be eligible for Coverage under the Plan.

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

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

9. **CONGENITAL ANOMALY** - means a defective development or formation of a part of the body that was present at the time of birth.

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.

11. **COVERAGE** - means a Member's entitlement to Plan benefits, subject to the limitations and Exclusions applicable to such benefits under the Summary Plan Description.

12. **COVERED SERVICES** - means a Medically Necessary Healthcare Service for which benefits are provided under the provisions of the Summary Plan Description. A Covered Service must be Medically Necessary and provided under the rules and policies of the Plan to be a benefit. Please see the definition of Medically Necessary.

13. **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.

14. **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.

15. **DEDUCTIBLE** - means the fixed expense you must incur for certain Covered Services before WIN will start paying benefits for them. Copayments and

Coinsurance do not count toward any deductible. Deductibles are based on a contract year unless otherwise specified.

16. **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.

17. **DESIGNATED ORGAN TRANSPLANT FACILITY** - means a Hospital named as such by the Plan that has entered into an agreement with WIN to provide Covered Services in connection with organ transplant procedures.

18. **DIRECT BENEFITS** - means Healthcare Services provided directly to you by a Participating Provider.

19. **DOMESTIC PARTNER** –means a person who is the same or opposite sex of an Eligible Person and who is not married and who cohabitates with the Eligible Person for purposes of maintaining a long-term personal relationship with the Eligible Person and who meets the requirements of Domestic Partner as defined in the affidavit of domestic partnership as provided for by the Employer.

20. **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.

21. **ELIGIBLE CHARGE** - The lowest amount of the following: (1) the provider's billed charges for a Covered Service; (2) an amount determined by WIN to be within a range of amounts customarily charged by providers for similar or identical services and supplies; (3) a reasonable and adequate allowance for the service or supply, as determined by WIN' provider fee schedule and accepted by Participating Providers as payment in full.

22. **ELIGIBLE DEPENDENT** - means a Spouse, Domestic Partner, Child or a disabled Child dependent of an Eligible Person.

23. **ELIGIBLE PERSON** - means a person who is in a class of persons specified in the Summary Plan Description as eligible to be enrolled for Coverage under the health Plan, and who is either employed in or has his or her principal residence in the Service Area.

24. **EMERGENCY** - means the sudden and unexpected onset of a condition or an Injury 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.

25. **EMERGENCY HEALTHCARE SERVICES** - means Covered Services that are provided for the treatment of an Emergency.

26. **EMPLOYEE** - An employee of Cheyenne Regional who meets the requirements to be eligible for benefits under the Plan. A person must be in a class of workers not excluded from Coverage by the Employer and be employed on a basis as described in this Summary Plan Description.

27. **EMPLOYEE CONTRIBUTION** – The monthly fee that must be paid by the Employee to Cheyenne Regional for benefits.

28. **ENROLLED DEPENDENT** - means an Eligible Dependent who is enrolled for Coverage under the health Plan.

29. **ENROLLED ELIGIBLE PERSON** - means an Eligible Person who is enrolled for Coverage under the health Plan.

30. **ENROLLMENT DATE** – is the first day of Coverage.

31. **EXCLUSIONS** - means the portion of the Summary Plan Description containing the schedule of Healthcare Services and supplies that are excluded from Coverage under the health Plan.

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 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. WIN 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 and 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. **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 the Summary Plan Description are Covered Services. Not all Healthcare Services are Covered Services.

36. **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.

37. **ILLNESS** - means physical illness, sickness or disease.

38. **INJURY** - means bodily damage other than Illness, including all related conditions and recurrent symptoms.

39. **LATE ENROLLEE OR LATE MEMBER** - means an eligible Employee or Eligible Dependent of such Employee of the Employer who requests enrollment in the health Plan following the initial enrollment period, and as defined in Wyoming Statutes Section 26-19-302. However, an Employee or Eligible Dependent will not be considered a Late Member if: 1) the individual lost coverage under another health benefit plan as a result of termination of employment or eligibility, the involuntary termination of the previous coverage, the death of a Spouse, divorce or legal separation; or 2) a court has ordered that Coverage be provided for a Spouse or Eligible Dependent and a request for enrollment is made within thirty-one (31) days of the issuance of the court order.

40. **LONG TERM ACUTE CARE HOSPITAL** – is a specialized healthcare facility that serves patients with serious medical problems and who will require prolonged periods of acute medical care.

41. **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.

42. **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 healthcare provider.

    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:
    a. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or,
    b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act; or,
    c. Milliman Care Guidelines®

    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 WIN.

43. **MEMBER** - means an Enrolled Eligible Person or an Enrolled Dependent.

44. **NON-COBRA CONTINUATION COVERAGE** - means any group policy or certificate of insurance on a master policy of a group policy that is not subject to continuation of rights as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985.

45. **NON-PARTICIPATING PROVIDER** - means any provider of Healthcare Services, including Physicians, Hospitals, and Skilled Nursing Facilities, etc. that have not entered into a Provider Agreement with WIN; i.e., not a Participating Provider.

46. **OPEN ENROLLMENT PERIOD** - means a period of time where Employees are allowed to make changes to their benefit Plans.

47. **OUT-OF-POCKET MAXIMUM** - The maximum expenses any Member or family will be responsible for during a contract year as indicated in the benefit summary. Generally, this would include expenses incurred through a Member's payment of applicable medical and prescription 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 eligible 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 eligible 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.
    e.

48. **PARTICIPATING HOME HEALTH AGENCY** - means an organization that (1) provides home Healthcare Services; (2) is duly authorized to provide such services under the law of the jurisdiction in which such services are provided; and (3) has entered into a Provider Agreement to provide Covered Services to Members under the health Plan.

49. **PARTICIPATING HOSPITAL** - means a Hospital that has entered into a Provider Agreement to provide Covered Services under the health Plan.

50. **PARTICIPATING PHYSICIAN** - means a Physician who has entered into a Provider Agreement to provide Covered Services under the health Plan.

51. **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.

52. **PARTICIPATING SKILLED NURSING FACILITY** - means a Skilled Nursing Facility that has entered into a Provider Agreement to provide Covered Services under the health Plan.

53. **PERSONAL CARE PHYSICIAN** - means the Physician that may manage the continuum of Healthcare Services required by any Member or enrolled dependent.

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 doctor of podiatric medicine ("D.P.M.") who is duly licensed and qualified as such under the law of the state in which the doctor provides Healthcare Services.

56. **PREAUTHORIZATION** - means the written approval by WIN of a service, procedure, equipment or supply based on a request from a Participating Provider prior to the service or procedure being rendered when applicable criteria for the service or procedure has been met. Preauthorization is based on Medical Necessity and is not a guarantee of benefits and is subject to the Plan provisions in effect at the time of service.

57. **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.

58. **PRIMARY CARE PROVIDER** - A Primary Care Provider is 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.

59. **PROSTHETIC DEVICE** - means any device, instrument or object that is an artificial body part used to replace a body limb or part.

60. **PROVIDER AGREEMENT** - means a contractual agreement between WIN 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.

61. **QUALIFIED MEDICAL CHILD SUPPORT ORDER** - means a judgment, decree, or order that has been determined by WIN to be adequate to qualify the Child for Coverage under the Plan.

62. **QUALIFYING PREVIOUS COVERAGE** - means benefits or coverage for a Member, other than coverage under the health Plan, which is provided under:

    1. Medicare or Medicaid;
    2. An employer-based or group health insurance or health benefit plan that provides benefits similar to or exceeding benefits provided under the health Plan; or,
    3. An individual health insurance policy under which a Certificate of Creditable Coverage can be issued.

Coverage preceding any break in coverage of ninety (90) days or more within twelve (12) months prior to enrollment will not be considered Qualifying Previous Coverage.

63. **REASONABLE AND CUSTOMARY** - means fees for Healthcare Services that WIN has determined are fees that regional providers customarily charge for such services.

64. **REIMBURSABLE EXPENSES** - means expenses for Covered Services provided by Non-Participating Providers, if such expenses meet the requirements of Reimbursement Benefits. The amount of the Reimbursable Expenses for any specific Covered Service shall be equal to (1) the total Reasonable and Customary expenses as such may be determined by WIN for such Covered Service; less (2) the Deductible, Copayment, or Coinsurance for such Covered Service, if any, if a Deductible, Copayment, or Coinsurance would have applied if the Covered Service had been provided by a Participating Provider.

65. **REIMBURSEMENT BENEFITS** - means the reimbursement to, or on behalf of, a Member for Reimbursable Expenses incurred by the Member for Covered Services provided by a Non-Participating Provider.

66. **SEMI-PRIVATE ACCOMMODATIONS** - means a room with two (2) or more beds in a Hospital or Skilled Nursing Facility.

67. **SKILLED NURSING FACILITY** - means an institution other than a Hospital, Long Term Acute Care Hospital, Acute Rehabilitation Unit or 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.

68. **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, foster Child placement, adoption and placement for adoption.

69. **SPECIALIST PROVIDER** - means any health care provider whose practice is limited to a specific area of medicine and who is seeing patients other than in a primary care capacity.

70. **SPOUSE** - means a person whose relationship with an Eligible Person is recognized as a legal marriage by the state of Wyoming or married in a state that recognizes same sex marriages.

71. **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, and do not have a break in treatment program greater than three (3) months.

72. **SUMMARY PLAN DESCRIPTION** - means the written description or Summary of Benefits and Coverage under the health Plan that is provided to Members.

73. **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.

74. **TIER 1** – means providers practicing in the State of Wyoming and contracted with WIN.

75. **TIER 2** – means providers practicing outside the State of Wyoming who are either contracted with WIN or Multiplan.

76. **TIER 3** – means providers who are not contracted with either WIN or Multiplan.

77. **URGENT CARE FACILITY** - means a healthcare 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.

78. **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.

SECTION 4

Eligibility and Enrollment

1. **ELIGIBILITY FOR COVERAGE**

Each Employee may enroll for Coverage under the Plan as long as the Employee is (a) either a full-time employee regularly scheduled to work at least thirty (30) hours per week or a part-time employee regularly scheduled to work at least sixteen (16) hours per week; (b) employed by Cheyenne Regional on the date the Coverage is to be effective; and (c) not in a class of Employees excluded from such Coverage. Temporary, contract hires, or consultants are not eligible for Coverage under the Plan. An Employee who has enrolled for Coverage may also enroll his or her Eligible Dependants for Coverage under the health Plan under the following conditions:

A. An Employee's legal spouse is eligible to enroll as a dependant;
B. An Employee's Domestic Partner is eligible to enroll as a dependant;
C. An Employee's Children are eligible to enroll as dependants through the month in which they reach the age of 26;
D. A Dependant 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 Employee 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;
E. A newborn of a Member will be an Eligible Dependant 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 past the initial thirty-one (31) days;
F. A court has ordered that Coverage be provided under the Member's health Plan;
G. A person for whom an Eligible Person becomes legally responsible by reason of placement for adoption or by foster child placement.

2. **ENROLLMENT**

Eligible Persons enroll themselves and their Eligible Dependants using the forms provided by WIN and Cheyenne Regional.

A. For persons who are Eligible Persons or Eligible Dependants on the date the health Plan becomes effective, an enrollment application may be filed at any time up to thirty (30) days after the Health Plan Effective Date.
B. For persons who first become Eligible Persons or Eligible Dependants after the Health Plan Effective Date, an enrollment application may be filed at any time up to thirty (30) days after the date on which the person becomes an Eligible Person or Eligible Dependant.
C. Notwithstanding the foregoing, a Child of an Enrolled Eligible Person is automatically enrolled for Coverage as of the Child's date of birth. Such

automatic Coverage, however, shall terminate after thirty (30) days unless the Child has been properly enrolled under Section 4(2) (B) within that period and payment of the applicable Premiums under Section 7(1) have been made.

D. For any Eligible Person who is covered under a group health plan other than the Plan, an enrollment form may be submitted within thirty (30) days of the date that the employer contribution for that plan ceases.

An Eligible Person or Eligible Dependant may only be enrolled for Coverage during one of the time periods specified in Sections 4(2) (A) through 4(2) (D). However, the Plan may approve the enrollment of an Eligible Person or Eligible Dependant at other times subject to evidence of insurability of such person. Notwithstanding the foregoing, a Child who is required to be enrolled for Coverage pursuant to a Qualified Medical Child Support Order shall be enrolled for Coverage as of the date required under that order.

3. **LIMITATIONS ON ENROLLMENT**

No Eligible Dependant of an Employee may be enrolled for Coverage prior to the date the Employee is enrolled for Coverage. No temporary, (as needed), contract hires or consultant employees may be enrolled for Coverage.

4. **NOTIFICATION OF ENROLLMENT**

Cheyenne Regional shall provide WIN with written notice of the enrollment and effective date of Coverage of all newly enrolled Members. Cheyenne Regional shall also provide WIN with written notice of any changes in a Member's eligibility classification. Any notice under this Section 4(4) must be provided to WIN within thirty (30) days of the effective date of each new Member's Coverage, and within thirty (30) days of the effective date of the change of eligibility classification for each Member so affected.

5. **EFFECTIVE DATE OF COVERAGE (ENROLLMENT DATE)** - A Member's Coverage under the health Plan shall be effective on the first day of the month following date of hire, or if the Member’s date of hire is on the first day of the month coverage will be effective on that day subject to the following:

A. A Member's Coverage shall not be effective prior to the Plan Effective Date notwithstanding anything in this Section 4(6) to the contrary.

B. If a Member marries a person who is subsequently enrolled within thirty (30) days as a Spouse under Section 4(2), Coverage for the Spouse will be effective on the date of marriage.

C. If a Child has been adopted by or placed for adoption with a Member and is subsequently enrolled within thirty (30) days as a Child under Section 4(2), Coverage for that Child will be effective as of the date the Child was adopted or placed for adoption.

D. If a Child has been placed as a foster Child with a Member and is subsequently enrolled within thirty (30) days as a Child under Section 4(2), Coverage for that Child will be effective as of the date the Child was placed into foster Care.

E. If a newborn Child of a Member is automatically enrolled for Coverage under Section 4(2), Coverage for such Child shall be effective as of the

Child's date of birth. The newborn must be formally enrolled within thirty (30) days of birth and the upcoming period premium must be paid for coverage to extend past the initial thirty (30) days.

F. If a Child is enrolled for Coverage pursuant to a Qualified Medical Child Support Order within thirty (30) days of the order, Coverage for that Child will be effective on the date required under that order.

G. If an unmarried Child of an Eligible Person becomes disabled and is primarily dependent upon the Eligible Person for support and maintenance, such Child shall be considered eligible and must be formally enrolled within thirty (30) days of the determination of disability.

H. If a Late Enrollee requests enrollment in the Plan after the initial thirty (30) day enrollment period, Coverage will become effective no later than eighteen (18) months after the date of the Late Enrollee's request.

I. If Cheyenne Regional receives a National Medical Support Notice, Coverage will be effective the first day of the month following the receipt of the National Medical Support Notice, determination that it is a Qualified Medical Child Support Order, determination that the non-custodial parent is an Eligible Person, and notification of the selected Plan. The effective date will not exceed ninety (90) days from the date of receipt of the notice if the Employee is still in a waiting period. The Employee and Dependent may be enrolled involuntarily based upon the receipt of this notice.

6. **DURATION OF COVERAGE** - A Member's Coverage will continue until terminated as provided in Section 8(1) if one of the events specified in that section occurs. Coverage for a Member who has elected COBRA Continuation Coverage under Section 10(2), however, shall not terminate until the termination of such COBRA Continuation Coverage. A person whose Coverage has terminated will no longer be a Member under the health Plan.

7. **RE-ENROLLMENT AFTER TERMINATION OF COVERAGE** - A Member whose Coverage has terminated as provided in Section 8(1) may again enroll for Coverage under Section 4(2), provided that all requirements for enrollment under this Section 4 are satisfied.

8. **SPECIAL ENROLLMENT RIGHTS** – A Member who is declining enrollment for themselves or their Eligible Dependents (including Spouse) because of other health insurance coverage may in the future be able to enroll themselves or Eligible Dependents in the health Plan, provided that enrollment is requested within thirty (30) days after the other coverage ends. In addition, if the Member has a new Eligible Dependent as a result of marriage, birth, adoption, placement for adoption, or placement of a foster child, they may be able to enroll themselves and their Eligible Dependents, provided that they request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption or the placement of a foster child.

When the Employee or Eligible Dependent loses other health coverage, a Special Enrollment opportunity in the health Plan may be triggered. To have a Special Enrollment opportunity in this situation, the Employee or Eligible Dependent must have had other health coverage when Coverage under the Plan was previously declined. If the other coverage was COBRA Continuation Coverage,

special enrollment can be requested only after the COBRA Continuation Coverage is exhausted. If the other coverage was not COBRA Continuation Coverage, Special Enrollment can be requested when the individual loses eligibility for the other coverage or if employer contributions toward the other coverage have been terminated.

In addition, a Special Enrollment opportunity may be triggered when a person becomes a new Eligible Dependent through marriage, birth, adoption or placement for adoption.

A Special Enrollment opportunity is also triggered when an Employee or their Eligible Dependents lose eligibility for coverage under a State Medicaid or CHIP program, or when an Employee or their Eligible Dependents become eligible for State premium assistance under Medicaid or CHIP. The Employee or their Eligible Dependent must request coverage within sixty (60) days of being terminated from Medicaid or CHIP or within sixty (60) days of being determined to be eligible for premium assistance to receive this Special Enrollment opportunity.

9. **QUALIFIED MEDICAL CHILD SUPPORT ORDER** –

If an Employee is subject to a Qualified Medical Child Support Order ("QMCSO"), the Employee is obligated to enroll himself in the Plan as well as the Children referenced in the QMCSO. If the Employee does not enroll such Children, the Employee must provide documentation to the Employer that other health benefits coverage has been obtained for the Children named in the QMCSO.

As long as the QMCSO is in effect and at least one Child identified in the QMCSO is still eligible under the health Plan, the Employee cannot cancel benefits under the Plan unless documentation of other coverage is provided. Contact your Employer for further information.

SECTION 5

Obtaining Plan Benefits

1. **OVERVIEW OF BENEFITS**

Each Member is entitled to receive Covered Services as described in Section 6. WIN reserves the right to reasonably interpret the terms of this Summary Plan Description 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 Expenses incurred by the Member for Covered Services provided by Non-Participating 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 eligible to enroll and 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(1) (or under Section 10(2) if the Member has elected COBRA Continuation Coverage).
   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 Summary Plan Description.

C. Preauthorization - Services that require Preauthorization by WIN include the following:
   1) Confinement to a Hospital, Skilled Nursing Facility, Rehabilitation Facility or other institution;
   2) Confinement to a behavioral health or chemical dependency facility;
   3) Durable Medical Equipment (DME);
   4) Covered Services in a Member's home;
   5) Covered Services rendered by a Podiatrist;
   6) Radiological scans, including MRA, MRI, PET, SPECT or CT Scan;
   7) Certain prescriptions;
   8) Any organ transplant.

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 WIN 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 WIN prior to obtaining services by contacting Member Services. WIN will determine whether the requested service can be preauthorized and will provide written notification to the Member and the provider.

D. Emergency Situations - Emergency Healthcare Services are Covered Services as long as they fit generally accepted guidelines for Emergency Healthcare 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. If the nurse advice line refers a Member to the Emergency Room, the Member's Copayment will be less than if not referred by the nurse advice line.

2. **DIRECT BENEFITS AND REIMBURSEMENT BENEFITS**

A. Covered Services - 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 Member has satisfied the applicable Deductible, Copayment or Coinsurance for the benefit, if any, in accordance with Section 7(2);
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.); and
4) No Exclusion or limitation applies to the Covered Services.

B. Direct Benefits - A Member obtains Direct Benefits for Covered Services when a provider submits to the Plan a claim for Covered Services on behalf of the Member within 180 days of the date of the Covered Services. Such provider is then paid directly based on the applicable benefit Tier. If the Direct Benefits consist of Emergency Healthcare 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 a Tier 3 provider, the Member is required to submit a claim for reimbursement to the Plan 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. The Plan and WIN 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. WIN may require a Member to submit additional proof in

support of a claim that WIN 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) Through WIN, the Plan will reimburse the Member for Reimbursable Expenses 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 Plan benefits:

1) Tier 1 Plan Direct Benefits provided by Participating Providers.
2) Tier 1 Plan Direct Benefits consisting of Preauthorized Emergency Healthcare Services or Urgent Healthcare Services provided by Non-Participating Providers.
3) Tier 1 Plan Reimbursement Benefits for Emergency Healthcare Services or Urgent Healthcare Services, whether or not provided by Participating Providers, if the Member was not provided Direct Benefits.
4) Tier 1 Plan benefits for Healthcare Services that have been preauthorized by the prior written approval of WIN.
5) Tier 2 Plan benefits for covered Healthcare Services rendered by MultiPlan providers in the absence of a referral and/or written Preauthorization by WIN.
6) Members may be reimbursed for Tier 3 Plan benefits for Covered Services rendered by Non-Participating Providers.

4. **SECOND OPINION**

A Member's Coverage under the health Plan is subject to the right of the Plan 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. The procedures for obtaining a second opinion are as follows:

A. The Plan or WIN shall notify the Member that a second opinion has been requested.

B. WIN 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 WIN consents to provision of the second opinion by an affiliated Physician.

C. The Member is responsible for arranging a consultation with the Provider 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.

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

E. In the event that the Plan or WIN requests a second opinion with respect to a specific Covered 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.

F. If the second opinion requested by the Plan or WIN is received within thirty-one (31) days after the first opinion was provided, or as soon thereafter as reasonably possible, the Member's Copay. Coinsurance and Deductible for the requested rendered service shall be waived.

G. If the third opinion requested by the Plan or WIN is received within thirty-one (31) days after the second opinion was provided, or as soon thereafter as reasonably possible, the Member's Copay. Coinsurance and Deductible for the requested rendered service 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 Tier 1 provider pursuant to applicable policies and procedures for obtaining such Healthcare Services, a Member shall be held harmless by the Plan 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). Tier 2 providers may elect to balance-bill members for the difference between the amount paid by the Plan and the total cost of the services rendered when preauthorization is required but not obtained. Tier 3 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

Covered Services

All benefits are subject to Plan limitations and Exclusions as defined in Section 6(II). Services that are not specifically identified in this Section are not Covered Services.

I. DESCRIPTION OF PLAN BENEFITS

1. Acute Rehabilitation

Covered

Acute Rehabilitation in a contracted facility is a Covered Service for Members who meet admission criteria and are preauthorized for this care by WIN. Determinations regarding whether or not criteria has been met will be made by WIN.

2. Ambulance

Covered

Ambulance for Emergency transport to the nearest Hospital or medical facility are Covered Services when Medically Necessary. Ambulance transport when used for patient or family convenience is not a Covered Service. A Copayment applies for both air and ground transport.

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

Not Covered

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 specially designed and licensed for transporting patients, and is operated by trained personnel is not a Covered Service.

3. Anesthesia

Covered

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 WIN 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 Certified Registered Nurse Anesthetist (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.

- 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.
- Surgeon performing the procedure is board-certified and accredited by the American Society of Metabolic and Bariatric Surgery.
- Eligible procedures:
  - Gastric restriction procedure with Roux-en-Y ("Gastric bypass")
  - Gastric restriction procedure without bypass ("Gastric band")
  - Vertical gastrectomy ("Gastric sleeve")
- All of the following criteria must be met:
  - 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.
  - Documentation of failure to achieve weight loss by nonsurgical means, including low-calorie diet, exercise, and medications.
  - Correctable causes of obesity have been ruled out.
  - 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.
  - Psychological evaluation and clearance to undergo surgery.
  - Full growth completed.
  - Ongoing post-operative supervision for weight loss by the bariatric surgeon and bariatric program. Prior to surgery, the surgeon will submit

to WIN a written outline of said post-operative care and weight loss management guidelines.

Limits
Physician referral and preauthorization by WIN is required.

5. Behavioral Health and Substance Abuse

Covered

- Outpatient benefit - Preauthorization for outpatient behavioral health / mental health services or substance abuse treatment is not required.
- Inpatient benefit - Inpatient mental health or substance abuse care is covered when the admission has been preauthorized by WIN.
- 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 WIN.

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(II) (4) Bariatric Surgery.
- Treatment for autism.
- Treatment for ADHD or ADD, 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 behavioral health or substance abuse treatment.
- Biofeedback.

6. Breast Reduction Surgery

Covered

When deemed Medically Necessary, preauthorized, and in compliance with ALL of the following criteria:

- Macromastia is present with estimated breast volume of 750 cc or greater, or, bra cup size of D or greater.
- Member is 18 years of age or older or breast growth is complete.
- Breast size interferes with activities of daily living and is causing at least ONE of the following conditions/symptoms for which no other etiology has been found upon appropriate evaluation:
  - chronic breast pain
  - severe bra strap grooving or ulceration of shoulder
  - neck, shoulder, or upper back pain
  - brachial plexus compression or arm nerve palsy
  - intertrigo, dermatitis, eczema, or hidradenitis of the inframammary fold
- Documented failure of at least one continuous three-month trial of appropriate medical management for the above listed conditions/symptoms, including but not limited to physical therapy, non-steroidal anti-inflammatory drugs, wound care, topical/oral antifungals, and medically-supervised weight loss program.
- Potential causes of the above conditions/symptoms, other than breast size (e.g., intervertebral disc disorder, arthritis and rheumatologic disorders) have been excluded or breast size has been documented to be exacerbating the underlying condition (e.g., intervertebral disc disorder, arthritis and rheumatologic disorders).
- Preoperative photographs confirm the presence of BOTH of the following:
  - significant breast hypertrophy
  - shoulder grooving from bra straps and/or intertrigo/dermatitis if stated to be present
- Average weight of tissue planned to be removed in each breast is above the 22nd percentile on the Schnur Sliding Scale based on the individual's body surface area (BSA).
- No evidence of breast cancer.

Limits

Physician referral and preauthorization by WIN is required.

Not Covered

- Breast asymmetry.
- Treatment of psychological symptoms or psychosocial complaints in the absence of documented and significant physical and objective signs.
- For the sole purpose of improving appearance

7. 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
There is a 20 visits per incident per plan year for tier 2 and tier 3 services.

8. Care Management Program

Covered
This program is offered with no Copayment or Coinsurance to the Member. The purpose of the program is to offer support to 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.

9. Chemotherapy

Covered
- Outpatient injectable chemotherapy, when oral administration of prescribed medication is not medically appropriate.
- Services and materials for chemotherapy.
- Participation in a clinical trial must be preauthorized as benefit limits or exclusions may apply.
- Select chemotherapy regimens may be provided on an inpatient basis and will be covered when the hospital confinement has been preauthorized.

10. Chiropractic Care

Covered
Services rendered by a chiropractor are covered. Such services may include, but are not limited to, manipulation of the spine, acupuncture, paraffin therapy, vitamins, exercise equipment, and massage therapy.

Limits
Benefits are subject to the Deductible, Copayment or Coinsurance per visit. There is a 20 visit maximum per year.

11. **Clinical Trials**

Charges related to Approved Clinical Trials, as defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in the Patient Protection and Affordable Care Act (PPACA), such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. Routine patient costs for items and services furnished in connection with participation in the trial are also covered. "Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include (i) the investigational item, device or service itself; (ii) items and services that are

provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (iii) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan's network area unless out-of network benefits are otherwise provided under the plan.

12. Dental Services

Covered

Coverage is available for the following dental services only:

- 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, and in which treatment is completed within twelve (12) months 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 replacesound natural teeth with the exception of dentures.
- Incision and drainage of a cyst or cellulitis that does not originate in the teeth.
- Surgical removal of tumors and cysts.
- 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:
    - Individual age seven years or younger
    - Individual who is severely psychologically impaired or developmentally disabled
    - Individual who has one or more significant medical comorbidities which require additional monitoring during and immediately following the procedure
    - Individuals in whom the complexity of the proposed dental procedure would preclude the use of local anesthesia or conscious sedation

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 at a Participating Provider Hospital for dental procedures are only covered when a non-dental medical condition exists that makes hospitalization necessary to safeguard the health of the Member. The Plan will not cover the dental procedure unless it is described as a Covered Service in this Section 6 and has been preauthorized.

Not Covered

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

- Shortening of the mandible or maxilla for cosmetic purposes.
- Hospitalization, including anesthesia, solely for extraction of teeth in the absence of a qualifying medical condition.
- All dental services or supplies for preventive treatment of disease of the teeth, alveolar processes, supportive tissues (gums) and dental x-rays.
- Dentures.

13. Diabetes Care

Covered

Coverage under this policy includes benefits for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items. Such services must be preauthorized by WIN.

14. Emergency Care

Covered

A medical Emergency is the sudden and unexpected onset of a condition or an Injury 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. When Emergency Healthcare Services are obtained, a Participating Provider must provide all follow-up care unless Healthcare Services by a Non-Participating Provider are preauthorized by WIN.

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-threateningEmergency, 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 aMember is in confinement in a hospital that is a Non-Participating Provider facility, WIN 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 not be covered.
- Determination that Healthcare Services Are Not Emergency Healthcare Services, - If WIN determines, based on generally accepted medical criteria, Healthcare Services or supplies are not Emergency Healthcare Services, then 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 – If a Member is unsure if symptoms require Emergency room services, the Member can access the nurse line by calling WIN 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. If a Member visits the Emergency room at the recommendation of the nurse line, the applicable Copayment will be less than if the Member had not called the nurse line. If a Member feels the Emergency is life- or limb-threatening or if, due to the Member's symptoms or condition, she/he is physically unable to call the nurse line, the higher Copayment will not apply.
- The lower Copayment will also apply if the Member is referred to the Emergency room by a Physician.
- If a Member is admitted to the Hospital, the Emergency room Copayment is waived.
- WIN may review use of Emergency facilities. Payment of claims may be denied and charges may be the Member's responsibility if WIN 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, WIN may elect to transfer the Member to a Participating Provider Hospital if it is Medically Necessary.
- WIN requests notification within forty-eight (48) hours of Emergency Healthcare Service 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.

- Follow up care provided by Non-Participating Providers unless preauthorized.
- 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

Covered

- Amniocentesis for chromosome determination.
- Breast Cancer Gene Test (BRCA) testing with Preauthorization
    - Counseling regarding BRCA genetic testing for women at high risk will be provided without cost sharing.
- Genetic tests which have therapeutic implications may be covered services when preauthorized by WIN.

Not Covered

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

16. Hemodialysis

Covered

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

17. Home Healthcare

Covered

Skilled home healthcare services are covered when a Member is homebound if such services are Medically Necessary, ordered by a Provider and preauthorized by WIN.

Limits

- For services to be covered, the home healthcare 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.
- Benefit is limited to sixty (60) visits per incident, inclusive of all services.
- 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.

Not Covered

- Care by a nurse's aide, family member, or person residing with Member
- Laundry services
- Housecleaning services
- Home companion
- Assisted daily living services
- Custodial Care
- Private duty nursing
- Transportation
- Items available over the counter

18. Hospice

Covered

Hospice care is covered when the member is in the final stages of a terminal Illness or life-limiting condition. The care is usually administered by a team of professionals and volunteers that typically include a Physician, registered nurse, social worker, member of the clergy, and a psychologist.

Limits

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 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 theconcept 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.

Not Covered

- Voluntary services or supplies.
- Counseling by clergy or voluntary groups
- Services performed after the death of the patient
- Curative services and supplies related to the terminal condition 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.

19. Hospital Care

Covered

Inpatient Hospital services, including surgical services, for medical conditions are Covered Services if the Confinement has been preauthorized.

- Room and board expenses including the cost of a room, meal services for the patient, nursing services and laundry services.
- Ancillary Services, which are rendered during an inpatient stay, include drugs and pharmaceuticals, medical supplies, blood administration, diagnostic and therapeutic services.
- Coordinated discharge planning services.

Not Covered

- Prescription drugs issued by the Hospital for use after Confinement ends.
- Private duty nursing.
- 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.

20. Laboratory Services

Covered

- Medically Necessary laboratory services are Covered Services when requested by a provider and rendered by a Participating Provider.
- STI screening as recommended 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.

21. Maternity Care

Covered

- Provider Services - Charges for prenatal, postnatal and delivery are covered.
- Hospital Services - Inpatient services including room expense and ancillary services provided by a Hospital are covered under the inpatient Hospital benefit.
- 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 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.
- Postnatal Care – charges for lactation counseling and one (1) breast pump are covered.

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

- Laboratory screenings for pregnant women:
    - Iron-deficiency anemia
    - Bacteria in urine
    - Hepatitis B virus
    - RH incompatibility
    - Syphilis
- Breastfeeding supplies, support, and counseling for pregnant and nursing women
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Tobacco use screening, intervention, and expanded counseling for pregnant tobacco users
- Folic acid supplements for women who may become pregnant.

Limits

- All maternity care must be coordinated by a Provider.
- Reduction of the number of fetuses in a multiple fetus pregnancy requires Preauthorization.

Not Covered

- Home delivery
- Any procedure intended solely for gender determination
- Birthing classes
- Maternity care for dependent children
- Nursing bras, pads, lotions, creams, etc.

22. 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

- Must be prescribed by a provider.
- Preauthorization is required.

Not Covered

- Nutritional ***supplements*** are benefit exclusions.
- 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.
- Banked breast milk is excluded.
- Standard cow's milk or soy-based formula is excluded.

23. Phototherapy for Psoriasis

Covered

Light therapy or phototherapy consists of exposure to daylight or to specific wavelengths of light using lasers, LEDs, fluorescent lamps, dichroic lamps or very bright, full-spectrum light, for a prescribed amount of time.
Phototherapy is a Covered Service for select conditions and requires Preauthorization.

Not Covered

- Purchase or use of tanning bed.

24. Physician Services

Covered

- 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.
- Physician's visits to the Member's home.
- Medical consultation services, including charges made by a Physician for a second opinion.

Not Covered

- Examination for employment, licensing, insurance, adoption, travel, school, or sports purposes; or court ordered examination or treatment.
- Expenses for medical reports, including preparation and presentation.
- Expenses for examinations and treatment conducted for the purpose of medical research.

- Expenses related to missed appointments and rescheduling fees.
- Expenses for Physician waiting or standby time, after-hours services and other additional charges, except for neonatal, transplant, and trauma standby.
- Exams or evaluations for the purpose of allowing a Member to return to work, unless required by Cheyenne Regional.

25. Podiatric Care

Covered

Services rendered by a Podiatrist are covered when preauthorized by WIN.

Not Covered

Benefits do not include the treatment of weak, strained or flat feet. Orthotic devices are covered for some diagnoses of the feet when preauthorized. The cutting, removal or treatment of corns, calluses or trimming the free edge of toenails in the absence of active treatment of a metabolic or peripheral vascular disease are not Covered Services.

26. 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 benefit plan summary. To fill a prescription, present the written prescription to a pharmacy along with your Plan identification card.

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 Preferred Drug List, are subject to a higher "non-preferred" 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 items for Members with a diagnosis of diabetes. To receive

this benefit, present a prescription from a Provider to a pharmacy. With participation in the WIN Care Management Program, the Deductible, Copayment, or Coinsurance may be waived on diabetic supplies. Contact Member Services at (307) 773-1305 for more information about this program.

Limits

- Quantity for a maintenance prescription drug purchased through either a mail service or retail pharmacy cannot exceed a ninety (90) day supply.
- For maintenance drugs, as defined by standard lists, a ninety (90) day supply may be dispensed if two (2) months' Copayments are paid.
- Prescriptions are covered with varying Copayments for brand and generic medications.
- 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 tier Copayment will still apply.
- 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:
    - Diabetes drugs
    - Cholesterol-lowering agents
    - Nonsteroidal anti-inflammatories
    - Proton pump inhibitors for reflux
    - Serotonin-based antidepressants
    - Triptans for migraine treatment

  The most recently updated list may be accessed on the Provider portal.
- Some prescription drugs require Preauthorization. A drug may be preauthorized for up to one (1) year period of time. Drugs requiring Preauthorization by WIN include, but are not limited to:
    - Injectable medications
    - Interferon/Intron/Avonex
    - Growth Hormones
    - Accutane
    - Retin A or equivalent for adult acne
    - Drugs exceeding $500 per month
    - Other drugs, not listed here, may be added to those requiring Preauthorization. Call WIN with any question as to whether a drug requires Preauthorization.

Not Covered

Excluded Drugs: Not all prescription drugs are covered. Members can contact the WIN 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*:*

- Weight-loss drugs.
- Smoking cessation drugs except Chantix.
- Medications available without a prescription except as described above under Over-the-Counter drugs.
- Experimental or investigational drugs.
- Drugs for cosmetic purposes.
- Drugs for infertility.

27. 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 preventive service recommended by the above agencies, Copayments and Deductibles may apply. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service. A current listing of preventive care can be accessed at www.healthcare.gov/center/regulations/prevention.html.

Examples **of Covered Health Services for preventive care include:**

Under One Year of Age

- One (1) newborn genetic screen within 24 to 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 ages 2 and 6 (but no more than one (1) exam in any twelve (12)-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
- Annual dental health risk assessment

Six Years but less than Twelve Years

- Annual Well-Child exams*
- One (1) routine eye exam every 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

Twelve Years but less than Eighteen Years

- Annual health maintenance visits*
- One (1) routine eye exam every 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
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, vasectomy, and contraceptive counseling as deemed appropriate by your provider
- Sexually Transmitted Infection (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

Eighteen Years but less than Forty Years

- Men:
  - Annual health maintenance visit*
  - EKG every five (5) years
  - Prostate examination for cancer, annually
  - Measles, mumps, rubella if recommended by 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 screen 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
- Sexually Transmitted Infection (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
  - Sexually Transmitted Infection (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 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 three (3) years

- Basic metabolic panel lab test annually
- Tuberculosis skin test annually

- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three years
- Thyroid Stimulating Hormone Test (TSH) every three (3) years
- Tetanus/Diphtheria booster
- Influenza vaccine annually
- Pneumococcal 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
- Sexually Transmitted Infection (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) annually 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 years
  - Tetanus/diphtheria booster
  - Pneumococcal vaccine
  - Influenza vaccine annually
  - 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 or FDA-approved ultrasonic exam every three (3) years after age 50 with identifiable risk factors for osteoporosis as deemed appropriate by your provider
  - Sexually Transmitted Infection (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
  - Sexually Transmitted Infection (STI) (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider

- Women:
  - 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
- Sexually Transmitted Infection (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, smoking cessation, and alcohol misuse; screening and intervention for tobacco use; provider screening for sexually transmitted diseases; and blood pressure screening.

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.

28. Radiology Services

Covered

- Medically Necessary radiology services are covered when they are ordered by your Provider Physician.
- 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 WIN.

Limits
The following procedures require Preauthorization and must be referred by a Provider. This list is not all inclusive. Please call Member Services for more information.

- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET), PET-CT
- Computerized Tomography Scans (CT)
- Single Photon Emission Computed Tomography (SPECT)

29. Reconstructive Surgery

Repair of congenital defect(s) with preauthorization. All stages of breast reconstruction surgery following a mastectomy, such as:

- Surgery to produce a symmetrical appearance on the other breast after cancer surgery;
- Treatment of any physical complications, such as lymphedemas;
- One (1) breast prosthesis every two (2) years and two (2) surgical bras per year;
- Preauthorization is required for these and other reconstructive surgeries.

Not Covered

- 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:
- Penile prosthesis (any type)
- Breast augmentation

To determine benefit coverage and Preauthorization requirements regarding a particular surgery, please contact Member Services.

30. 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 WIN is required. Lifetime limit of one-hundred (100) covered days.

Not Covered

Facility and service charges that are maintenance or custodial in nature.

31. Supplies and Equipment

Covered

Durable Medical Equipment (DME) - The purchase or rental of DME is covered when prescribed by a Provider and preauthorized by WIN. 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 versus or rent the equipment will be made by WIN.

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 when Medically Necessary and preauthorized by WIN unless otherwise Excluded. Covered prostheses and orthopedic appliances include, but are not limited to:

- Artificial limbs
- Leg braces
- Arm and back braces

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:
- Wheelchairs
- Crutches
- Infusion pump

Limits
- DME must be obtained from a Provider and requires Preauthorization by WIN.
- 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:
- Convenience items
- Consumable supplies and equipment
- Deluxe items
- Maintenance of equipment
- Devices not medical in nature
- Customization of rental equipment that is not Medically Necessary
- Special braces or equipment not specifically listed above
- Braces used as aids in sports and activities
- Corsets and other non-rigid appliances
- Prostheses for cosmetic purposes
- Repair, maintenance or replacement due to loss or for duplication.
- Orthotic devices for podiatric use and arch support including wrapping.
- 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.)
- Surgical trays
- Non prescription food items

32. Surgical Assistants

Covered

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

33. Therapy, Occupational

Covered

Occupational therapy is covered when ordered by a Provider and provided by a participating occupational therapy provider.

Limits

Benefit is limited to twenty (20) visits per incident per contract 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 a medical procedure, an Illness, or an Injury where the therapy is being offered to regain a previous level of function. Occupational therapy is only offered to regain a previous level of function after the Member has experienced an incident.

34. Therapy, Physical

Covered

Physical therapy is a Covered Service when ordered by a Provider and provided by a participating physical therapy provider.

Limits

Benefit is limited to twenty (20) visits per incident per contract year and is subject to applicable Deductible, Copayment, and/or Coinsurance. An incident is a medical procedure, an Illness, or an Injury where the therapy is being offered to regain a Member's previous level of function. The benefit maximum per incident for physical therapy is offered in combination with the benefit maximum per incident for occupational therapy. 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

35. Therapy, Speech

Covered

Speech therapy is covered when ordered by a Provider.

Limits

- Preauthorization by WIN 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 contract year.

36. Therapy, Radiation Covered

Radiation Therapy.

37. Therapy and Rehabilitation, General

Not Covered

Special evaluation and therapies including, but not limited to, the following are not Covered Services:

- Acupuncture
- Communication delay diagnosis
- Learning disability diagnosis
- Behavioral retardation and related conditions
- Multiple handicaps for which therapy and rehabilitation is palliative rather than curative
- Perceptual disorders
- Sensory deficit
- Vision therapy/orthoptic therapy
- Behavioral training
- Biofeedback
- Coma stimulation
- Developmental and neuroeducational testing or treatment
- Educational services or studies
- Hearing therapies
- Hypnotherapy
- Myofunctional therapy
- Vocational rehabilitation
- Chelation therapy, except for heavy metal toxicity.

This list is not all-inclusive. Please call Member Services at (307) 773-1305 to obtain benefit coverage information and limitations for services.

38. Transplants

Covered

Human organ 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 WIN 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.

Donor Expenses - Reasonable surgical costs directly related to the donation of the organ for an eligible Member are covered if the organ transplant is a Covered Service.

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.

Transportation and Lodging - Transportation and lodging expenses for the patient and one other individual accompanying the patient are covered up to a maximum of $5,000 per transplant. Proof of expenses via itemized receipts must be provided.

Limits

- All services related to a human organ transplant must be preauthorized by WIN and must be provided in a Designated Organ Transplant Facility.
- Coverage for transplants will not be provided when resulting from a condition that is not a Covered Service under the Plan.
- Transportation and lodging expenses shall be limited to one (1) round trip to the facility and shall not exceed $5,000 per transplant.
- Post transplant prescription drugs are subject to the regular prescription Copayments.
- Repeat pre-transplant evaluations at the same or another transplant center are not Covered Services if the Member has previously been determined to not be a candidate by a WIN Designated Organ Transplant Facility.

39. 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 Healthcare center do not require Preauthorization. Participating Urgent Healthcare centers are listed in the provider directory.

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 Healthcare Services facility for treatment. If the Urgent Healthcare Services facility is a Non-Participating Provider, the Member must first notify WIN. Urgent Healthcare Services rendered by a Non-Participating Provider must be preauthorized by WIN. Your provider may request Preauthorization by calling WIN Medical Management.

Limits

- Urgent Healthcare Services visits that are rendered by Non-Participating Providers are Covered Services only when Medically Necessary and preauthorized by WIN. 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 Tier level is applied to the visit.

- Out-of-area follow-up care at an Urgent Healthcare Services facility is not a Covered Service.

40. Routine Vision Services

Covered

- Only as listed above as part of the Schedule of Preventive Services.

II. 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 provided in conjunction with a phase 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.

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 WIN.

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 and the treatment is received within twelve (12) months after the injury. Refer to Section 6(I) (11) 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 WIN.

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.

10. Service for orthomolecular therapy including nutrients, vitamins, and food supplements are excluded unless otherwise indicated in the Summary Plan Document and preauthorized by WIN.

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, convalescence, Custodial Care, the care or treatment of alcoholism or drug addiction, training, schooling, or occupational therapy.

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

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.

19. Charges or services for treatment of weak, strained, or flat feet; or for orthotic devices or strapping and orthopedic shoes; or for cutting, trimming or, removal of corns, calluses, or the trimming of the free edge of toenails, nails are excluded. Coverage for these services is allowed when there is a metabolic or peripheral vascular disease.

20. Charges or services for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses are not covered.

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, or cochlear implants, and follow up care for cochlear implants are excluded.

23. Charges or services for any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of an insured, or for the treatment of obesity are excluded, unless otherwise indicated in the Summary Plan Document and preauthorized by WIN.

24. Charges or services for treatment of autistic disease, learning disabilities, behavioral problems or behavioral retardation are excluded.

25. Charges or services for ADD/ADHD or for inpatient Confinement for environmental changes are limited to initial medical diagnosis and medication management. Preauthorization by WIN may be required.

26. Charges for services and supplies for or related to fertility testing, treatment of infertility and 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 the preservation techniques used in such or similar procedures are excluded.

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

28. Charges or services for any result of conception in a dependent Child, including but not limited to pregnancy, tubal pregnancy, miscarriage or elective abortion are excluded.

29. Charges or services for any condition, disease, ailment, Injury or diagnostic service to the extent that benefits are provided for persons eligible for Coverage under (Medicare) Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law are excluded.

30. Charges for private duty nursing are excluded.

31. Charges or services for medical care when transported by the police or sheriff office to the Emergency room for treatment of intoxication are excluded.

32. Charges or services for lifestyle improvements including nutrition counseling, or physical fitness programs except as described in Section 6(I)(12) for diabetic care are excluded.

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

34. Court-ordered treatment is excluded.

35. Emergency room services for non-emergent conditions are excluded. Examples of non-emergent conditions include, but are not limited to: recurrent migraine headaches, sprains, and strains.

36. Non-durable (consumable or disposable) medical supplies are limited to coverage when dispensed during an approved hospitalization, or at the time of a preauthorized home healthcare visit.

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

38. Services rendered at health fairs are excluded.

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

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

41. Any Healthcare Service that is not a Covered Service regardless of the recommendation or order by a Participating or Non-Participating Provider is excluded.

42. Breast augmentation is excluded.

43. Labial reduction is excluded.

44. Penile prostheses of any type are excluded.

45. Surgical or chemical treatment of skin tags or common warts is excluded. Coverage for surgical or chemical treatment of warts is limited to genital or plantar warts.

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

SECTION 7

Employee Contributions and Copayments

1. **Employee Contributions.**

Employees are required to make contributions via payroll reductions in accordance with the benefit Plan they choose. Each Member may also be required to make applicable Deductible, Copayments or Coinsurance payments for Healthcare Services received under the health Plan.

2. **Copayments and Coinsurance**

A. Payment of Copayments and coinsurance

1) Member's Responsibility for Copayments and Coinsurance: Direct Benefits - Each Member who receives Direct Benefits under the health Plan shall pay any applicable Copayment or Coinsurance for such Direct Benefits directly to the Participating Provider who provides the Direct Benefits.

2) Member's Responsibility for Copayments and Coinsurance: Reimbursement Benefits - A Member who is entitled to Reimbursement Benefits for Healthcare Services provided by a Non-Participating Provider does not pay a Deductible, Copayment or Coinsurance to the Non-Participating Provider for such services because the member is 100% responsible for all billed charges. However, in such case, reimbursement will be made in accordance with the Reasonable and Customary fee schedule as determined by WIN minus any applicable Deductible, Copayment and/or Coinsurance.

3) Amount of Copayment and Coinsurance - Subject to the annual limits in subsection 7(2) (A) (4) and to the exception in subsection 7(2) (A) (3) (a), the amount of the Copayment or Coinsurance, if any, that applies to a specific Healthcare Service is listed in the benefit plan summary.

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

4) Annual Limits on Copayments - A Member shall be entitled to reimbursement for Copayments made during a Plan year if the total Copayments made by the Member during the year exceed the amount listed on the active health Plan benefit summary.

5) Reimbursement of Excess Copayments - If a Member has paid Copayments in excess of the annual limit in subsection (4) above, the Member is entitled to be reimbursed for such excess Copayments. The Member must claim reimbursement for such excess Copayments no later than March 31 of the next calendar year. The Member's claim will be processed in the same manner as a claim for Reimbursement Benefits under Section 5. If a Member is reimbursed for all or a portion of a Copayment under subsection (l), the Member may not include such

reimbursed Copayment in determining whether the Member is entitled to reimbursement under subsection (2).

3. **Provider Reimbursement**

A. Payment to Providers

1) Except for any applicable Deductible, Copayment or Coinsurance specified in the benefit plan summary, a Member shall not be required to pay any amounts to any Participating Provider who provides Covered Services to the Member. All charges for such Healthcare Services in excess of the Deductible, Copayment or Coinsurance specified in the benefit plan summary will be paid by WIN on behalf of the Plan directly to the Participating Provider under the terms of the applicable Participating Provider agreement. If a Member is erroneously charged a fee by a Participating Provider in excess of any applicable Deductible, Copayment or Coinsurance specified in the benefit plan summary, the Member should immediately contact WIN for correction of the erroneous charge.

2) A Member is liable for the entire amount charged for Healthcare Services provided by Non-Participating Providers, except for Emergency Healthcare Services, Urgent Healthcare Services, Direct Benefits preauthorized by the health Plan under Section 5(2) (B) or Reimbursement Benefits described in Section 5(2) (C).

B. Adjustments to copayments – Copayments applicable to specific Healthcare Services, as specified in the benefit plan summary and in any Schedule of Supplemental Coverage, may be adjusted by the Plan.

SECTION 8

Termination of Member's Coverage

1. **Termination of Coverage**

A Member's Coverage under the health Plan shall automatically terminate on the earliest of the following dates:

A. The day after the last day of the monthly payment period in which the Member ceases to be an Eligible Person or Eligible Dependent.

B. The date as of which the Member requests termination of Coverage in a written notice to Cheyenne Regional. If no termination date is specified, Coverage shall terminate as of the date the Plan Sponsor receives the Member's written notice.

C. The date specified by WIN in a written notice to the Member informing the Member that the Member's Coverage under the health Plan is being terminated as of the specified date for one of the following reasons:

1) The Member knowingly provided materially false information to the Plan or WIN with regard to any person's eligibility for Coverage, or with regard to the health status of the Member or the Member's Enrolled Dependents.

2) The Member knowingly and without authorization from Plan or WIN used another Member's Plan identification card or permitted another person to use his or her Plan identification card.

Any termination of Coverage under this Section 8 shall be effective as of 12:01 A.M. Mountain Time on the specified date.

A Member's Coverage may not be terminated retroactively except in cases of fraud, intentional misrepresentation or a failure to timely pay required premiums or contributions toward premiums.

A Certificate of Creditable Coverage shall be issued within fourteen (14) days after notification to WIN of termination of Coverage. Certificates of Creditable Coverage may be requested for up to twenty-four (24) months after the date Coverage is terminated.

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) (B), Reimbursement Benefits claim in accordance with Section 5(2) (C), or a second opinion in accordance with Section 5(4).

2. **Initial Benefits Determinations**

After written notice of a claim for benefits or Preauthorization request is received by WIN, WIN shall review and provide a benefits determination to the member as follows:

A. Preauthorized Services – WIN shall notify a Member within fifteen (15) days after receipt of the Preauthorization request whether a service is covered under the Plan. WIN may extend this period by not more than fifteen (15) days provided the Member is notified of the extension prior to the expiration of the initial fifteen (15) day period and informed of the circumstances requiring the extension. If an extension is necessary due to the failure of the Member to submit the necessary information for WIN to evaluate the request for benefits, WIN shall specifically describe the required information and shall provide the Member at least forty-five (45) days from receipt of the notice to provide the specified information.

B. Reimbursement of Reimbursable Services – In addition to the procedure described in Section 5(2) (C), WIN shall notify a member within thirty (30) days after receipt of the claim whether a service is eligible for Reimbursement Benefits under the Plan. WIN may extend this period by not more than fifteen (15) days provided the Member is notified of the extension prior to the expiration of the initial thirty (30) day period and informed of the circumstances requiring the extension. If an extension is necessary due to the failure of the Member to submit the necessary information for WIN to evaluate the claim for benefits, WIN shall specifically describe the required information and shall provide the Member at least forty-five (45) days from receipt of the notice to provide the specified information.

C. Urgent Care Services Out of Network – WIN shall notify a Member as to whether an urgent care 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, WIN 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 WIN to make a benefit determination.

D. 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:
   1) date of service;
   2) provider of service;
   3) claim amount (if applicable);
   4) information regarding availability of diagnosis and treatment codes and corresponding meanings upon request;
   5) the specific reason(s) for the adverse determination, including the denial code and corresponding meaning;
   6) a description of the Plan provision or standard (if any) on which the determination is based;
   7) a description of the Plan's review procedures and time limits applicable to such procedures;
   8) 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;
   9) 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;
   10) 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.

E. Payment of Covered Benefits Claims – All covered benefits claims shall be paid by WIN within forty-five (45) days of

written proof of the service(s) and sufficient supporting evidence.

3. **Appeal Procedure**

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

A. Informal Resolution: WIN' Member Services Department shall contact the Member or the Member's authorized representative to attempt to resolve the issue through informal discussions.

B. Internal Appeal: A Member may appeal an adverse benefit determination and obtain a full, independent review of the determination by submitting a request in writing to WIN. 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).

1) Timing**:** WIN must receive a request for appeal within one hundred eighty (180) days of the initial determination by WIN. An appeal of a service already provided will be decided within forty-five (45) calendar days of WIN' receipt of the appeal request. An appeal regarding a service not yet provided will be decided within thirty (30) calendar days of WIN' receiving the appeal request.

2) 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 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 WIN.

3) 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 72 hours after the Plan's receipt of the request for review.

4) 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.

5) 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 WIN on a form approved by the DOI within sixty (60) days of receiving the Internal Appeal determination. WIN 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 WIN relied in making the adverse benefit determination.

ii. 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 WIN 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. WIN shall be responsible for the cost of the IRO's review. Within five (5) days, the IRO will notify WIN 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 WIN.

iii. 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, WIN, and the DOI of its decision to uphold or reverse WIN' 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, WIN will authorize the services and/or approve the claim(s) for payment and notify the Member of such approval within five (5) days.

iv. 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.

4. **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 WIN. The Medical Director will respond to the Member to confirm receipt of the question or issue and proceed to investigate the matter pursuant to the WIN Quality Assurance Program and the Healthcare Quality Improvement Act of 1986, as applicable.

5. **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
Continuation of Coverage

1. **Continuation of Coverage**

A Member whose Coverage has terminated under Section 8(1) shall be entitled to continuation of his or her Coverage if the Member qualifies for COBRA Continuation Coverage under Section 10(2).

2. **COBRA**

A. **Election of cobra continuation coverage**

1) **Eligibility for Coverage** - For a Member to be eligible to elect COBRA Continuation Coverage under this Section 10(2), (a) the Plan must be subject to the Title 42, Chapter 6A, Subchapter XX of the United States Code of Federal Regulations, and (b) the Member's Coverage must have terminated under Section 8(1) as a result of one of the following "Qualifying Events":

a. The death of an Enrolled Eligible Person, with respect to loss of Coverage by such person's Enrolled Dependents.
b. The termination of an Enrolled Eligible Person's employment with the Plan Sponsor (other than for gross misconduct), or the reduction of the Enrolled Eligible Person's hours of work with the Plan Sponsor.
c. The divorce or legal separation of a Spouse from an Enrolled Eligible Person.
d. Entitlement of an Enrolled Eligible Person to Medicare benefits.
e. A Member ceasing to be a Child.
f. The Plan Sponsor's filing for bankruptcy under Title 11, United States Code, with respect to Coverage of an Enrolled Eligible Person who has retired from employment with the Plan Sponsor.

2) **Election of Coverage** - A Member may elect COBRA Continuation Coverage as follows:

a. Cheyenne Regional shall notify COBRA vendor (Sterling HSA) of the occurrence of a Qualifying Event relating to death, termination of employment or reduction in hours of work, eligibility for Medicare, or certain bankruptcy proceedings. Such notification must be made within thirty (30) days of the event (described in subsections (1) (a), (b), (d) or (f) above).
b. The Member shall notify Cheyenne Regional of the occurrence of a Qualifying Event relating to divorce or to the non-eligibility of a Child for Coverage. Such notification must be made within sixty (60) days of the occurrence of the event (described in subsections (1) (c) or (e) above).
c. Within fourteen (14) days of the notice provided to Sterling HSA under subsections (2) (a) or (b) above, Sterling HSA will notify any Members who are entitled to COBRA Continuation Coverage.

d. A Member who is eligible for COBRA Continuation Coverage may elect such Coverage at any time within sixty (60) days after the occurrence of the Qualifying Event (or, if later, within sixty (60) days after notice is provided to the Member by Sterling HSA under subsection (c) above) on forms that will be provided or approved by Sterling HSA.

e. A Member electing COBRA Continuation Coverage will receive the identical Plan benefits that he or she would have received had the Member's Coverage not terminated under Section 8(1).

3) **Duration of Coverage** - A Member's COBRA Continuation Coverage will continue from the date of the Qualifying Event until the earliest of the following:

a. The day after the end of the grace period for payment of the COBRA Continuation Coverage Premium, if such Premium has not been paid by the Member as required below.

b. The date the Member is covered under any other group health plan.

c. The date the Member becomes entitled to Medicare, except for Members entitled to COBRA Continuation Coverage as a result of a Qualifying Event described in subsection (1)(f) above).

d. Eighteen (18) months after a Qualifying Event relating to termination of employment or reduction in hours of work (described in subsection (1)(b) above) unless Coverage is extended under subsections (e), (f), or (g) below.

e. If a second Qualifying Event occurs during a Member's eighteen (18) month continuation period under subsection (3)(d), the Member shall be entitled to thirty-six (36) months of COBRA continuation Coverage, measured from the date of the first Qualifying Event.

f. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA Continuation Coverage for Eligible Dependents other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement.

g. Twenty-nine (29) months after a Qualifying Event described in subsection (1) (b), if the Employee or any of his/her Enrolled Dependents is determined under Title II or Title XVI of the United States Social Security Act to be disabled within the first sixty (60) days of electing COBRA Continuation Coverage, written documentation of the disability must be provided to Sterling HSA no later than sixty (60) days after the date the Member is determined to be disabled. The Member must notify Sterling HSA within thirty (30) days of a final determination that he or she is no longer disabled. The extended Coverage under this paragraph will

terminate on the last day of the payment period that begins more than thirty (30) days after the date the Member is determined not to be disabled, whether or not notice is given to Sterling HSA.

h. Thirty-six (36) months after a Qualifying Event not described in subsection (1) (b) or (f).

i. In the case of a Qualifying Event described in subsection (1)(f) (relating to bankruptcy proceedings), the date of the death of the Enrolled Eligible Person, or, in the case of the surviving Spouse or other Eligible Dependents of the Enrolled Eligible Person, thirty-six (36) months after the date the death of the Enrolled Eligible Personal.

4) **Coverage for Members of the Armed Services**

a. When an Employee is performing service in the uniformed services, he or she is entitled to continuing Coverage under the Plan for himself or herself and Eligible Dependents. Such Employee may elect to continue coverage for a period of twenty four (24) months, commencing when the Employee is absent for the purpose of performing service.

b. Employees performing service in the uniformed service for fewer than thirty-one (31) days will not be required to pay more than the regular employee share of Coverage under the Plan. Employees performing service in the uniformed service for thirty-one (31) or more days may be required to pay up to one-hundred-two percent (102%) of the full premium under the Plan.

5) **Payment of Premiums**

a. A Member electing COBRA Continuation Coverage must pay directly to Sterling HSA a monthly premium in an amount equal to one-hundred-two percent (102%) of the amount that would have been paid by Cheyenne Regional (including any Member contribution) had the Member's Coverage not terminated under Section 8(1). If the duration of the Member's COBRA Continuation Coverage has been extended to twenty-nine (29) months under Section 10(2) (A) (3)(g) above due to a Member's disability, the Member must pay one-hundred-fifty percent (150%) of the premium that would have been paid by Cheyenne Regional, for each month after the first eighteen (18) months of COBRA Continuation Coverage.

b. The Member must pay all required premiums on the date that the Plan Sponsor would have been required to pay the Member's premiums had Coverage not terminated under Section 8(1) except that a thirty-one (31) day grace period shall apply. Notwithstanding the foregoing, the initial payment of premiums is not due until forty-five (45) days after the date the Member elected COBRA Continuation Coverage, at which time the Member must pay all premiums due through that date.

c. In addition to paying monthly premiums, the Member must also pay any Deductible, Copayment or Coinsurance applicable to a particular Healthcare Service received by the Member.

6) **Coordination with COBRA** - The provisions of this Section 10(2) (A) shall be interpreted and applied in accordance with the requirements of Title 42, Chapter 6A, Subchapter XX of the United Stated Code of Federal Regulations.

SECTION 11

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 when a Member has healthcare coverage under more than one (1) plan. If this COB Provision applies, the order of benefit determination rules listed herein determine whether the benefits of the Plan are applied before or after those of another coverage plan. The benefits of the Plan:

1) Shall not be reduced when, under the order of benefit determination rules, WIN 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 11(4).

2. **COB Provision Definitions**

For purposes of Section 11, 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 the Plan is a Primary Plan, its benefits are determined before those of the other Coverage Plan without considering the other Coverage Plan's benefits. When the Plan 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, the Plan may be a Primary Plan as to one (1) 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 healthcare, 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. When a Coverage Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

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 the Plan or any part of a year before the date this COB Provision or a similar provision takes effect.

3. **Order of Benefit Determination Rules**

WIN 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 an Employee is the Primary Plan.

B. **Dependent Child/Parents not Separated or Divorced** - Except as stated in subsection (3) 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 healthcare 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 BESTLIFE 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 the Plan's 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 payable under the Primary Plan, do not exceed the Allowable Expenses in the Claim Determination Period.

5. **Right to Receive and Release Needed Information**

WIN 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 the Plan benefits must provide any reasonable information requested by WIN under this Section 11(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, WIN, on behalf of Cheyenne Regional, 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. WIN and Cheyenne Regional will not have to pay that amount again.

7. **WIN and Cheyenne Regional Right of Recovery**

If the amount of the payments made by WIN on behalf of Cheyenne Regional exceeds the amount the Plan should have paid under this COB Provision, then WIN and Cheyenne Regional 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 12

Subrogation

1. **Subrogation Rights**

A. As a condition of eligibility to receive benefits under the health Plan, each Member agrees that the Plan 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 the Plan such cause of action.

B. The Member shall cooperate with WIN and Cheyenne Regional and do whatever is reasonably necessary to secure those rights of recovery. The Member shall do nothing that would prejudice those rights.

C. 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 after twenty (20) days' written notice WIN or Cheyenne Regional 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.

D. In the event that WIN and/or Cheyenne Regional recover an amount greater than the benefit paid, the excess, reduced by the expenses of recovery, will be paid to the Member. WIN and Cheyenne Regional reserve the right to compromise the amount of the claim if, in the opinion of WIN and Cheyenne Regional, it is appropriate to do so.

E. 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 under the Plan. The Plan 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 13

Miscellaneous Provisions

1. **Notices**
Notice given by the Plan to enrolled Employees shall constitute notice to all enrolled Members.

2. **Records and Information**
A. 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 WIN 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 WIN 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. WIN agrees that such information and records will be considered confidential.
C. WIN shall have the right to submit to appropriate medical or other review bodies or individuals all information regarding Healthcare Services provided to Members.

3. **Examinations**
In the event of a question or dispute concerning the provision of WIN benefits, WIN may reasonably require that a Member be examined, at the health Plan's expense, by a Physician acceptable to WIN.

4. **Limitation of Actions**
No action in law or equity may be brought against the health Plan, WIN, or any officer, director, or Employee of WIN, by any Member with respect to any matter arising under the Summary Plan Description or the relationship between that Member and WIN until the Member has fully complied with the claims and complaint procedures set forth in Section 9 of the Summary Plan Description.

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

6. **Effective Date**
The Summary Plan Description shall take effect on the date specified on the Summary Plan Description and will continue in force until terminated.

7. **Commencement and Termination of Coverage**
All Coverage under the Summary Plan Description shall begin and end at 12:01 A.M. Mountain Time on the date as of which the Coverage begins or ends.

8. **Governing Law**

The Summary Plan Description is delivered in and shall be governed by the laws of the State of Wyoming.

9. **Conformity With Statutes**

Any provision of the Summary Plan Description 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 Summary Plan Description is hereby amended to conform to the minimum requirements of such statutes and regulations.

10. **Workers' Compensation Not Affected**

The Coverage provided under the Summary Plan Description 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 Summary Plan Description.

11. **Nondiscrimination**

In compliance with federal and state law, WIN 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.

12. **Headings**

The subject headings used in the Summary Plan Description are included for purposes of reference only and shall not affect the construction or interpretation of any of its provisions.

13. **Construction**

Throughout the Summary Plan Description, 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 14

Privacy Practices

1. 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.

Neither the Plan nor WIN will disclose Member PHI to the Plan Sponsor unless the Plan Sponsor certifies that this Summary Plan Description has been amended to incorporate the provisions of this Section 13(14) and agrees to abide by this Section. Plan Sponsor shall have access to PHI from the Plan only as provided in this Section or as otherwise required or permitted by HIPAA.

2. Permitted Disclosures of PHI to Plan Sponsor

The Plan may disclose to the Plan Sponsor the following information:

A. Enrollment/Disenrollment Information – The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

B. Summary Health Information – The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests such information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan; or modifying, amending or terminating the Plan. Summary health information is information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a health plan from which identifying information such as names, addresses other than zip codes, and birth dates has been deleted.

C. Administrative Purposes – The Plan may disclose PHI to the Plan Sponsor provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes, including quality assurance, claims processing, auditing and monitoring as well as investigating the payment of claims on behalf of and at the request of a Member of the Plan.

3. Restrictions on Plan Sponsor's Use and Disclosure of PHI

Plan Sponsor is subject to the following restrictions with respect to use and disclosure of Member PHI:

A. Plan Sponsor will not use or further disclose Member PHI, except as permitted or required by this Summary Plan Description or required by law.

B. Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Members' PHI agrees to the restrictions and conditions of this Summary Plan Description, including this Section 13(14) with respect to Members' PHI.

C. Plan Sponsor will not use or disclose Members' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

D. Plan Sponsor will report to the Plan any use or disclosure of Members' PHI that is inconsistent with the uses and disclosures allowed under this Section 13(14) promptly upon learning of such inconsistent use or disclosure.

E. Plan Sponsor will make PHI available to the Member who is the subject of the information.

F. Plan Sponsor will make Members' PHI available for amendment and, on notice, amend Members' PHI in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

G. Plan Sponsor will track disclosures it may make of Members' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA regulations.

H. Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of Members' PHI to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA regulations.

I. Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium, received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

4. **Separation Between Plan Sponsor and Plan**

Plan Sponsor shall allow designated persons in the Human Resources, Benefits and Accounting Departments and their supervisors access to the PHI received from the Plan. No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan.

In the event that any of these specified employees do not comply with the provisions of this section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

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 BestLife Medical and Prescription Drug Plan (the "Plan") and WINhealth Partners (WIN) are collectively 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 and WIN (third party administrator of the Plan) are required by law to maintain the privacy of protected health information (PHI). PHI is information that is created or received by the Plan and/or WIN 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. We will provide a revised Notice to you within 60 days of any material change.

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 health care providers in order to facilitate medical treatment. For example, WIN' 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** (Cheyenne Regional Medical Center) – 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.

- **Other** – We may disclose PHI of deceased members to coroners or funeral directors. In addition, we may disclose PHI to organ donation and transplant associations to facilitate organ transplants.

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. 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 protected health information held by the Plan and/or WIN.
- You have the right to request restrictions on certain uses and disclosures of your PHI. However, we are not required to agree to requested restrictions.
- 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 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. 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, WIN, 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 or electronically to the addresses below:

BestLife Medical and Prescription Drug Plan
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