WINhealth

Plan Well, Live Healthy

Individual Freedom Plans Evidence of Coverage

Effective January 1, 2015

This Evidence of Coverage includes all comprehensive adult wellness benefits as defined in Wyoming Statute 26-19-107. For more information about the comprehensive adult wellness benefits, see *Preventive Services* under Section 6(1) of this Evidence of Coverage.

WINHEALTH
MEMBER RIGHTS AND RESPONSIBILITIES

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

YOU HAVE A RIGHT TO:

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

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

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

YOU HAVE A RESPONSIBILITY TO:

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

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

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

Contents

SECTION 1

General Plan Information

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

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

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

Payment for Covered Services

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

Participating Provider Network

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

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

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

The following providers will be considered Primary Care Providers:

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

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

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

Out-of-Network Benefits – Not Covered

Out-of-Network providers are Hospitals, Physicians, and ancillary providers who are not part of WINhealth's network of providers. Out-of-Network providers have no contractual obligation to adhere to WINhealth's policies and reimbursement schedules; therefore, you may incur additional costs when you see an Out-of-Network provider. In order to avoid unexpected additional costs associated with Out-of-Network providers, you should verify that all services recommended or ordered by a Participating Provider, such as surgical assistants, pathology, or anesthesiology, are also provided by Participating Providers.

Obtaining Covered Services

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

In an Emergency situation, you should attempt to contact a Participating Provider or the nurse line by calling WINhealth or the number on your identification card; if that is not reasonably possible, you should 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 WINhealth fee schedule. Reimbursement mechanisms may be used to encourage Participating Providers to offer the most medically-appropriate, cost-effective care.
You should always show the health care provider your Plan identification card to ensure that claims for services you receive are submitted in a timely manner. Failure to show your Plan identification card may result in delays in payment. Prior to your appointment, you should also ensure that you have satisfied all requirements for obtaining Covered Services (e.g., a proper referral and/or Preauthorization from WINhealth).

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

SECTION 2

Contact Information

Name and Address:

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

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

Member Secure Web Portal:

https://WINhealth.healthtrioconnect.com

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

Member Services Department Contact:

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

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

Other Department Contacts:

Health Management and Preauthorization:	(307) 773-1320

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

Language Services

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

SECTION 3

Definitions

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

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

2. **BEHAVIORAL HEALTHCARE SERVICES** – means those Healthcare Services for the diagnosis and treatment of a covered behavioral disorder.

3. **CHILD** – means a person who is the child, stepchild, legally adopted child, ward of a legal guardianship, or foster child of an Employee, subject to the following:
   A. A person who is under the age of twenty-six (26) shall be considered a Child.
   B. A person who has reached age twenty-six (26) is primarily dependent on the Employee for support and maintenance, and provides disability documentation from the United States Social Security Administration shall be considered a Child.
   C. For purposes of this definition, the term "foster child" means a person who meets all of the following criteria:
      1) principal place of residence is with the Member;
      2) is being raised as a Child of the Member;
      3) is primarily dependent on the Member for support and maintenance;
      4) the Member has taken full parental responsibility and control, and;
      5) Has been placed with the Member legally by any State department of family services.
   D. A person for whom a Member becomes legally responsible by reason of placement for adoption shall be considered a Child.

4. **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.

5. **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 ("COBRA"), 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.

6. **COINSURANCE** – means the percentage of the fee that the Member must pay for care. Coinsurance does not begin until any applicable annual deductible is satisfied.

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

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

9. **COPAYMENT** – means the fixed amount of money paid by the Member to any Participating Provider when Covered Services are received. Copayments are to be paid at the time treatment is rendered. Copayments do not begin until any applicable deductible is satisfied.

10. **COVERAGE** – means services and benefits to which a Member is eligible as defined by the Member's Plan, subject to the Limitations and Exclusions applicable to such benefits under the Group Contract and this Evidence of Coverage.

11. **COVERED SERVICES** – means services that are Medically Necessary and provided under the rules and policies of the Evidence of Coverage. Please see the definition of Medically Necessary.

12. **CREDITABLE COVERAGE** – means health coverage of an individual under: a group health Plan, COBRA Continuation Coverage, Medicare, Medicaid, a state health benefits risk pool, a public health Plan and certain other health programs.

13. **CUSTODIAL CARE** – means skilled or unskilled care, behavioral or medical care by a Physician, licensed nurse, registered therapist, family member, or other care-giver or practitioner that does not seek to cure, but is designed primarily to maintain a current level of function or 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.

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

15. **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.

16. **DIRECT BENEFITS** – means Healthcare Services provided to you for which Plan benefits are paid directly to your provider.

17. **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.

18. **EFFECTIVE DATE** – means the date coverage becomes effective under the Plan.

19. **ELIGIBLE DEPENDENT** – means a Spouse, Child or disabled Child dependent of an Eligible Person.

20. **ELIGIBLE PERSON** – means a person who is in a class of persons specified in the Group Contract Application as eligible to be enrolled for Coverage under the health Plan and meets the eligibility requirements of the PPACA.

21. **EMERGENCY** – means the sudden and unexpected onset of a condition or an event that the Member believes endangers 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.

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

23. **ENROLLED DEPENDENT** – means an Eligible Dependent who is enrolled for Coverage.

24. **ENROLLED ELIGIBLE PERSON** – means an Eligible Person who is enrolled for Coverage.

25. **ENROLLMENT DATE** – is the date an Eligible Person or Eligible Dependent enrolls in the Plan.

26. **EVIDENCE OF COVERAGE (EOC)** – means the written description of Coverage under the Plan that is provided to Members and is considered to be a contract or agreement between an Enrolled Eligible Person and the Plan.

27. **EXCLUSIONS** – means the portion of EOC containing the schedule of Healthcare Services and supplies that are excluded from Coverage under the Plan.

28. **EXPERIMENTAL, INVESTIGATIONAL, UNPROVEN, UNUSUAL, OR NOT CUSTOMARY TREATMENTS, PROCEDURES, DEVICES, AND/OR DRUGS** – means medical, surgical or psychiatric procedures, treatments, devices and pharmacological regimen (including investigational drugs and drug therapies), or supplies where either (a) the service is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question regardless of whether the service is authorized by law or used in testing or other studies, or (b) the service requires approval by a governmental authority and such authority has not been granted prior to the service being rendered.

29. **FAMILY PLANNING** – A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. WINhealth provides coverage of physician charges for contraception management, medication for birth control, and procedures, such as an IUD insertion or vasectomy. Generic medication for birth control, IUD insertion, tubal ligation, and vasectomy are considered essential health benefits and are covered without cost sharing. Hysterectomy solely for sterilization purposes and reversal of vasectomy are specifically excluded. IUD removal for the purpose of conception is not covered.

30. **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.

31. **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 Group Contract are Covered Services. Not all Healthcare Services are Covered Services.

32. **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.

33. **ILLNESS** – means physical and/or behavioral illness, sickness or disease.

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

35. **IN-NETWORK** – means all providers who have entered into a direct or indirect contractual agreement with WINhealth.

36. **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.

37. **MEDICALLY NECESSARY** – means a medical or behavioral health service, procedure or supply provided for the purpose of preventing, diagnosing or treating an Illness, Injury, disease or symptom and is a service, procedure or supply that:
    a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, Illness, disease or Injury.
    b. Provides for the diagnosis, direct care and treatment of the patient's condition, Illness, disease or Injury.
    c. Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care.
    d. A prudent Physician would provide.
    e. The omission of which could adversely affect or fail to maintain the Member's condition.
    f. Is not primarily for the convenience of the patient, Physician or other health care provider.

    A medical or behavioral health 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. A nationally recognized resource including, but not limited to, Hayes Inc. or Milliman Care Guidelines®.

38. **MEMBER** – means an Enrolled Eligible Person.

39. **NON-PARTICIPATING PROVIDER** – means any Physician, Hospital, Skilled Nursing Facility, or other provider of Healthcare Services or supplies that has not entered into a Provider Agreement with WINhealth.

40. **OUT-OF-NETWORK PROVIDER –** See Non-Participating Provider.

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

42. **PPACA** – Patient Protection and Affordable Care Act - Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (2010) (codified as amended in scattered titles of U.S.C.). These two statutes are collectively known as PPACA or ACA or "Obamacare."

43. **PARTICIPATING HOME HEALTH AGENCY** – means an organization that provides home Healthcare Services that has entered into a Provider Agreement to provide Covered Services to Members under the health Plan.

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

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

46. **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.

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

48. **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.

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

50. **POLICY OR EVIDENCE OF COVERAGE (EOC)** – means the written description of Coverage under the Health Plan that is provided to Members and is considered to be a contract or agreement between and Enrolled Eligible Person and the health Plan.

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

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

53. **PREMIUM** – means the monthly fee that must be paid to WINhealth Partners for each Member enrolled for Coverage under this health Plan.

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

55. **PROSTHETIC DEVICE** – means any artificial device, instrument or object that is intended to replace a limb or body part.

56. **QUALIFYING PREVIOUS COVERAGE** – means health insurance coverage and other health coverage such as coverage under group health plans (whether or not provided through an insurer), Medicaid, Medicare, and public health plans, as well as other types of coverage set forth in HIPAA and the regulations. All forms of health insurance are included, whether in the individual market or group market, and whether the coverage is short-term, limited-duration coverage or other coverage for benefits for medical care for which no certificate of credible coverage is required.

57. **REASONABLE AND CUSTOMARY** – means fees for Healthcare Services that WINhealth has determined are fees that regional providers customarily charge for such services.

58. **SERVICE AREA** – means the geographical area served by the health Plan, as approved by the Wyoming Insurance Commissioner or other regulatory agencies, within which WINhealth provides or arranges for the provision of Covered Services to Members.

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

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

61. **SPECIAL ENROLLMENT** – allows certain individuals who are otherwise eligible for coverage to enroll in the Plan, regardless of the Plan's regular enrollment dates. Special Enrollment rights may be triggered upon loss of eligibility for other coverage, including loss of employer contributions toward other coverage, such as: marriage, divorce, death of spouse, birth of a Child, adoption, and placement for adoption. Eligibility requirements are governed by the Master Group Contract, Group Contract Application, the SBC, this EOC and the PPACA.

62. **SPOUSE** – means a person whose relationship with an Employee is recognized as a legal marriage.

63. **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.

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

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

66. **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.

67. **URGENT CARE FACILITY** – means a health care facility that is not a Hospital and has as its primary purpose the provision of immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

68. **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.

69. **WINHEALTH GROUP HEALTH PLAN (PLAN)** – means the health Plan established under this EOC through which certain Covered Services are provided to Members pursuant to the terms and conditions of the EOC and under applicable Federal and State law and regulation.

SECTION 4

Eligibility

ELIGIBILITY FOR COVERAGE

Due to PPACA, eligibility for coverage is no longer applicable.

SECTION 5

Obtaining Plan Benefits

1. **OVERVIEW OF BENEFITS**

Each Member is entitled to receive Covered Services as described in Section 6 from Participating Providers. WINhealth reserves the right to reasonably interpret the terms of this Evidence of Coverage and to provide standards of interpretation and review in making the benefit determinations described herein.

A. Each Member is entitled to receive the following benefits:
   1) Direct Benefits consisting of the provision of Covered Services by either Participating Providers or Non-Participating Providers; and,
   2) 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 (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 Evidence of Coverage.

2. **OVERVIEW OF DIRECT BENEFITS**

A. Members are entitled to receive benefits for Covered Services specified in Section 6 if ALL of the following requirements are satisfied:
   1) The Covered Services are Medically Necessary;
   2) The Premium for the Member has been paid pursuant to Section 7(1);
   3) Services were provided by a Participating Provider, qualify as Emergency services or were specifically Preauthorized by WINhealth Partners;
   4) The Member has paid the applicable Copayment or Coinsurance for the Benefit, if any, in accordance with Section 7(2), and the Benefit Plan;
   5) The Member has obtained applicable Preauthorization for the Covered Services if required for the service; and
   6) No Exclusion or limitation applies to the Covered Services.

B. Obtaining Covered Services – A Member may obtain Covered Services by contacting his or her Primary Care Physician who is a Participating Provider. If the Direct Benefits consist of Emergency or Urgent

Healthcare Services, the Member must follow the procedures described in Section 6 in order to receive Coverage.

C. Member's Obligation to Verify Status of Provider – Members are responsible for verifying that the Provider of any Healthcare Services or supplies is a Participating Provider. With the exception of Emergency Care, if a Member obtains services from a Non-Participating Provider without the specific Preauthorization of WINhealth Partners, the Member will be responsible for all expenses.

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, you should call 911, or proceed directly to the emergency room. Non-emergent services rendered in an Emergency room are not Covered Services. WINhealth offers its Members 24-hour/7-day access to a medical advice line. A Member may call the medical advice line to obtain help in evaluating the severity of a situation to assist in deciding the urgency of care required. By calling the medical advice line, a Member may be able to avoid unnecessary and costly emergency room services.

E. Preauthorization – by WINhealth is required when the following are true:

i. A Member is to be confined in a Hospital, Skilled Nursing Facility, rehabilitation facility or other institution;
ii. A Member requires Durable Medical Equipment (DME);
iii. A Member requires Covered Services in their home;
iv. A Member requires Covered Services rendered by a non-Physician provider, including but not limited to podiatry, hospice, and transplant related services;
v. A Member requires a radiological scan including but not limited to: an MRA, MRI, PET or CT Scan;
vi. A Member requires a prescription drug that requires Preauthorization;
vii. A Member is referred to a Non-Participating provider for Covered Services;
viii. A Member is receiving any Organ transplant.

3. REIMBURSABLE SERVICES

WINhealth Partners will reimburse a Member for Covered Services for which the Member may have made payment at the time of service, as long as such Covered Services are provided under the rules of WINhealth Partners.

A. Reimbursement of Reimbursable Services – A Member obtains reimbursement of Reimbursable Services as follows:

1) A Member must file a written claim for reimbursement (including the documentation required under subparagraph (2)) with the Health Plan no later than one-hundred-twenty (180) days after the date the Healthcare Services giving rise to the claim were provided, unless it is not reasonably possible to file a claim within such period. In all cases, the Member must file the claim for

reimbursement no later than one (l) year after the expiration of the foregoing one-hundred-twenty (120) day period (unless the Member is under a legal incapacity, in which case the one (l) year period shall be extended as may be required under Wyoming law).

2) As part of the written claim for reimbursement, the Member must submit documentation of the Healthcare Services that are the subject of the claim. WINhealth Partners may establish rules regarding the documentation or other proof to be submitted. WINhealth Partners may require a Member to submit additional proof in support of a claim that WINhealth Partners determines has not been satisfactorily verified.
3) If a Member fails to file a claim within the time period set forth in subparagraph (l), or fails to provide proof as required by subparagraph (2) the Member shall have no Coverage for the Healthcare Services or supplies that are the subject of the claim.
4) WINhealth Partners will reimburse the Member for Reimbursable Services within forty-five (45) days of receiving both the written claim for reimbursement and satisfactory documentation of the claim.

4. **TEMPORARY ABSENCE FROM SERVICE AREA**

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

A. Emergency Healthcare Services or preauthorized Urgent Healthcare Services.
B. Healthcare Services that have been preauthorized by WINhealth.

5. **SECOND OPINION**

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

A. WINhealth shall notify the Member that a second opinion has been requested.
B. WINhealth will provide the Member with a list of Physicians who are authorized to provide a second opinion. The Physician who is to provide the second opinion must not be affiliated with the Physician who provided the initial opinion, unless WINhealth consents to provision of the second opinion by an affiliated Physician.
C. The Member is responsible for arranging a consultation with the Physician who will provide the second opinion. The consultation must take place

within thirty-one (31) days after the first opinion was provided, or as soon thereafter as reasonably possible.

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

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

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

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

6. **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.

7. **MEMBERS HELD HARMLESS**

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

SECTION 6

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 a covered benefit.

I. DESCRIPTION OF PLAN BENEFITS

A. AMBULANCE

Covered

Ambulance for Emergency transport to the nearest Hospital or medical facility that is equipped to furnish the services is covered when medically indicated. Ambulance transport when used for patient or family convenience is not a covered benefit. 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.

Alternate Transportation – benefits are not payable for transportation other than by a ground or air ambulance that is specially designed and licensed for transporting patients, and is operated by trained personnel.

Limits

A per trip benefit maximum applies for both air and ground transport. Ambulance services must be for emergency transportation. Non-emergent ambulance services must be preauthorized by WINhealth or requested by WINhealth.

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.

B. 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 Participating Physician or Certified Registered Nurse Anesthetist (CRNA).

When surgery is performed during a Hospital Confinement, anesthesia services will only be covered when WINhealth has Preauthorized the Hospital

Confinement. All elective surgical procedures require the use of a WINhealth Partners network Participating Provider in order to be Covered Services.

Limits

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

C. CARDIAC REHABILITATION

Covered

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 or no later than eight (8) months after the triggering cardiac event. Cardiac Rehabilitation services must be Preauthorized.

Limits

Benefits for cardiac rehabilitation services are covered on an outpatient basis up to the maximum per incident, subject to the applicable Copayment or Coinsurance.

D. CHEMOTHERAPY

Covered

- Outpatient injectable chemotherapy, when oral administration of prescribed medication is not medically appropriate.
- Services and materials for chemotherapy.

E. DENTAL SERVICES

Covered

Coverage is available for the following dental services only:

- Accidental Injury to the mouth, teeth or jaw that has occurred during the Coverage period and is within 12 months of the accident. The initial service must be performed within 90 days of the accident. The accidental Injury cannot be a result of biting or chewing. Treatment must be for restorative services and supplies necessary to promptly repair but not replace sound natural teeth.
- Incision and drainage of a cyst or cellulitis that does not originate in the teeth.
- Surgical removal of tumors and cysts.
- All dental services must be Preauthorized.

Limits

- Restoration of the mouth, teeth or jaw due to an accidental Injury is limited to those determined by WINhealth Partners to be appropriate for dental needs.
- Facility charges for hospitalization at a Participating Hospital for dental procedures only when a non-dental medical Condition exists that makes hospitalization necessary to safeguard the health of the patient. WINhealth

does 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.
- Oral appliances, regardless of medical indications, are considered a dental benefit and are not covered.

F. DIABETES CARE

Covered

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

G. EMERGENCY CAER WINTHIN SERVICE AREA

Covered

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

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

- Obtaining Emergency Healthcare Services – In a life- or limb-threatening Emergency, a Member should call 911 or go directly to the nearest Hospital emergency room or medical facility for treatment.
- Transfer to participating facility following an out-of-area emergency – If a Member is in confinement in a hospital that is a Non-Participating Provider facility, WINhealth may elect to transfer the Member to a facility that is a Participating Provider, if the Member's attending Physician approves the transfer as medically appropriate. The Plan will pay for such transfer. If, after the attending Physician has approved the transfer, the Member chooses to remain in the Non-Participating Provider facility, further services will be covered at the appropriate benefit level, if any.
- Determination that Healthcare Services Are Not Emergency Healthcare Services – If WINhealth determines, based on generally accepted medical criteria, Healthcare Services or supplies are not Emergency Healthcare Services, 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 medical advice line – If a Member is unsure if symptoms require Emergency room services, the Member can access the medical advice line by calling WINhealth or the number on the Member's identification card. The medical advice line personnel will review the symptoms and help the Member decide if a visit to the Emergency room is necessary. Under most plans, 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. Refer to your Summary of Benefits and Coverage for information about your Plan. If, under a prudent layperson standard, the Member's symptoms or condition is life- or limb-threatening or the Member is physically unable to call the nurse line due to the symptoms or condition, the higher Copayment will not apply.
- Under most plans, if a Member visits the Emergency room at the recommendation of a physician, the applicable Copayment will be less than if the Member had not been referred by a physician. Refer to your Summary of Benefits and Coverage for information about your Plan.
- If a Member is admitted to the Hospital, the Emergency room Copayment is waived.
- WINhealth may review use of Emergency facilities. Payment of claims may be denied and charges may be the Member's responsibility if WINhealth determines that the claim was for non-emergent services.
- In a life- or limb-threatening Emergency, the Member should call 911 or the local equivalent.

- If the Member is hospitalized at a Non-Participating Provider facility, WINhealth may elect to transfer the Member to a Participating Provider Hospital if it is Medically Necessary.
- WINhealth 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.
- 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.

H. EMERGENCEY CARE OUTSIDE SERVICE AREA

Covered

- If a Member receives Emergency Healthcare Services outside the WINhealth Partners' Service Area, Reimbursable Services will include: Reasonable and Customary Charges for Hospital services that are emergent Covered Services.
- Reasonable and Customary Charges for professional services that are covered benefits.
- Reasonable and Customary Charges for transportation authorized by WINhealth Partners to return the Member to a Participating Hospital, less the cost of Member's normal return trip expense.

Limits

- WINhealth Partners must Preauthorize Hospital admissions including those that occur outside the Service Area. Claims for Reimbursable Services must be submitted to WINhealth Partners within one- hundred-twenty (120) days after the date of the Healthcare Service.

I. GENETIC TESTING/GENETIC COUNSELING

Not Covered

All testing for genetic information.

J. HEMODIALYSIS

Covered

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

K. HOME HEALTHCARE

Covered

Home Healthcare expenses are Covered Services when a Member is homebound if such services are determined to be considered Medically

Necessary and ordered by a Participating Physician and Preauthorized by WINhealth.

Limits

- For services to be covered, the home health care agency must provide a treatment program that includes the estimated time that home care is needed and the frequency and duration of all services to be provided.
- 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

Home health services that are not Covered Services include, but are not limited to the following:

- 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
- Disposable supplies
- Transportation
- Items available over the counter

L. HOSPICE

Covered

Hospice care is covered with Preauthorization when the Member is in the final stages of a terminal Illness or condition.

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 the concept that those Members receiving hospice care choose not to avail themselves of Healthcare Services related to seeking a cure for the terminal condition. While receiving hospice care in the Member's home or in a hospice facility, if a Member requires treatment for a condition not related to the terminal Illness, the Plan will pay for such Healthcare Services to the extent that they are Covered Services.

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

Not Covered

- Voluntary services or supplies.
- Counseling by clergy or voluntary groups.
- Services performed after the death of the Member.
- Curative services and supplies related to the terminal conditions that are not part of hospice care.
- Services of a caregiver other than provided by the hospice agency, including but not limited to, someone who lives in the Member's home or someone who is a relative of the Member.
- Services that provide a protective environment where no professional skill is required, such as companionship or sitter services.
- Services not related to the medical care of the Member, including but not limited to legal services, estate planning, funeral costs, food services such as Meals-On-Wheels, transportation services except covered Medically Necessary professional ambulance services.

M. HOSPITAL CARE

Covered

- Inpatient Hospital services 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.
- Private duty nursing limited to professional services of a registered nurse in an inpatient acute-care setting when ordered by a physician. Preauthorization by WINhealth is required.
- Emergency Confinement requires notification to WINhealth Partners within two (2) business days.

N. LABORATORY SERVICES

Covered

- Medically Necessary laboratory services are Covered Services when requested by a Participating Physician and rendered by a Participating Provider.
- STD screening for documented cases of sexual assault, reported to police.

Not Covered

- Laboratory tests that are not related to a specific Illness or Injury are not Covered Services unless provided according to the schedule of preventive services.

- Laboratory services ordered by a non-Participating Physician or performed by a Non-Participating Provider.
- Genetic Testing.

O. MATERNITY CARE

(See Prenatal Care for an explanation of these benefits)

P. MENTAL HEALTH AND SUBSTANCE ABUSE

Not Covered

All Mental Health and Substance Abuse services are not Covered Services under this Health Plan.

Q. 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 when Medically Necessary and only if the Member is too ill or disabled to go to the Physician's office.
- Medical consultation services, including charges made by a Physician for a second opinion.
- Examination for employment, licensing, insurance, adoption purposes, or court-ordered examination or treatment, travel, school or sports.
- 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 hour's services and other additional charges.
- Exams or evaluations for the purpose of allowing a Member to return to work.

R. PODIATRIC CARE

Covered

- Services rendered by a Podiatrist are covered when referred by a Participating Physician and Preauthorized by WINhealth Partners.

Limits

All podiatry services must be referred by a Participating Physician to a Participating Podiatrist. Services must be Preauthorized.

Not Covered

- Treatment of weak, strained or flat feet.
- Shoe-insert foot orthotics.

- 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.

S. PRENATAL AND POST-NATAL CARE

Covered

- Prenatal Care billed at time of delivery.
- Covered with no copay and with a $1000.00 maximum benefit per delivery.

Limits

- Prenatal Care must be authorized for coverage.
- Member must be eligible for coverage at time of delivery.

T. PRESCRIPTION DRUGS

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

Covered

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

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

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

Over-the-Counter Drugs

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

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

Limits

- After meeting any applicable annual Deductible, Copayment and/or Coinsurance, a 34-day supply of the covered drug may be dispensed from a participating retail pharmacy.
- For maintenance drugs, as defined by standard lists, a ninety (90) day supply may be dispensed if applicable Copayments and/or Coinsurance are paid.
- Prescriptions are covered with varying Copayments for brand and generic medications.
- If a brand drug is listed in the Preferred Drug List and is dispensed, a brand Copayment is required even if the medication being ordered has no generic equivalent. This is the 2nd or middle tier co-payment. 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.
- A maximum quantity for a maintenance prescription drug purchased through either the mail service or retail cannot exceed a ninety (90) day supply.
- Some prescription drugs need Preauthorization before benefits will be available. A drug is authorized for the length of treatment not to exceed a one-year period of time. Examples of drugs needing Preauthorization by WINhealth Partners include:
  - Injectable medications
  - Impotency Agents
  - Interferon/Intron/Avonex and other specialty drugs
  - 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 WINhealth Partners with any question as to whether a drug requires Preauthorization.

Not Covered

Excluded Drugs: Not all prescription drugs are covered. Members can contact the WINhealth Medical Management 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
- Medications available without a prescription
- Experimental or investigational drugs
- Drugs for cosmetic purposes
- Drugs for Conditions that are excluded from Coverage

U. PREVENTIVE SERVICES

Covered

The list of preventive services covers a full range of immunizations and diagnostic tests and screenings for Members of all ages. Charges incurred for preventive services that are rendered in accordance with the WINhealth SBC are Covered if such services are provided through a Participating Physician.

Schedule of Preventive Benefits

Under One Year of Age

- Two (2) normal newborn care exams prior to Hospital discharge
- Six (6) Well-Child exams
- One (1) newborn genetic screen as recommended by the Wyoming Department of Health
- 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

Six Years but less than Twelve Years

- Well-Child exams (one (1) exam every two (2) years)
- One (1) routine eye exam every two (2) years by an ophthalmologist or optometrist, max benefit per exam of $60.00
- One (1) tuberculosis skin test annually
- One (1) dipstick urine per Well-Child exam
- One (1) hematocrit/hemoglobin per Well-Child exam
- Immunizations for measles, mumps, rubella, if not done previously between ages 4-6

Twelve Years but less than Eighteen Years

- Health maintenance visit (one (1) exam every two (2) years)
- One (1) routine eye exam every two (2) years by an ophthalmologist or optometrist, max benefit per exam of $60.00
- One (1) Diphtheria/tetanus booster, 10 years from previous booster
- Tuberculosis skin test per health maintenance visit
- Dipstick urine per health maintenance visit
- Hepatitis B vaccine series
- Pelvic examination and cervical cancer screening (including Pap smear) annually for females

Eighteen Years but less than Forty Years

Men:

- Prostate examination and laboratory tests for cancer, annually
- Health maintenance visit every five (5) years
- Measles, mumps, rubella under age 20
- Dipstick urine every five (5) years
- Complete blood count (CBC) every five (5) years
- Basic metabolic panel lab test every five (5) years
- Cholesterol every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually

Women:

- Pelvic examination and cervical cancer screening (including Pap smear) annually until age 21
- After age 21, annual pelvic examination
- After age 21, cervical cancer screening (including Pap smear) every three (3) years
- Clinical breast examination, annually
- Screening mammogram, annually
- Health maintenance visit every five (5) years
- Measles, mumps, rubella under age 20
- Dipstick urine every five (5) years
- Complete blood count (CBC) every five (5) years
- Basic metabolic panel lab test every five (5) years
- Cholesterol every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually

High Risk Patients Only:

- ✓ EKG every 5 years
- ✓ Pneumococcal vaccine
- ✓ Influenza vaccine annually
- ✓ Hepatitis B vaccine

Forty Years but less than Sixty-five Years

Men:

- Prostate examination and laboratory tests for cancer, annually
- Health maintenance visit every three (3) years
- Dipstick urine every three (3) years
- Complete blood count (CBC) every three (3) years
- Basic metabolic panel lab test every five (5) years
- Cholesterol every five (5) years
- Tetanus/Diphtheria booster every ten (10) years
- Colorectal cancer examination and laboratory tests for cancer, annually

Women:

- Pelvic examination, annually

- Cervical cancer screening (including Pap smear) every three (3) years
- Clinical breast examination, annually
- Screening mammogram, annually
- Health maintenance visit every three (3) years
- Dipstick urine annually
- Complete blood count (CBC) every three (3) years
- Basic metabolic panel lab test every five (5) years
- Cholesterol every five (5) years
- Tetanus/Diphtheria booster every ten (10) years
- Colorectal cancer examination and laboratory tests for cancer, annually
- DEXA scan for osteoporosis every three (3) years after age 49
- Shingles vaccine after the age of sixty (60)

High Risk Patients Only:

- ✓ EKG
- ✓ Tuberculosis skin test
- ✓ Colonoscopy
- ✓ Pneumococcal vaccine
- ✓ Influenza vaccine annually

Sixty-five Years and Over

Men:

- Prostate examination and laboratory tests for cancer, annually
- Health maintenance visit annually
- Dipstick urine annually
- Thyroid function test
- Complete blood count (CBC) annually
- Basic metabolic panel lab test annually
- Cholesterol annually
- Tetanus/Diphtheria booster every ten (10) years
- Influenza vaccine annually
- Pneumococcal vaccine
- Colorectal cancer examination and laboratory tests for cancer, annually

Women:

- Pelvic examination, annually
- Cervical cancer screening (including Pap smear) every three (3) years
- Clinical breast examination, annually
- Screening mammogram, annually
- Health maintenance visit annually
- Complete blood count (CBC) annually
- Basic metabolic panel lab test annually
- Cholesterol annually
- Dipstick urine annually
- Thyroid function test
- Tetanus/Diphtheria booster every ten (10) years

- Influenza vaccine annually
- Pneumococcal vaccine
- Colorectal cancer examination and laboratory tests for cancer, annually
- DEXA scan for osteoporosis annually
- Shingles vaccine after the age of sixty (60)

High Risk Patients Only:

- ✓ Hepatitis B vaccine series
- ✓ EKG annually
- ✓ Tuberculosis skin test annually
- ✓ Colonoscopy every three (3) years
- ✓ Fecal/Occult blood

Limits

These recommendations are subject to change. All preventive services should be rendered upon the advice of a Participating Primary Care Physician.

V. RADIOLOGY SERVICES

Covered

Medically Necessary Medically Necessary radiology services are covered when they are ordered by a Participating Physician and performed at a Participating facility.

Not Covered

ProstaScint

Limits

The following procedures require Preauthorization and must be referred by a Provider.

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET)
- Computerized Tomography Scan (CT)
- Radiology services ordered by a Non-Participating Physician or performed in a Non-Participating facility are not a Covered Service unless Preauthorized by WINhealth Partners.

W. RECONSTRUCTIVE SURGERY

Covered

All stages of breast reconstruction surgery following a mastectomy when it is a Covered Service, 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.

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 and breast implants
- Breast reduction and reduction mammoplasty

X. SUPPLIES AND EQUIPMENT

Covered

Durable Medical Equipment (DME) – The purchase or rental of DME is covered when prescribed by a Provider and Preauthorized by WINhealth. Benefits paid for the rental of equipment will apply to the purchase price when applicable. The option to purchase versus rental of equipment will be determined solely by WINhealth.

Prostheses and Orthopedic Appliances – Devices used to support, eliminate or restrict motion in a part of the body that is diseased or Injured are Covered Services when Preauthorized by WINhealth and medically indicated unless otherwise Excluded. The following prostheses and orthopedic appliances are covered:

- Standard non-computerized 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 pumps (requires Preauthorization)
- CPAP and all oxygen supplies and equipment (requires Preauthorization)

Limits

DME must be obtained from a Provider and requires Preauthorization by WINhealth.

Medically necessary durable medical supplies and equipment are subject to a Coinsurance per item and a maximum benefit per plan year for both rental and purchase of items. Repair of DME when properly maintained and verified by service records-requires Preauthorization.

Replacement costs will be Covered Services 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
- 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 (Examples: support hose, bandages, adhesive tape, gauze, antiseptics)
- Surgical trays
- Replacement batteries of any kind
- Mouth guards

Y. SURGICAL ASSISTANTS

Covered

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

Z. THERAPY, SPEECH

Covered

Speech therapy is covered when ordered by a Participating Physician and provided by a Participating speech therapy provider.

Limits

Coverage is only available when service is provided for treatment of head injury, stroke/CVA (Cerebral Vascular Accidents), or Injury to the structures and mechanism of phonation to restore previously existing speech and is subject to applicable Copayment. Benefit is limited to twenty (20) visits per incident per Plan Year.

AA. THERAPY, OCCUPATIONAL

Covered

Occupational therapy is covered when ordered by a Participating Physician and provided by a Participating occupational therapy provider.

Limits

Coverage is only available when service is provided for treatment of head injury, stroke/CVA (Cerebral Vascular Accidents), or Injury to the structures and

mechanism of phonation to restore previously existing speech and is subject to applicable Copayment. Benefit is limited to twenty (20) visits per incident per Plan Year.

BB. THERAPY, PHYSICAL

Covered

Physical therapy is a Covered Service when ordered by a Participating Physician and provided by a Participating physical therapy provider.

Limits

Benefit is limited to the applicable benefit maximum per incident per plan year and is subject to applicable Copayment. Benefit is limited to a total combined benefit with Occupational therapy for a total of twenty (20) visits per incident per Plan Year.

Not Covered

- Massage therapy
- Myofascial release therapy
- Paraffin bath

CC. THERAPY, RADIATION

Covered

Services for radiation therapy when provided by a Participating Provider.

DD. THERAPY AND REHABILITATION, GENERAL

Not Covered

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

- Accupuncture
- Communication delay
- Mental retardation and related Conditions
- Multiple handicaps
- Perceptual disorders
- Sensory deficit
- Sex addiction
- Vision 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

EE. Transplants

Covered

Human organ transplant services are Covered Service if not considered experimental or investigational, and when performed at a Designated Organ Transplant Facility. Services are covered based on criteria established by the medical community and WINhealth and are provided only upon referral by the Member's Participating Physician. 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 a Member are covered if the organ transplant is covered.
Recipient Expenses – Recipient expenses directly related to the transplant procedure are covered, 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.

Limits

- All services related to human organ transplant must be reauthorized by WINhealth and must be provided in a Designated Organ Transplant Facility.
- This Coverage is limited to the lifetime maximum of the benefit plan as shown on the SBC.
- Coverage for transplants will not be provided when resulting from a Condition that is not covered by WINhealth.
- Transportation and lodging expenses shall not exceed $5,000 per transplant.
- Post transplant prescription drugs are subject to the regular prescription Copayments and/or Coinsurance.
- 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 WINhealth Designated Organ Transplant Facility.

FF. URGENT CARE

Covered

Urgent Healthcare Services are for conditions that are not emergencies but need medical attention within twenty-four (24) to forty-eight (48) hours when a Member does not have ready access to a Physician. Services rendered by a Participating Urgent Care Facility do not require Preauthorization. Participating Urgent Care Facilities are listed in the provider directory. If a Member is unsure if

symptoms require Urgent Healthcare Services, the Member can access the medical advice line by calling WINhealth or the number on the Member's identification card. The medical advice line personnel will review the symptoms and help the Member decide if a visit to the Urgent Care Facility is necessary.

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

Limits

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

II. BENEFIT PLAN EXCLUSIONS AND LIMITATIONS

The following services are not covered or are subject to limitations:

- **Alcoholism and Substance Abuse services.**
- **Alternative/complementary therapies.**
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply that are inconsistent with generally accepted principals of professional medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the Evidence of Coverage.
- **Athletic trainers.**
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be puréed for oral or tube feedings.
- **Benefits and services not specified as Covered Services.**
- **Biofeedback.**
- **Breast Reduction and Breast Augmentation surgery.**
- **Care for Conditions which State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled to receive treatment and for which facilities are reasonably available to the Member.

- **Care for any Condition** 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.
- **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.
- **Charges above Reasonable and Customary charges**.
- **Charges for failure** to keep a scheduled visit, charges for completion of any form or charges for medical information.
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Co-dependency** treatment.
- **Convenience items** and personal hygiene items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment.
- **Complications or side effects** arising from services, procedures, or treatments excluded by this policy.
- **Cosmetic Surgery, treatments, devices, orthotics, and medications,** including surgery and any related services intended solely to improve appearance but not restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies or 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 expense under this Health Plan of benefits or would not have been covered if the patient had been insured.
- **Costs for extended warranties** and premiums for other insurance coverage.
- **Counseling**.
- **Court ordered evaluation or treatment.**
- **Covered Services obtained from a Non-Participating Provider/Practitioner** except as provided in the Evidence of Coverage and as Preauthorized by WINhealth Partners.
- **Custodial or 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 aged, the care or treatment of alcoholism or drug addiction, or training schooling, or occupational therapy.
- **Dental care** and dental x-rays, except as provided in the Evidence of Coverage.
- **Dental implants.**
- **Disposable medical supplies**, except when provided in a Hospital or Physician's office or by a home health professional.
- **Donor Sperm.**

- **Durable Medical Equipment/Prosthetics/Orthotics –** Additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, loss, neglect, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.
- **Experimental or investigational** drugs, medicines, treatments, or procedures devices and/or drugs shall be deemed excluded (not Covered) as Experimental, Investigational, Unproven, Unusual or Not Customary if:
  - 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
  - It is the subject of a current Investigational new drug or new device application on file with the FDA; or,
  - It is being provided pursuant to a Phase I or Phase II Clinical Trial or as the Experimental or research arm of a Phase III Clinical Trial; and is not otherwise a Covered Service, or,
  - 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,
  - 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 Human Health Services (HHS); or,
  - The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; or,
  - 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,
  - It is Experimental, Investigational, Unproven, Unusual or not a generally acceptable medical practice in the predominant opinion of independent experts; or,
  - 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.

  - A nationally recognized resource including, but not limited to, Hayes Inc., DATTA or other recognized source has deemed that Healthcare Services to be Experimental, or Investigational. All such determinations shall be final, conclusive and binding.
- **Extracorporeal shock wave therapy.**
- **Eye movement therapy.**
- **Eye refractive procedures,** including radial keratotomy, laser procedures and other techniques.
- **Eyeglasses (corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof.
- **Foot care (routine)**, except as provided in the Evidence of Coverage.
- **Foot orthotics** functional and/or customized except as described in the Evidence of Coverage.
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses**.
- **Healthcare Services that are not a Covered Service** regardless of the recommendation or order by a Participating or Non-Participating Provider.
- **Health fair services.**
- **Hearing aids** and the evaluation for the fitting of hearing aids or cochlear implants.
- **Hospice benefits are not available for the following services**: food, housing, and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under Durable Medical Equipment) homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hospital, physician, mid-wife** and other charges related to prenatal care and delivery of a newborn child.
- **Hypnotherapy**.
- **Infant formula**.
- **Infertility treatment/Artificial Conception and drugs.**
- **In-vitro, GIFT and ZIFT fertilization**.
- **Lithotripsy of plantar fascia for plantar fasciitis.**
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Maternity/Obstetrical Care** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery and postnatal care, including conception in dependent Children.
- **Massage Therapy.**
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Member or when the transplant procedure is not a Covered Service.
- **Mental Health Services.**

- **New medications** for which the determination of criteria for Coverage has not yet been established by WINhealth Partners' Pharmacy and Therapeutics Committee.
- **Nutritional supplements**.
- **Organ transplants (Non-human),** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges and dentures**.
- **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges and denture used for the treatment of Craniomandibular (CMJ) and Temporomandibular Joint (TMJ) disorders.
- **Orthomolecular therapy** including nutrients, vitamins and food supplements.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Over-the-counter medications**.
- **Personal or comfort items, services or treatments**.
- **Photopheresis** for all conditions other than mycosis fungoides.
- **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or for purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related schooling, sports or employment.
- **Prescriptions** purchased at a Non-Participating Pharmacy**.**
- **Prescription Drug** replacements due to loss, theft or destruction.
- **Prescription Drugs** received upon Hospital discharge or provided by a Hospital pharmacy.
- **Prescription Drugs** hormone replacement therapy (including estrogen, testosterone or progesterone) or compounded medications.
- **Prescription Drugs requiring Preauthorization when Preauthorization was not obtained**.
- **Private duty nursing.**
- **Psychological testing.**
- **Reduction mammoplasty.**
- **Residential Treatment Centers.**
- **Reversals of voluntary sterilization**.
- **Services for which the Member is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member.
- **Services incurred** after the Termination Date of the Member's Coverage.
- **Smoking cessation**, except as designed within the WINhealth Wellness Program.
- **Covered Services requiring Preauthorization** when Preauthorization was not obtained.
- **Sex transformation surgery and drugs related to sex transformation**.

- **Sexual dysfunction treatment**, including medication, counseling and clinics.
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or behavioral or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances.
- **Special Medical Foods.**
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes or other human tissue.
- **Substance Abuse Treatment.**
- **Surgical or chemical treatment of skin tags, or common warts, except genital or plantar warts.**
- **Termination of unwanted pregnancy.**
- **Travel and lodging** expenses, except as provided in the Evidence of Coverage.
- **Treatment for autistic disease, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.**
- **Treatment for ADD/ADHD,** including initial medical diagnosis, or for inpatient Confinement for environmental changes.
- **Treatment for Injuries or Illness caused by a Member's intoxication over the legal limit, non-prescribed use of controlled substances, intention to Injure his or her self or another, or culpable negligence while sane or insane.**
- **Vision Care (routine) and Eye Refractions** for determining prescriptions for corrective lenses.
- **Visual training**.
- **Vocational Rehabilitation services and Long-Term Rehabilitation services**.
- **Weight reduction or control treatments and medications** including gastric bypass surgery or gastric banding.
- **Work related accidents or Injuries or occupational Illness or disease** if the Member is required to be covered under Workers' Compensation insurance whether or not such coverage actually exists.

NOTE: THIS LIST IS NOT ALL INCLUSIVE. TO DETERMINE COVERAGE AND BENEFITS FOR SPECIFIC SERVICES, PLEASE CONTACT WINHEALTH MEMBER SERVICES.

SECTION 7

Premiums and Copayments

1. PREMIUM PAYMENTS

A. **PAYMENT OF PREMIUMS** Under the health Plan, the Member is required to make a payment on behalf of each Enrolled Member. Each Member may also be required to make applicable Copayments for Healthcare Services received under the health Plan.

1) **Responsibility for Payment** – The Member is responsible for the payment of monthly Premiums for each Enrolled Member for Coverage under the health Plan. The Member shall pay in advance the aggregate amount of Premiums for all Enrolled Members no later than the monthly due date specified in this Evidence of Coverage.
2) **Amount of Premiums –** The total amount of Premiums that the Subscriber must pay for each monthly payment period shall be the sum of the individual Premiums for each Member, calculated on the basis of each Member's enrollment classification and rate.
3) **Grace Period** – The Member shall be entitled to a grace period of thirty-one (31) days following each monthly due date for the payment of Premiums. If the Member pays the aggregate amount of Premiums due for a monthly payment period within the applicable grace period, the Member shall be deemed to have made the required payment on the monthly due date. If the Member does not pay the aggregate amount of Premiums due by the end of the grace period, the health Plan will terminate on the last day of the last month for which the Member has made the required Premium payment in full.

2. COPAYMENTS

A. **PAYMENT OF COPAYMENTS**

Member's Responsibility for Copayments: Direct Benefits – Each Member receiving services under the Health Plan benefits shall pay any applicable Copayment for such services directly to the in-network Participating Provider at the time of service.

1) **Amount of Copayment** – Subject to the annual limits in the Member's SBC.
   a. **More than One Copayment** – The Member is responsible for paying all applicable Copayments if more than one Copayment applies to a particular Healthcare Service.

b. **Maximum Copayment** – The maximum Copayment that must be paid for a particular Healthcare Service is 50% of the Reasonable and Customary Fees for such Healthcare Service. Upon request, WINhealth Partners will provide Members with the Reasonable and Customary Fees for any Healthcare Service to which a Copayment applies.

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 either of the following limits:

a. With respect to Copayments made by any Member, the lesser of the limit set forth in this Health Benefit plan, or 200% of the total Premiums paid by the Subscriber during the plan year for that Member.

b. With respect to Copayments made for a family unit consisting of an Enrolled Eligible Person and that person's Enrolled Dependents, the lesser of the limit set forth in this Health Benefit Plan, or 200% of the total Premiums paid by the Subscriber during the plan year for the Enrolled Eligible Person and his or her Enrolled Dependents.

5) **Reimbursement of Excess Copayments** – If a Member has paid Copayments in excess of either of the annual limits 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(3). If a Member is reimbursed for all or a portion of a Copayment under paragraph (l), the Member may not include such reimbursed Copayment in determining whether the Member is entitled to reimbursement under paragraph (2).

3. PROVIDER REIMBURSEMENT

A. PAYMENT TO PROVIDERS

1) Except for any applicable Copayment or other payment specified in the Schedule of Benefits, a Member shall not be required to pay any amounts to any Participating Provider who provides Covered Healthcare Services to the Member. The Member should immediately contact WINhealth for correction of the erroneous charge.

2) A Member is liable for the entire expense charged for Healthcare Services provided by Non-Participating Providers, except for Emergency Healthcare Services, Urgent Healthcare Services,

Direct Benefits arranged by the Health Plan under Section 5(2) or Reimbursement Benefits described in Section 5(3).

4. ADJUSTMENT TO RATES

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

SECTION 8

Termination of Member's Coverage

1. TERMINATION OF COVERAGE

A 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 grace period for a specified monthly payment period, as described in Section 7(1)(A)(6), if the Premium for the Member for such monthly payment period has not been paid. If the required Premium is received by WINhealth Partners after the expiration of the grace period, WINhealth Partners will (1) return the Premium to the Subscriber, or (2) accept the Premium and reinstate the Member's Coverage retroactively.

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

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

D. In the case of a Member who fails to pay an applicable Copayment for Healthcare Services received by such Member, the date specified by WINhealth Partners in a written notice to the Member. The notice must be sent to the Member at least thirty-one (31) days in advance of the specified date of termination.

E. The date specified by WINhealth Partners 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 WINhealth Partners 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 WINhealth Partners used another Member's WINhealth Partners identification card or permitted another person to use his or her WINhealth Partners identification card.

3) The Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the Plan.

F. Any termination of Coverage under this Section 8 shall be effective as of 12:01 a.m. Mountain Standard Time on the specified date.

G. A Member's Coverage may not be terminated retroactively except in cases of fraud, intentional misrepresentation, or a failure to timely pay required premiums. WINhealth will provide the Member with thirty (30) days' advance written notice of its intent to retroactively terminate coverage.

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

2. NOTIFICATION OF TERMINATION EVENTS

The Member shall notify WINhealth Partners if any of the following events occurs:

A. The Member ceases to have his or her principal residence in the Service Area.

B. The Member has requested termination of Coverage under Section 8(1)(D).

The notification shall be made as soon as possible after the occurrence of the applicable event. Any termination of Coverage under Section 8(1), however, shall be effective even if notice is not given to WINhealth Partners under this Section 8(2).

3. RENEWABILITY

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

A. For nonpayment of the required Premiums by the Member.

B. For fraud or material misrepresentation by the Member under the terms of the Coverage.

C. For noncompliance with material plan provisions that have been approved by the Commissioner.

D. If WINhealth stops writing new individual policy business as long as:

1) WINhealth provides notice to the Commissioner and contract holder of its decision to stop writing new individual policy business; and,

2) No policies are cancelled for at least 180 days after the date of the notice of WINhealth's decision to stop writing new individual policy business.

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SECTION 9

Claims Procedure and Resolution of Appeal or Quality of Care Issue

1. **Claims For Benefits**

A Member's claim for benefits under the health Plan is processed as a Direct Benefits claim in accordance with Section 5(2), a Reimbursement Benefits claim in accordance with Section 5(3), or a second opinion in accordance with Section 5(5).

2. **Initial Benefits Determinations**

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

1) Preauthorized Services – WINhealth shall notify a Member within fifteen (15) days after receipt of the Preauthorization request whether a service is covered under the Plan. If an extension of this period is necessary due to the failure of the Member to submit the necessary information for WINhealth to evaluate the request for benefits, WINhealth shall contact the Member and/or provider and specifically describe the required information and allow the Member and/or provider thirty (30) days from receipt of the original authorization request to provide the specified information. If the requested information is not provided within thirty (30) days of the original authorization request, the request will be cancelled.

2) Urgent Healthcare Services Out-of-Network – WINhealth shall notify a Member as to whether an Urgent Healthcare Service is covered under the Plan as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the authorization request, provided that the Plan defers to the attending provider with respect to the decision of whether the claim constitutes "urgent care". If a Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, WINhealth shall notify the Member as soon as possible and not later than twenty-four (24) hours after receipt of the authorization request by the Plan. The Member shall be afforded a reasonable amount of time under the circumstances, and not less than forty-eight (48) hours, to provide the information necessary for WINhealth to make a benefit determination.

3) Notice Provided to Member of Benefit Determination – In the event of an adverse benefit determination, the Plan shall provide a notice of the determination containing the following information:

a. date of service;
b. provider of service;

c. claim amount (if applicable);
d. information regarding availability of diagnosis and treatment codes and corresponding meanings upon request;
e. the specific reason(s) for the adverse determination, including the denial code and corresponding meaning;
f. a description of the Plan provision or standard (if any) on which the determination is based;
g. a description of the Plan's review procedures and time limits applicable to such procedures
h. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of cost upon request;
i. if the adverse benefit determination is based on a medical necessity or experimental treatment or other similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
j. In the case of an adverse benefit determination involving urgent care, a description of the expedited review process applicable to such claims, except that notice of the determination may be provided orally, with a written confirmation within three (3) days.

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

3. Complaint Procedure

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

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

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

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

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

4. **Appeal Procedure**

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

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

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

D. **Timing –** WINhealth must receive a request for appeal within one-hundred-eighty (180) days of the initial determination by WINhealth. An Appeal of a service already provided will be decided within forty-five (45) calendar days of WINhealth's receipt of the appeal request.

An Appeal regarding a service not yet provided will be decided within thirty (30) calendar days of WINhealth's receiving the appeal request. Medical Necessity: If the adverse benefit determination on appeal involves medical judgment, a qualified, independent health professional will be consulted in reviewing the determination and and identified in the decision on appeal provided to the Member. At the Member's election, a signed opinion will be obtained from a medical consultant not employed by WINhealth.

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

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

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

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

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

J. **IRO Review –** The IRO shall determine whether the Member is or was covered under the Plan at the time the medical services were requested or provided; whether such services appear to be Covered Services under the Plan; whether the Member has exhausted the

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

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

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

5. Quality Assurance Procedure

If a Member has a concern or complaint about the quality of the Healthcare Services rendered by a Participating Provider, the Member may report the matter in writing to the Medical Director at WINhealth. The Medical Director will respond to the Member to confirm receipt of the question or issue and proceed investigate the matter pursuant to WINhealth's Quality Assurance Program and the Healthcare Quality Improvement Act of 1986, as applicable.

6. **Department Of Insurance**

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

SECTION 10

Coordination of Benefits

8. APPLICABILITY OF COORDINATION OF BENEFITS PROVISION

A. **In General** – This Coordination of Benefits ("COB") Provision is intended to avoid delays in claims payment and duplication of benefits when a Member is covered by two (2) or more coverage plans providing benefits or services for medical care or treatment.

B. **Application** – This COB Provision applies to WINhealth when a Member has health care coverage under more than one (1) plan. If this COB Provision applies, the order of benefit determination rules listed herein determine whether the benefits of WINhealth are applied before or after those of another coverage plan. The benefits of WINhealth:

1) Shall not be reduced when, under the order of benefit determination rules, WINhealth applies the Plan benefits before another plan; but

2) May be reduced when, under the order of benefits determination rules, another plan applies its benefits first. The effect of any such reduction is described in this Section 10.

9. COB PROVISION DEFINITIONS

For purposes of Section 12, the following defined terms shall have the meanings set forth below:

A. **Coverage Plan** – means any of the following plans that provides benefits or services for, or because of, medical or dental care or treatment:

1) Group insurance or group-type coverage Plans, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage Plans. It also includes coverage other than school accident-type coverage.

2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid.

Each contract or other arrangement for coverage under subsections (1) or (2) above is a separate Coverage Plan. Also, if an arrangement has two parts and the COB Provision rules apply only to one of the two parts, each of the parts is a separate Coverage Plan.

B. **Primary Plan** – means the Plan whose benefits must be determined without taking into account the existence of any other plan. When WINhealth is a Primary Plan, its benefits are determined before those of the other Coverage Plan without considering the other Coverage Plan's benefits. When WINhealth is a Secondary Plan, its benefits are determined after those of the Primary Coverage Plan and may be reduced

because of the Primary Coverage Plan's benefits. When there are more than two (2) Coverage Plans covering the insured person, WINhealth may be a Primary Plan as to one (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 health care, when the item of expense is covered at least in part by one (1) or more Coverage Plans covering the person for whom the claim is made.

E. **Claim Determination Period** – means a Plan Year. However, it does not include any part of a year during which a person has no Coverage under WINhealth or any part of a year before the date this COB provision or a similar provision takes effect.

10. ORDER OF BENEFIT DETERMINATION RULES

WINhealth determines whether the Plan is a Primary Plan or Secondary Plan with respect to another Coverage Plan by using the first of the following rules that applies:

A. **Employee/Non-Employee** – The Coverage Plan that covers the person as an Employee is the Primary Plan.

B. **Dependent Child/Parents not Separated or Divorced** – Except as stated in subsection (C) below, when the Plan and another Coverage Plan cover the same Child as a dependent, and the parents are not separated or divorced:

1) The Coverage Plan of the parent whose birthday falls earlier in a year is the Primary.
2) If both parents have the same birthday, the Coverage Plan that covered one parent for the longer period of time is the Primary Plan.

C. **Dependent Child/Parents Separated or Divorced** – If two or more Coverage Plans cover a person as a dependent Child of divorced or separated parents, the Coverage Plan described in the first of the following subsections is the Primary Plan:

1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and the entity obligated to pay or provide the benefits under that parent's Coverage Plan has actual knowledge of those terms, that Coverage Plan is the Primary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
2) The Coverage Plan of the parent with custody of the Child;
3) The Coverage Plan of the Spouse of the parent with custody of the Child.
4) The Coverage Plan of the parent not having custody of the Child.

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

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

11. EFFECT ON WINHEALTH BENEFITS

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

B. **Reduction in WINhealth'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.

12. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

WINhealth shall have the right to obtain or provide such information that it determines to be necessary to administer this COB provision. The Plan may obtain or provide such information without notice to, or consent from, any person. Each Member who receives WINhealth benefits must provide any reasonable information requested by WINhealth under this Section 12(5).

13. PAYMENTS MADE UNDER THE OTHER COVERAGE PLAN

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

14. WINHEALTH RIGHT OF RECOVERY

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

SECTION 11

Subrogation

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

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

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

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

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

SECTION 12

Service Area

The Service Area for the health Plan is the State of Wyoming.

SECTION 13

Amendment and Termination of Contract

1. AMENDMENT OF CONTRACT

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

2. TERMINATION OF CONTRACT

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

A. The day after the last day of the last month for which the Member has made the required Premium payment in full, if the Member has not paid the total amount of Premiums due by the end of the grace period defined in Section 7(1)(6).

B. The date specified by either WINhealth or the Member in a written notice of termination given to the other party at least thirty-one (31) days prior to the specified date of termination.

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

SECTION 14

Miscellaneous Provisions

1. **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 WINhealth at any reasonable time.
   - B. As a condition of eligibility for Coverage under the health Plan, each Member authorizes and directs any person or facility that has examined or treated the Member to furnish to WINhealth at any reasonable time, upon its request, any and all information and records or copies of records relating to examination or treatment rendered to the Member. WINhealth agrees that such information and records will be considered confidential.
   - C. WINhealth shall have the right to submit to appropriate medical or other review bodies or individuals all information regarding Healthcare Services provided to Members.

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

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

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

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

6. **Effective Date**
The Group Contract shall take effect on the date specified on the Group Contract Application and will continue in force until terminated.

7. **Commencement and Termination of Coverage**
All Coverage under the Group Contract 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 Group Contract is delivered in and shall be governed by the laws of the State of Wyoming.

9. **Conformity With Statutes**
Any provision of the Group Contract 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 Group Contract is hereby amended to conform to the minimum requirements of such statutes and regulations.

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

11. **Workers' Compensation Not Affected**
The Coverage provided under the Group Contract 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 Group Contract.

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

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

14. **Headings**

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

15. **Construction**

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

16. **Employee Retirement And Income Security Act ("ERISA")**

As a participant in the WINhealth health plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) so long as your employer meets the requirements. ERISA provides that all plan participants shall be entitled to:

A. **Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Evidence of Coverage and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.

C. **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and

beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

D. **Enforce Your Rights**

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 15

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 WINhealth Partners will disclose Member PHI to the Plan Sponsor unless the Plan Sponsor certifies that this Evidence of Coverage has been amended to incorporate the provisions of this Section 16 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:

- 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.
- 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.
- 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:

- Plan Sponsor will not use or further disclose Member PHI, except as permitted or required by this Evidence of Coverage or required by law.
- Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Members' PHI agrees to the restrictions and conditions of this Evidence of Coverage, including this Section 16 with respect to Members' PHI.
- 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.
- 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 16 promptly upon learning of such inconsistent use or disclosure.
- Plan Sponsor will make PHI available to the Member who is the subject of the information.
- 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.
- 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.
- 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.
- 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.

NOTICE OF PROTECTION
PROVIDED BY
WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $300,000 in hospital, medical and surgical insurance benefits or major medical insurance
  - $300,000 in disability insurance benefits
  - $300,000 in disability income insurance
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming law.

EXCLUSIONS FROM COVERAGE

Persons holding such policies are *not* protected by this Association if:

• they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

• the insurer was not authorized to do business in this state;

• their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

• any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

• any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy of contract);

• interest rate yields that exceed an average rate or interest earned on an equity indexed policy;

• dividends;

• credits given in connection with the administration of a policy by a group contract holder;

• annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;

• unallocated annuity contracts (which give rights to group contract holders, not individuals).

• any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

• an obligation that does not arise under the express written terms of the policy or contract

• Medicare supplement plans

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at wyoming.lhiga.com or contact:

Wyoming Life and Health
Insurance Guaranty Association
P.O. Box 36009
Denver, CO 80236-0009
Phone: (303) 292-5022
Toll Free: (888) 959-4091
Fax: (303) 292-4663
Website: wyoming.lhiga.com
Email: jkeldorf@aol.com

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.

APPENDIX A

NOTICE OF PRIVACY PRACTICES

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

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

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

We are required by law to:

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

Permitted Uses and Disclosures of Your Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Those Involved in Your Care** – We may disclose your PHI to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition. If you are not present, our disclosure will be limited to the PHI that directly relates to the individual's involvement in your medical care.

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

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

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

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

Your Rights with Respect to Your Protected Health Information

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

Complaints

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

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

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