WINhealth

Plan Well, Live Healthy

Large Group Health Plan 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.

4. Pay for Medical Treatment, medical services/supplies and/or prescription(s) with your own money and not use your WINhealth Plan benefits. However, if you choose to do this, the claims are subject to the same time limitations as set forth in Section 9 as well as any contractual items WINhealth has negotiated with the Provider and policies set forth in this EOC.

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.

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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. This Evidence of Coverage is a part of the Group Contract entered into between your Employer and WINhealth under which the Plan benefits are provided. Defined terms are identified by being capitalized throughout the Evidence of Coverage and definitions can be found in Section 3.

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.

Your Employer is your Plan Sponsor and is responsible for sending to WINhealth the monthly Premium that must be paid for each enrolled Member (or for each family unit). If you are responsible for paying a portion of this monthly Premium, you will receive separate notice from your Plan Sponsor regarding the amount your Plan Sponsor will collect from you each month. Your Plan Sponsor will pay to WINhealth the entire amount of the required monthly Premium.

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 include psychiatrists (MD/DO). psychologists (PhD/PsyD), professional counselors (LPC), clinical social workers (LCSW), marriage and family therapists (LMFT), addiction therapists (LAT), social workers, addiction practitioners, addiction practitioner assistants, and mental health workers. Behavioral healthcare providers are not listed as primary care providers, but members have open access to any such provider at the same copayment as a primary care provider."

Out-of-Network Benefits

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, regardless of your benefit Plan. **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.** You should keep in mind that your annual Deductible Out-of-Pocket Maximums are more for services rendered by Out-of-Network providers. Emergency services outside of the United States will be covered. We ask that you notify WINhealth of the emergency healthcare services within forty-eight (48) hours. Non-emergent services provided outside of the United States are not covered.

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.

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 and/or balanced billing to the Member. 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.

Understanding Your Benefit Plan

The Plan includes five "families" of benefit plans: Shelter, Horizon, Protect, Select, and Choice. The following paragraphs describe each family and highlight important distinctions with respect to Covered Services under each benefit plan family. References throughout this Evidence of Coverage to "the Plan" shall include all benefit plan families unless the context requires otherwise.

Shelter Plans: Covered Services must be provided by WINhealth's Participating Providers. If your Employer has selected the Shelter-P option, you may obtain services from an Out-of-Network provider; however, an additional deductible and 50% coinsurance applies to all Out-of-Network services. If your Participating Provider recommends a service that is not available within the WINhealth's network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Shelter plan benefits.

Shelter Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Horizon Plans: Covered Services must be provided by WINhealth's Participating Providers. If your Employer has selected the Horizon-P option, you may obtain services from an Out-of-Network provider; however, an additional deductible and 50% coinsurance applies to all Out-of-Network services. If your Participating Provider recommends a

service that is not available within the WINhealth's network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Horizon plan benefits.

Horizon Plans have an aggregate deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, the entire family deductible must be met before the Plan begins to pay benefits. One member of a family group or a combination of family members may satisfy the entire family deductible.

Protect Plans: Covered Services must be provided by WINhealth's Participating Providers. If your Participating Provider recommends a service that is not available within the WINhealth's network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Please review your Summary of Benefits and Coverage for an overview of your Protect plan benefits.

Protect Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Select Plans: Covered Services must be provided by WINhealth's Participating Providers in order to receive the optimum benefit. Your cost for Covered Services provided by Out-of-Network providers will be higher than your cost for Covered Services provided by a Participating (In-Network) Provider. If your Participating Provider recommends a service that is not available within the WINhealth's network, he/she may request Preauthorization for you to see an Out-of-Network provider. Preauthorization is not a guarantee that the Out-of-Network services will be covered under your In-Network benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. In an effort to encourage healthy behaviors, the Select plans offer incentives to Members who participate in the Care Management Program, which offers support to Members living with chronic health conditions such as diabetes and heart disease. Please review your Summary of Benefits and Coverage for an overview of your Select plan benefits, and contact WINhealth to learn more about the Care Management Program.

Select Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible,

the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible.

Choice Plans: Choice plans include three benefit Tiers. Tier 1 offers the greatest benefit and applies to Covered Services provided by WINhealth's Participating Providers. Tier 2 applies to Covered Services performed by providers in WINhealth's extended network. Members' share of the cost for Tier 2 services is greater than Members' share of the cost for Tier 1 services. Tier 3 applies to Covered Services performed by Out-of-Network providers. If your Participating Provider recommends a service that is not available within WINhealth's network, he/she may request Preauthorization for you to see a Tier 3 (Out-of-Network) provider. Preauthorization is not a guarantee that the Tier 3 services will be covered under your Tier 1 (In-Network) benefit. You are responsible for verifying that authorization has been requested and obtained prior to seeing the Out-of-Network provider. Each Tier is described in further detail below. Please review your Summary of Benefits and Coverage for an overview of your Choice plan benefits.

Choice Plans have an embedded deductible. If you have single coverage, once your individual deductible has been met, the Plan will begin to pay benefits. If you have family coverage, any combination of family members may contribute to meet the family deductible. Once any member of the family group meets his or her individual deductible, the Plan will begin to pay benefits for that family member but no further charges for that member will be applied to the family deductible. A separate deductible applies to each tier. Services rendered by Tier 1 providers apply only to the Tier 1 deductible. Services rendered by Tier 2 providers apply to the Tier 2 deductible, and services rendered by Tier 3 providers apply to the Tier 3 deductible.

Tier 1 Level Benefits. The Plan encourages you to receive care from a Participating Provider (In-Network or Tier 1). You may receive Covered Services from any Participating Provider. Some health care services require a referral from a provider and Preauthorization by WINhealth. If care cannot be delivered locally because of the need for specialized services, a request from a provider and Preauthorization by WINhealth enables you to seek care from an approved provider outside the Service Area (a Tier 2 or Tier 3 benefit) and receive Tier 1 level benefits. It is important to remember that these Tier 2 benefits will be reimbursed at the Tier 1 level ONLY when the services are not available from an In-Network (Tier 1) provider and the services are preauthorized by WINhealth. Emergency Healthcare Services obtained outside the Service Area will be Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare Services will be covered outside the Service Area only when WINhealth is notified in advance and the services are preauthorized. If Urgent or Emergency Healthcare Services are pursued after business hours or over the weekend, please call Member Services to leave a message so that the correct Tier level can be applied to your benefit. If you are unsure whether your symptoms require Urgent or Emergency Healthcare Services, you can access the nurse line by calling WINhealth or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent or Emergency Healthcare Services.

Tier 2 Level Benefits. Members may choose to obtain services from providers in our Extended Network, which includes MultiPlan providers, some university health systems, and others. Extended Network providers can be accessed without a referral and

are subject to the Tier 2 benefit level. For a listing of Extended Network providers, please follow the "Find a Provider" link on the WINhealth website. Members are still responsible for verifying whether a service requires Preauthorization. Services that require Preauthorization In-Network will still require Preauthorization in our Extended Network for any Coverage to apply. Emergency Healthcare Services obtained outside the Service Area will be Tier 1 Covered Services when they are Medically Necessary and indicated for an Emergency. Urgent Healthcare Services will be covered outside the Service Area at Tier 1 only when WINhealth is notified in advance and the services are preauthorized. If Urgent or Emergency Healthcare Services are pursued after business hours or over the weekend, please call Member Services to leave a message so that the correct Tier level can be applied. If you are unsure whether your symptoms require Urgent or Emergency Healthcare Services, you can access the nurse line by calling WINhealth or the number on your identification card. The nurse line personnel will review your symptoms with you and help you decide if you need to seek Urgent Emergency Healthcare Services.

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

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

2. **BEHAVIORAL HEALTHCARE PROVIDERS** – means providers which include but are not limited to psychiatrists (MD, DO), psychologists (PhD/PsyD), professional counselors (LPC), clinical social workers (LCSW), 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. Behavioral Health Providers may be found using the "Find a Provider" tool on the WINConnect Portal. The WINhealth network is Open Access, which means that you may contact a Behavioral Healthcare Provider and arrange an appointment directly. You do not need a referral from a Primary Care Provider to see a Behavioral Health Provider.

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

4. **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 Employee;
      2) is being raised as a Child of the Employee;
      3) is primarily dependent on the Employee for support and maintenance;
      4) the Employee has taken full parental responsibility and control, and;
      5) Has been placed with the Employee legally by any State department of family services.
   D. A person for whom an Employee becomes legally responsible by reason of placement for adoption shall be considered a Child.

In the event that the Plan Sponsor makes an election in the Master Group Contract to provide coverage to Domestic Partners as Eligible Dependents, the child of such Domestic Partner is a Child for purposes of this definition.

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

6. **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.

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

8. **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.

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

10. **CONTINUOUS QUALITY IMPROVEMENT (CQI)** – means the continual process of monitoring which leads to repeated program enhancements and performance improvement.

11. **CONTRACT EFFECTIVE DATE** – means the date as of which the Group Contract is effective as specified in the Group Contract Application.

12. **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.

13. **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.

14. **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.

15. **CREDENTIALING** – means assessment and validation of the qualifications of a licensed provider to deliver health services.

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

17. **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.

18. **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.

19. **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.

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

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

22. **DOMESTIC PARTNER** – means an unmarried person who is of the same or opposite sex of an unmarried Employee, and who shares a common domestic life with the Employee for purposes of maintaining a long-term personal relationship with the Employee. A Domestic Partner shall be an Eligible Dependent only if such eligibility is elected by the Plan Sponsor in the Master Group Contract, and the Plan Sponsor verifies such eligibility in writing.

23. **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.

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

25. **ELIGIBLE DEPENDENT** – means a Spouse, Domestic Partner (if elected by the Plan Sponsor), Child or a disabled Child dependent of an Eligible Person.

26. **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.

27. **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.

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

29. **EMPLOYEE** – A member of the organization or employing unit to which the Group Contract has been issued. A person must be in a class of workers not excluded from Coverage by an Employer in the Group Contract. The person must be actively employed on the date of enrollment.

30. **EMPLOYEE CONTRIBUTION** – means the employee's portion of the monthly fee that must be paid by the Plan Sponsor to WINhealth for each Member enrolled for Coverage under the health Plan.

31. **EMPLOYER** – The Plan Sponsor who has elected Coverage through WINhealth for its Employees and their Dependents under the Group Contract.

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

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

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

35. **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.

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

37. **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.

38. **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.

39. **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.

40. **GROUP CONTRACT** – means the entire contractual agreement between WINhealth and the Plan Sponsor under which Healthcare Services will be provided as Covered Services through the health Plan to the Members. The Group Contract consists of the Group Contract Application, the Master Group Contract, the Group Health Plan Evidence of Coverage, the Summary of Benefits and Coverage, and any amendments thereto that may be agreed to in writing between WINhealth and the Plan Sponsor.

41. **GROUP CONTRACT APPLICATION** – means the portion of the Group Contract containing the Plan Sponsor's application for participation in the health Plan.

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

    Habilitation services do not include respite, day-care, recreational care, residential treatment, social services, custodial care, assistance with activities of daily living or education services of any kind, including but not limited to vocational training or services provided under an individualized education program as defined under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1500, et seq.) and its implementing state and federal regulations, nor devices which are not intended to directly treat the impairment or which are able to be used by persons without the specific impairment. For a medical device to be covered by this definition, it must be one that requires FDA approval and a prescription to dispense the device.

43. **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.

44. **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.

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

43. **INFERTILITY** – means the inability to become pregnant after one year of having regular sexual intercourse without the use of contraception for women age thirty-five (35) or younger, or the inability to become pregnant after six (6) months of having regular sexual intercourse without the use of contraception for women older than age thirty-five (35).

45. **INFERTILITY TREATMENT** – means medical and surgical treatment to diagnose and treat infertility.

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

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

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

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

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

51. **MASTER GROUP CONTRACT** – means the portion of the Group Contract containing the general terms and conditions agreed to by WINhealth and the Plan Sponsor.

52. **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.

53. **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.
    g. 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®.

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

55. **NATIONAL MEDICAL SUPPORT NOTICE (NMSN)** – means a notice sent to an employer by a state child support enforcement agency. The purpose of the NMSN is to ensure that children receive health care coverage when it is available and required as part of a child support order.

56. **NETWORK PROVIDER** – See Participating Provider.

57. **NON-COBRA CONTINUATION COVERAGE** – means any group policy or certificate of insurance for a large group policy that is not subject to continuation of rights as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

58. **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.

59. **OPEN ACCESS** – means that the Plan does not require a Member to choose a Primary Care Provider in order to obtain referrals to see Specialist Providers.

60. **OPEN ENROLLMENT PERIOD** – means an annual period during which Eligible Persons may enroll themselves and their Eligible Dependents for Coverage under the health Plan or make changes to their benefit plan.

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

62. **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.
    e. Expenses incurred by the Member for prescription drugs under the pharmacy benefit.

63. **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."

64. **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.

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

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

67. **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.

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

69. **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.

70. **PLAN SPONSOR OR SPONSOR** – means the Employer or other entity that has entered into the Group Contract with WINhealth.

71. **PLAN YEAR** – means the coverage period specified in the Master Group Contract.

72. **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.

73. **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.

74. **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.

75. **PRE/POST NATAL CARE** – means care during pregnancy and for six (6) weeks after delivery provided by a Physician, a licensed midwife, or a nurse practitioner specializing in obstetrics/gynecology or family practice.

76. **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.

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

78. **QUALIFIED MEDICAL CHILD SUPPORT ORDER** – means a judgment, decree, or order that has been determined by WINhealth pursuant to Section 609 of the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. § 1169), to be adequate to qualify the Child for Coverage under the Plan.

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

80. **QUALITY CONTROL** – means the use of systematic methods to ensure that a service or program conforms to a desired standard.

81. **QUALITY IMPROVEMENT (QI)** – means the betterment or enhancement of programs or services.

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

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

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

85. **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.

86. **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.

87. **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.

88. **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.

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

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

91. **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.

92. **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.

93. **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.

94. **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.

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

96. **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.

97. **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.

98. **WINHEALTH GROUP HEALTH PLAN (PLAN)** – means the health plan established under the Group Contract through which Covered Services are provided to Members pursuant to the terms and conditions of the Group Contract.

SECTION 4

Eligibility and Enrollment

1. **ELIGIBILITY FOR COVERAGE**

Unless otherwise specified by the Plan Sponsor in the Master Group Contract, each Employee may enroll for Coverage under the Plan as long as the Employee is (a) a full-time employee regularly scheduled to work at least thirty (30) hours per week; (b) employed by the Plan Sponsor on the date the Coverage is to be effective; (c) meet the eligibility requirements of the PPACA; and (d) not in a class of Employees excluded from such Coverage. An Employee who has enrolled for Coverage may also enroll his or her Eligible Dependents for Coverage under the health Plan under the following conditions:

A. An Employee's legal Spouse is eligible to enroll as a dependent;
B. An Employee's Domestic Partner is eligible to enroll as a dependent, pursuant to the Master Group Contract;
C. An Employee's Children are eligible to enroll as dependents if they meet the definition of Child under Section 3;
D. A newborn of a Member will be an Eligible Dependent as of the date of birth for the first thirty (30) days. The newborn must be formally enrolled within thirty (30) days of birth and premium for the upcoming period must be paid for the coverage to continue past the initial thirty (30) days;
E. A court has ordered that Coverage be provided under the Member's health Plan;
F. A person for whom an Eligible Person becomes legally responsible by reason of placement for adoption or by foster child placement; and
G. A person who meets the eligibility requirements of the PPACA.

2. **ENROLLMENT**

Eligible Persons enroll themselves and their Eligible Dependents using the forms provided by WINhealth and the Plan Sponsor.

A. For persons who are Eligible Persons or Eligible Dependents on the date the health Plan becomes effective, an enrollment application may be filed at any time up to thirty (30) days after the Contract Effective Date.
B. For persons who first become Eligible Persons or Eligible Dependents after the Contract Effective Date, an enrollment application may be filed at any time up to thirty (30) days after the date on which the person becomes an Eligible Person or Eligible Dependent.
C. For any Eligible Person or Eligible Dependent who is not otherwise enrolled for Coverage, an enrollment application may be filed at any time during an Open Enrollment Period.
D. Notwithstanding the foregoing, a Child of an Enrolled Eligible Person is automatically enrolled for Coverage as of the Child's date of birth. Such automatic Coverage, however, shall terminate after thirty (30) days unless the Child has been properly enrolled under Section 4(2)(B) within that period and payment of the applicable Premiums under Section 7(1) have been made.

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

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

3. **LIMITATIONS ON ENROLLMENT**

No Eligible Dependent of an Employee may be enrolled for Coverage prior to the date the Employee is enrolled for Coverage. Eligibility is determined by the Employer.

4. **NOTIFICATION OF ENROLLMENT**

The Plan Sponsor shall provide WINhealth with written notice of the enrollment and Effective Date of Coverage of all newly enrolled Members. The Plan Sponsor shall also provide WINhealth with written notice of any changes in a Member's eligibility classification (as specified in the Group Contract Application). Any notice under this Section 4(4) must be provided to WINhealth within thirty (30) days of the Effective Date of each new Member's Coverage, and within thirty (30) days of the change of eligibility classification for each Member so affected.

5. **NOTIFICATION OF STATUS CHANGE**

A Member must notify the Plan Sponsor of any change in his/her status, including addition of a new Eligible Dependent by reason of marriage, adoption, birth of a child, etc.; removal of an Eligible Dependent by reason of divorce, dissolution of a domestic partnership, etc.; and changes to the Member's address or telephone number. WINhealth cannot accept Notification of Status Change from the Member; they must be submitted through the Plan Sponsor.

6. **EFFECTIVE DATE OF COVERAGE**

A Member's Coverage under the health Plan shall be effective as of the date specified in the Group Contract Application, subject to payment of premium and the following:

A. A Member's Coverage shall not be effective prior to the Contract Effective Date notwithstanding anything in this Section 4(7) to the contrary.

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

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

D. If a Child has been placed as a foster Child with a Member and is subsequently enrolled within thirty (30) days as a Child under Section 4(2),

Coverage for that Child will be effective as of the date the Child was placed into foster care.

E. If a newborn Child of a Member is automatically enrolled for Coverage under Section 4(2), Coverage for such Child shall be effective as of the Child's date of birth. The newborn must be formally enrolled within thirty (30) days of birth and the upcoming period premium must be paid for coverage to extend past the initial thirty (30) days.

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

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

H. If a Late Enrollee requests enrollment in the Plan after the initial thirty (30) day enrollment period, Coverage will become effective no later than twelve (12) months after the date of the Late Enrollee's request.

I. If WINhealth receives a National Medical Support Notice, Coverage will be effective on the earliest possible date following: the receipt of the National Medical Support Notice; determination that it is a Qualified Medical Child Support Order; determination that the non-custodial parent is an Eligible Person; and notification of the selected Plan if the Plan Sponsor offers more than one benefit option. The effective date will not exceed ninety (90) days from the date of receipt of the notice if the Employee is still in a waiting period. The Employee and Dependent may be enrolled involuntarily based upon the receipt of this notice.

7. DURATION OF COVERAGE

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

8. RE-ENROLLMENT AFTER TERMINATION OF COVERAGE

A Member whose Coverage has terminated as provided in Section 8 may again enroll for Coverage under Section 4(2), provided that all requirements for enrollment under this Section 4 are satisfied.

9. SPECIAL ENROLLMENT RIGHTS

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

When the Employee or Eligible Dependent loses other health coverage, a Special Enrollment opportunity in the health Plan may be triggered. To have a Special Enrollment opportunity in this situation, the Employee or Eligible Dependent must have had other health coverage when Coverage under the Group Contract was previously declined. If the other coverage was COBRA Continuation Coverage, special enrollment can be requested only after the COBRA Continuation Coverage is exhausted. If the other coverage was not COBRA Continuation Coverage, Special Enrollment can be requested when the individual loses eligibility for the other coverage or if employer contributions toward the other coverage have been terminated.

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

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

10. **QUALIFIED MEDICAL CHILD SUPPORT ORDER**

If an Employee is subject to a Qualified Medical Child Support Order ("QMCSO"), the Employee is obligated to enroll himself in the Plan as well as the Children referenced in the QMCSO. If the Employee does not enroll such Children, the Employee must provide documentation to the Employer that other health benefits coverage has been obtained for the Children named in the QMCSO. As long as the QMCSO is in effect and at least one Child identified in the QMCSO is still eligible under the health Plan, the Employee cannot cancel benefits under the Plan unless documentation of other coverage is provided. Contact your Employer for further information.

SECTION 5

Obtaining Plan Benefits

1. **OVERVIEW OF BENEFITS**

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

A. Each Member is entitled to receive the following benefits:
   1) Direct Benefits consisting of the provision of Covered Services by either Participating Providers or Non-Participating Providers.
   2) Reimbursable Costs incurred by the Member for Covered Services provided by Non-Participating Providers; and,
   3) Emergency and Urgent Healthcare Services as described in Section 6

B. Members are entitled to receive the Covered Services described in Section 6, subject to the following:
   1) Benefits will be provided only during the period that the Member is eligible to enroll and is enrolled.
   2) Benefits will be provided to a person only while that person is a Member and prior to the time Coverage for such Member has terminated under Section 8 (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.

C. Preauthorization – Services that require Preauthorization by WINhealth include the following:
   1) Acute Inpatient Rehabilitation
   2) Anesthesia and Facility Services for Dental Procedures
   3) Biologic Specialty Medications
   4) Bone Growth Stimulators
   5) Continuous Passive Motion (CPM) Device
   6) DME as listed in the DME Policy
   7) Genetic Testing or Screening including BRCA
   8) Home IV Therapy
   9) Home Health Care
   10) Hospice Care
   11) Inpatient Hospital Medical Care
   12) Inpatient, Partial Inpatient, and Intensive Outpatient Mental Health Care
   13) Inpatient Surgical Procedures, including but not limited to:
      a. Bariatric Surgery Roux-en-Y
      b. Hysterectomy
      c. Lumbar Diskectomy
      d. Lumbar Fusion

e. Lumbar Laminectomy

14) In Vitro IgE Allergy Testing
15) Intraoperative Neuromonitoring
16) MRI, MRA, PET, PET-CT, SPECT, and CT scans
17) Nutritional Support and Therapy
18) Phototherapy
19) Podiatry Procedures
20) Prescription Medications when indicated by the Pharmacy Benefit Manager
21) Pulmonary Rehabilitation
22) Outpatient Procedures
    a. Bariatric Surgery Lap Band or Gastric Sleeve
    b. Virtual Colonoscopy and Capsule Endoscopy
    c. Dental Procedures
    d. Interspinous Process Decompression Systems including X-STOP
    e. Nuclear Cardiac Stress Test and Stress Echocardiography unless ordered by a participating cardiologist
    f. TENS or Spinal Stimulator
    g. Temporomandibular Joint (TMJ) Surgery
    h. Varicose Vein Surgery including EndoVenous Laser Treatment (EVLT)
    i. Vertebroplasty/Kyphoplasty
23) Reconstructive Surgery
24) Skilled Nursing Facility
25) Transplants, Bone Marrow and Solid Organ

This list is not all inclusive and is subject to change. In an emergency situation, an authorization should be requested within forty-eight (48) hours after the service is rendered. The Member should contact WINhealth to determine benefit Coverage and Preauthorization requirements. The requesting or referring provider must initiate the Preauthorization process prior to the services being rendered. The Member should ensure that Preauthorization has been obtained from WINhealth prior to obtaining services by contacting Member Services at (307) 773-1330. WINhealth will determine whether the requested service can be preauthorized and will provide written notification to the Member and the requesting and performing providers.

D. Emergency Situations – Emergency Healthcare Services are Covered Services as long as they fit generally accepted guidelines for Emergency Healthcare Services. In the case of an Emergency, a Member should call 911 or proceed directly to the emergency room. Non-emergent services rendered in an emergency room are not Covered Services. 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.

2. **DIRECT BENEFITS AND REIMBURSEMENT BENEFITS**

A. Covered Services – Members are entitled to receive benefits for Covered Services specified in Section 6 if ALL of the following requirements are satisfied:

1) The Covered Services are Medically Necessary;
2) The Member has satisfied the applicable Deductible, Copayment or Coinsurance for the benefit, if any, in accordance with Section 7(2);
3) The Member has obtained Preauthorization for the Covered Services, if required (Member is responsible for verifying that the proper Preauthorization has been granted. If Preauthorization is required for Covered Services or supplies but is not obtained, the Member may not receive reimbursement for the Covered Services or supplies.); and
4) No Exclusion or limitation applies to the Covered Services.

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

C. Reimbursement Benefits – If a Member seeks treatment from an Out-of-Network provider, the Member is required to submit a claim for reimbursement not later than one-hundred-eighty (180) days after the date of the Covered Service.

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

3. **TEMPORARY ABSENCE FROM SERVICE AREA**

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

1) Emergency Healthcare Services or preauthorized Urgent Healthcare Services.
2) Healthcare Services that have been preauthorized by WINhealth.

4. **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.

5. **SUBSTITUTION OF BENEFITS**

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

6. **MEMBERS HELD HARMLESS**

To the extent that Healthcare Services are Covered Services under the health Plan and are rendered by a Participating Provider pursuant to applicable policies and procedures for obtaining such Healthcare Services, a Member shall be held harmless by WINhealth for the cost of such Covered Services, except for any Copayment,

Coinsurance or Deductible payable with respect to such Covered Services under Section 7(2). Out-of-Network providers may elect to "balance-bill" members for any difference between the amount paid by the Plan and the total cost of the services rendered.

SECTION 6

Covered Services

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

1. DESCRIPTION OF PLAN BENEFITS

A. Acute Rehabilitation

Covered

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

B. Ambulance

Covered

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

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.

Limits

Coverage is limited to professional ambulance transport services. 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.

C. Anesthesia

Covered

The provision of anesthesia during surgical procedures is a Covered Service when necessary for a covered surgical procedure and when provided by either a Physician or Certified Registered Nurse Anesthetist (CRNA).

When surgery is performed during a Hospital confinement, anesthesia services will only be Covered Services when WINhealth has preauthorized the Hospital confinement. All elective surgical procedures that are preauthorized (if required) will be Covered Services when the service is provided by a Physician or CRNA.

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

D. Bariatric surgery

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

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

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

E. Behavioral Health and Substance Abuse

Covered

- Outpatient benefit – Preauthorization for outpatient physician and counseling services for behavioral health/mental health substance abuse treatment is not required.
- Intensive Outpatient/Inpatient benefit – Intensive outpatient treatment and inpatient mental health or substance abuse care are covered when the treatment and/or admission have been preauthorized by WINhealth.
- Partial Hospitalization benefit – Partial hospitalization days may be substituted in a ratio of one and one-half (1-1/2) partial days equal one (1) inpatient day when preauthorized by WINhealth.
- Transitional Care – Transitional inpatient mental health or substance abuse care is covered when the admission has been preauthorized by WINhealth. The maximum lifetime benefit is one hundred (100) days.
- Autism Screening – is a one-time Covered Service as part of an annual wellness vist without cost-sharing. Autism testing is not a Covered Benefit.

Not Covered

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

F. Cardiac Rehabilitation (Phase II)

Covered

Phase II cardiac rehabilitation is supervised by a physician and occurs on an outpatient basis. Cardiac rehabilitation benefits are available to Members following acute cardiac diagnoses and treatment, as long as the rehabilitation takes

place no earlier than two (2) months prior to and no later than eight (8) months after the triggering cardiac event.

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

G. Care Management Program

Covered

A. Support for a Member living with a chronic disease, including asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and congestive heart failure. The program includes coordination of care with providers and may include visits by a registered nurse. These services are offered with no Copayment or Coinsurance.
B. Nutritional counseling with applicable Deductible, Copayment or Coinsurance.
C. Diabetic Education Programs with applicable Deductible, Copayment or Coinsurance.

H. Chemotherapy

Covered

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

I. Chiropractic Care

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

Not Covered

- Acupuncture
- Paraffin therapy
- Vitamins
- Exercise equipment
- Massage therapy

Limits
Benefits are subject to the Deductible, Copayment or Coinsurance per visit and are limited to 15 visits per plan year.

J. Dental Services

Covered
Coverage is available for the following dental services only:

- Treatment for an accidental Injury to the mouth, teeth or jaw in which the initial service is performed within ninety (90) days of the accident. The accidental Injury cannot be a result of biting or chewing. Treatment must be for restorative services and supplies necessary to promptly repair or replace sound natural teeth.
- Incision and drainage of a cyst or cellulitis.
- Surgical removal of tumors and cysts.
- Anesthesia and facility charges are covered for dental procedures when preauthorized, whether performed in a Hospital, outpatient facility or other free-standing surgery center and when one of the following criteria is met:
  - Individual age seven years or younger
  - Individual who is severely psychologically impaired or developmentally disabled
  - Individual who has one or more significant medical comorbidities which require additional monitoring during and immediately following the procedure
  - Individuals in whom the complexity of the proposed dental procedure would preclude the use of local anesthesia or conscious sedation

All dental services must be preauthorized.

Limits

- Restoration of the mouth, teeth or jaw due to an accidental Injury is limited to those services that are Medically Necessary.
- Facility charges for hospitalization for dental procedures are only covered when a medical condition exists that makes hospitalization necessary to safeguard the health of the Member. WINhealth will not cover the dental procedure unless it is described as a Covered Service in this Section 6 and has been preauthorized.

Not Covered

- 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.

K. Dermatology Services

Covered

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

Not Covered

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

L. 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. Such services must be preauthorized by WINhealth.

M. Emergency Care

Covered

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

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

- Obtaining Emergency Healthcare Services – In a life- or limb-threatening Emergency, a Member should call 911 or go directly to the nearest Hospital emergency room or medical facility for treatment.
- Transfer to participating facility following an out-of-area emergency – If a Member is in confinement in a hospital that is a Non-Participating 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 nurse line – If a Member is unsure if symptoms require Emergency room services, the Member can access the nurse line by calling WINhealth or the number on the Member's identification card. The nurse line personnel will review the symptoms and help the Member decide if a visit to the Emergency room is necessary. 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.

N. Genetic Testing

Covered

- Amniocentesis for chromosome determination.

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

Not Covered

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

O. Hemodialysis

Covered

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

P. Home Healthcare

Covered

Skilled home Healthcare Services are covered if such services are Medically Necessary, ordered by a Provider 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

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

Q. 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.

R. 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.

Not Covered

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

- Convenience items: those services and supplies provided for personal convenience that are not Medically Necessary such as grooming items, guest meals, television, telephone expenses, etc.
- Elective births less than thirty-nine (39) weeks gravita.

S. INFERTILITY DIAGNOSIS AND TREATMENT

Infertility Diagnosis and Treatment is not covered.

Not Covered

A. Artificial insemination, intracervical or intrauterine;
B. Maternal surrogacy or the artificial insemination of a gestational carrier
C. Gamete intrafallopian transfer (GIFT);
D. Peritoneal oocyte and sperm transfer
E. Sperm and/or egg preservation for any reason including but not limited to the diagnosis of cancer or other condition that may render the member infertile.
F. Genetic testing of either parent or a fertilized oocyte;
G. Zygote intrafallopian transfer (ZIFT);
H. ZIntracytoplasmic sperm injection (ICSI);
I. Selective embryo or fetal reduction;
J. Services for reversal of sterilization such as tubal ligation/occlusion or vasectomy.

T. Laboratory Services

Covered

- Medically Necessary laboratory services are Covered Services when requested by a Participating Provider and rendered by a Participating Provider.

Not Covered

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

U. Inherited Enzymatic Disorders

Covered – requires Prior Authorization by WINhealth

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

Limits

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

V. Maternity Care

Covered

- Provider Services – Charges for prenatal, postnatal and delivery are covered.
- Hospital Services – Inpatient services including room expense and ancillary services provided by a Hospital are covered under the inpatient Hospital benefit Pursuant to the Newborns' and Mothers' Health Protection Act, (NMPHA), inpatient benefits may not be restricted to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery if delivery occurs in a hospital. If the birth occurs outside the hospital and the Member is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. Any decision made regarding the early discharge of either the mother or the newborn child prior to the 48-hour (or 96-hour) period shall be made by the attending physician in consultation with the mother or authorized representative.
- Newborn Care – Hospital nursery charges for newborn babies and Physician newborn care are Covered Services as part of covered maternity care. If the mother is discharged prior to the newborn, a separate Deductible, Copayment or Coinsurance for the newborn will apply to the remainder of the newborn's stay. When the mother is not covered under this Plan, the child's newborn care may be covered separately from maternity care if the father is covered under this Plan; however, Deductibles, Copayments or Coinsurances may apply.
- When delivery of a newborn Child is a Covered Service, benefits are not restricted for any Hospital length of stay in connection with childbirth for the mother or newborn Child when the services are Medically Necessary.
- Postnatal Care – charges for lactation counseling and one (1) breast pump are covered.
- Provider and Hospital Services for prenatal/postnatal care and delivery – are Covered Services for a Members dependent child. The newborn child of a dependent child will not be covered following delivery unless the child is otherwise eligible for coverage under the Plan.
    - Prenatal/postnatal care and delivery are Covered Services for a Member's Elibible dependent. However, newborn care for the child is not Covered unless the Child is eligible for coverage under the health Plan and enrolled within sixty (60) days from the birth of the Child.
    - Prenatal/postnatal care and delivery are not Covered Services for a surrogate person not otherwise eligible for coverage under the Plan. The newborn child of the surrogate will be covered as a Child under the Member's Plan if enrolled within sixty (60) days from the birth of the Child.
    - Non-invasive prenatal testing for fetal DNA is covered pursuant to the Plan's policies on genetic testing.

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

- Laboratory screenings for pregnant women:
    - Iron-deficiency anemia

  - Bacteria in urine
  - Hepatitis B virus
  - RH incompatibility
  - Syphilis
- Breastfeeding supplies, including manual and small electric (AC and/or DC) breast pumps, support, and counseling for pregnant and nursing women
- Gestational diabetes screening for women 24 to 28 weeks' pregnant and those at high risk of developing gestational diabetes
- Tobacco use screening, intervention, and expanded counseling for pregnant tobacco users
- Folic acid supplements for women who may become pregnant

Not Covered

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

W. Nutritional Therapy

Covered

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

Limits

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

Not Covered

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

X. Pediatric Dental Health Risk Assessment

Covered

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

Limits

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

Y. Pediatric Vision

Covered

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

Not Covered

- Special coatings such as anti-scratch, or UV screening
- Transition lenses
- Designer frames
- Designer lenses

Z. 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 appropriate.
- Medical consultation services, including charges made by a Physician for a second opinion.
- Telemedicine as defined in Section 3.

Not Covered

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

AA. Podiatric Care

Covered

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

Not Covered

- 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.

BB. 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.

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

Limits

- Quantity for a maintenance prescription drug purchased through either a mail service or retail pharmacy cannot exceed a ninety (90) day supply.
- For maintenance drugs, as defined by standard lists, a ninety (90) day supply may be dispensed if two (2) months' Copayments are paid.
- Prescriptions are covered with varying Copayments for brand and generic medications.
- If a brand name medication is dispensed when the generic equivalent is available, the Member will be responsible for the brand Copayment plus the difference in price between the generic and brand medications. If the Member's provider can document Medical Necessity as to why the Member cannot tolerate the generic equivalent, the difference in price may be waived; however, the Copayment will still apply.

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

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

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

Not Covered

Excluded Drugs: Not all prescription drugs are covered. Members can contact the WINhealth Member Services department with questions about Coverage for the specific drug prescribed. Some examples of drugs excluded from Coverage include, but are not limited to*:*

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

CC. Preventive Services

Covered

The list of preventive services covers a full range of immunizations and diagnostic tests and screenings for Members of all ages. The services below are recommended by the following agencies: Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the State of Wyoming. There will be no member cost sharing for the preventive services listed below as long as the services are provided by a Participating Provider and are offered in accordance with the following schedule, unless

otherwise indicated.** If at any point, any of the below preventive services ceases to be a preventive service recommended by the above agencies, Copayments and Deductibles may apply.

Schedule of Preventive Benefits

Under One Year of Age
- One (1) newborn genetic screen within twenty-four (24) to seventy-two (72) hours of birth, and a second genetic screening at age 7 to 10 days
- One-time newborn test for hearing loss
- Six (6) Well-Child exams*
- Immunizations per Centers for Disease Control and Prevention guidelines

One Year but less than Six Years
- Three (3) Well-Child exams between ages 1 and 2 years *
- Annual Well-Child exam between ages 2 and 6 (but no more than one (1) exam in any twelve (12)-month period) *
- Immunizations as per Centers for Disease Control and Prevention guidelines
- Annual hematocrit/hemoglobin
- One (1) annual eye exam between ages 3 and 6 by a pediatrician, an ophthalmologist, or an optometrist
- Hearing screening and testing recommended and performed by a participating Provider
- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months (this does not include a Dentist)

Six Years but less than Twelve Years
- Annual Well-Child exams*
- One (1) routine eye exam every 2 years by an ophthalmologist or optometrist
- One (1) tuberculosis skin test annually
- One (1) dipstick urine annually
- One (1) hematocrit/hemoglobin annually
- Immunizations, including influenza, per Centers for Disease Control and Prevention guidelines
- Hearing screening and testing as recommended and performed by a participating Provider
- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months (this does not include a Dentist)

Twelve Years but less than Eighteen Years
- Annual health maintenance visit*
- One (1) routine eye exam every 2 years by an ophthalmologist or optometrist
- Diphtheria/tetanus booster, if appropriate
- Tuberculosis skin test annually
- Dipstick urine annually
- Hepatitis B vaccine series
- Pelvic examination and cervical cancer screening (including Pap smear) annually for females.
- Reflex HPV testing for sexually active females and males annually

- HPV vaccine serview
- Immunizations, including influenza, per Centers for Disease Control and Prevention Guidelines
- Hearing screening and testing as recommended and performed by a Participating Provider
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, vasectomy, and contraceptive counseling as deemed appropriate by your provider
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Domestic violence screening and counseling for women, as deemed appropriate by your provider
- Dental health risk assessment by Primary Care Provider or pediatrician every six (6) months (this does not include a Dentist)

Eighteen Years but less than Forty Years

- Men:
  - Annual health maintenance visit*
  - EKG every five (5) years
  - Prostate examination for cancer, annually
  - Measles, mumps, rubella if recommended by your provider
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Hepatitis B vaccine
  - Reflex HPV testing annually
  - Tuberculosis skin test annually
  - Dipstick urine annually
  - Complete blood count (CBC) annually
  - Basic metabolic panel lab test annually
  - Lipid screen every five (5) years
  - Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every five (5) years
  - Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
  - STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
  - Vasectomy
  - HPV vaccine series up to age 26
- Women:
  - Annual health maintenance visit*
  - EKG every five (5) years
  - Pelvic examination and cervical cancer screening (including Pap smear) annually and reflex HPV testing annually until age 21
- After age 21, annual pelvic examination
- After age 21, cervical cancer screening (including Pap smear) every three (3) years
- After age 21, reflex HPV testing every five (5) years
  - Clinical breast examination, annually
  - Measles, mumps, rubella under age 20
  - Influenza vaccine annually

- Pneumococcal vaccine
- Hepatitis B vaccine
- Dipstick urine annually
- Tuberculosis skin test annually
- Complete blood count (CBC) annually
- Lipid screen every five (5) years
- Basic metabolic panel lab annually
- Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every five (5) years
- Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
- STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by your provider; IUD removal for purposes of conception is not covered
- Domestic violence screening and counseling, as deemed appropriate by your provider
- Breast cancer chemoprevention counseling for women at high risk
- HPV vaccine series up to age 26

Forty Years but less than Sixty-five Years

- Men:
  - Annual health maintenance visit*
  - EKG
  - Prostate examination and laboratory tests for cancer, annually
  - Reflex HPV testing annually
  - Dipstick urine annually
  - Complete blood count (CBC) annually
  - Lipid screen every three (3) years
  - Basic metabolic panel lab test annually
  - Tuberculosis skin test annually
  - Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three years
  - Thyroid Stimulating Hormone Test (TSH) every three (3) years
  - Tetanus/Diphtheria booster
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Hepatitis B vaccine
  - Zostavax vaccine for men age 60 and older
  - Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
  - Colonoscopy for colorectal cancer screening for men age 50 to 75 is a covered benefit
  - STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
  - Vasectomy

- Low dose CT scan for lung cancer if Member has a 30 pack year history of smoking use (pack year history is calculated by multiplying the number of packs of cigarettes smoked per day by the number of years smoked), is between age of 55-80 years, and requires prior authorization by WINhealth
- One time screening and immunization for Hepatitis C for Members born between 1945 and 1965

- Women:
  - Annual health maintenance visit*
  - EKG
- Annual pelvic examination
- Cervical cancer screening (including Pap smear) every three (3) years
- Reflex HPV testing every five (5) years
  -
  - Clinical breast examination, annually
  - Screening mammogram, annually
  - Dipstick urine annually
  - Complete blood count (CBC) annually
  - Lipid screen every three (3) years
  - Basic metabolic panel lab annually
  - Tuberculosis skin test annually
  - Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test every three years
  - Tetanus/diphtheria booster
  - Pneumococcal vaccine
  - Influenza vaccine annually
  - Hepatitis B vaccine
  - Zostavax vaccine for women age 60 and older
  - Digital rectal exam and fecal occult blood test to screen for colorectal cancer annually
  - Colonoscopy for colorectal cancer screening for women age 50 to 75 is a covered benefit
  - Screening for osteoporosis by DEXA scan every three (3) years after age 50 with identifiable risk factors for osteoporosis as deemed appropriate by your provider
  - STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
  - Generic FDA-approved medication for birth control, IUD insertion, tubal ligation, and contraceptive counseling as deemed appropriate by your provider; IUD removal for purposes of conception is not covered
  - Domestic violence screening and counseling, as deemed appropriate by your provider
  - Breast cancer chemoprevention counseling for women at high risk
- Low dose CT scan for lung cancer if Member has a 30 pack year history of smoking use (pack year history is calculated by multiplying the number of packs of cigarettes smoked per day by the number of years smoked), is between age of 55-80 years, and requires prior authorization by WINhealth

- One time screening and immunization for Hepatitis C for Members born between 1945 and 1965

Sixty-five Years and Over

- Men:
  - Annual health maintenance visit*
  - EKG annually
  - Prostate examination and laboratory tests for cancer, annually
  - Reflex HPV testing annually
  - Lipid screen annually
  - Dipstick urine annually
  - Tuberculosis skin test annually
  - Thyroid Stimulating Hormone (TSH) test
  - Tetanus/Diphtheria booster every ten (10) years
  - Complete blood count (CBC) annually
  - Basic metabolic panel lab test annually
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Zostavax vaccine
  - Hepatitis B vaccine series
  - Colorectal cancer examination, including colonoscopy, and laboratory tests for cancer annually
  - Diabetes screening with either fasting glucose and two-hour postprandial glucose or glucose tolerance test annually
  - One-time screening with ultrasound for abdominal aortic aneurysm for men with a history of smoking
  - STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
- Low dose CT scan for lung cancer if Member has a 30 pack year history of smoking use (pack year history is calculated by multiplying the number of packs of cigarettes smoked per day by the number of years smoked), is between age of 55-80 years, and requires prior authorization by WINhealth
- One time screening and immunization for Hepatitis C for Members born between 1945 and 1965

- Women:
  - Annual health maintenance visit *
  - EKG annually
- Annual pelvic examination
- Cervical cancer screening (including Pap smear) every three (3) years
- Reflex HPV testing every five (5) years
  -
  - Clinical breast examination, annually
  - Screening mammogram, annually
  - Lipid screen annually
  - Dipstick urine annually
  - Tuberculosis skin test annually

  - Thyroid function test
  - Tetanus/diphtheria booster every ten (10) years
  - Complete blood count (CBC) annually
  - Basic metabolic panel lab annually
  - Influenza vaccine annually
  - Pneumococcal vaccine
  - Zostavax vaccine
  - Hepatitis B vaccine series
  - Diabetes screening with either fasting glucose or two-hour postprandial glucose or glucose tolerance test annually
  - Screening for osteoporosis with DEXA scan every two (2) years as deemed appropriate by your provider
  - Colorectal cancer examination, including colonoscopy and laboratory tests for cancer, annually
  - STI (Gonorrhea, Chlamydia and Syphilis) and HIV screening and counseling as deemed appropriate by your provider
  - Breast cancer chemoprevention counseling for women at high risk
  - Domestic violence screening and counseling as deemed appropriate by your provider
- Low dose CT scan for lung cancer if Member has a 30 pack year history of smoking use (pack year history is calculated by multiplying the number of packs of cigarettes smoked per day by the number of years smoked), is between age of 55-80 years, and requires prior authorization by WINhealth
- One time screening and immunization for Hepatitis C for Members born between 1945 and 1965

*Well-Child examinations and adult health maintenance visits include but are not limited to provider counseling regarding diet and exercise; provider screening for obesity, depression, and alcohol misuse; screening and intervention for tobacco use; provider screening for sexually transmitted diseases; and blood pressure screening. An annual visit is limited to one (1) per calendar year regardless of Plan year.

**Pursuant to Wyoming Statute § 26-19-107, the following screenings will be covered at eighty percent (80%) of allowable charges up to a total annual benefit of two-hundred and fifty dollars ($250.00) per Member if provided by an out-of-network provider:

  - A pelvic examination and pap smear for any nonsymptomatic woman;
  - A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person;
  - A prostate examination and laboratory tests for cancer for any nonsymptomatic man; and
  - A breast cancer examination including a screening mammogram and clinical breast examination for any nonsymptomatic person.

This shall not apply to high deductible policies where the deductible equals or exceeds one thousand dollars ($1,000.00) per person or per family per year or policies qualifying as federal medical savings accounts

Limits

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

DD. Radiation Therapy

Covered

Radiation Therapy

EE. Radiology Services

Covered

- Medically Necessary radiology services are covered when they are ordered by your provider.
- Radiology services ordered by a Non-Participating Provider or performed in a non-participating facility will be covered at a lower benefit level unless preauthorized by WINhealth.

Limits

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

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

FF. Reconstructive Surgery

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

Not Covered

- Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily

form, except repair of accidental Injury. Examples include, but are not limited to:

- Penile prosthesis (any type)
- Breast augmentation and breast implants
- Breast reduction and reduction mammoplasty

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

GG. Rehabilitative Services and Habilitative Services

Limits

Rehabilitative and Habilitative Services must be medically necessary health care services and medical devices that assist an individual in acquiring or improving, partially or fully, skills and functioning due to a medically determinable physical or mental impairment. These services address the skills and abilities needed for function in interaction with their environment as normally as possible, taking into account the health capacity of the individual receiving services. Benefit is limited to twenty (20) visits per incident per plan year and is subject to applicable Deductible, Copayment and/or Coinsurance.

Rehabilitative and Habilitation services do not include respite, day-care, recreational care, residential treatment, social services, custodial care, assistance with activities of daily living or education services of any kind, including but not limited to vocational training or services provided under an individualized education program as defined under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1500, et seq.) and its implementing state and federal regulations, nor devices which are not intended to directly treat the impairment or which are able to be used by persons without the specific impairment. For a medical device to be covered by this definition, it must be one that requires FDA approval and a prescription to dispense the device.

B. Physical Therapy

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

Limits

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

Not Covered

Massage therapy
Myofascial release therapy

Paraffin bath

C. Occupational Therapy

Covered

Occupational therapy is covered when ordered by a Provider.

Limits

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

D. Speech Therapy

Speech therapy is covered when ordered by a Provider.

Not Covered

Developmental speech therapy for children

Limits

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

E. Excluded from Rehabilitative and Habilitative Care Coverage

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

1) Acupuncture
2) Communication delay
3) Learning disability
4) Mental retardation and related Conditions
5) Multiple handicaps
6) Perceptual disorders
7) Sensory deficit
8) Sex addiction
9) Vision therapy
10) Behavioral training
11) Biofeedback
12) Coma stimulation
13) Developmental and neuroeducational testing or treatment
14) Educational services or studies
15) Hearing therapies
16) Hypnotherapy
17) Myofunctional therapy
18) Vocational rehabilitation
19) Chelation therapy, except for heavy metal toxicity

20) Maintenance Therapy

F. Skilled Nursing Facility

Covered

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

Limits

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

Not Covered

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

G. Supplies and Equipment

Covered

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

Prostheses and Orthopedic Appliances – Devices used to support, eliminate or restrict motion in a part of the body that is diseased or injured are covered when Medically Necessary and preauthorized by WINhealth unless otherwise Excluded. Covered prostheses and orthopedic appliances include, but are not limited to:

- Standard non-computerized artificial limbs
- Leg braces
- Arm and back braces
- Orthopedic shoes for diabetes and peripheral vascular disease only. Requires Preauthorization.

Medical Supplies – Including but not limited to:

- Colostomy bags and other supplies for their use
- Needles for administering insulin
- Oxygen services and supplies

Medical Equipment – Including but not limited to:

- Manually operated wheelchairs
- Crutches
- Infusion pump
- CPAP and all oxygen supplies and equipment

Limits

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

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

Not Covered

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

- Convenience items
- Consumable supplies and equipment
- Deluxe items
- Maintenance of equipment
- Devices not medical in nature
- Customization of rental equipment that is not Medically Necessary
- Special braces or equipment not specifically listed above
- Braces used as aids in sports and activities
- Corsets and other non-rigid appliances
- Prostheses for cosmetic purposes
- Repair, maintenance or replacement due to loss or for duplication.
- Shoe-insert foot orthotics for podiatric use and arch support including wrapping.
- Medical supplies used for comfort, convenience, personal hygiene or first aid that do not require special fabrication, fitting, or a physician's prescription (Examples: support hose, bandages, adhesive tape, gauze, antiseptics.)
- Surgical trays
- Non prescription food items
- Hot tubs
- Exercise equipment
- Air conditioners
- Humidifiers
- Motorized wheelchairs
- Robotic limbs and organs (except for LVAD)
- Replacement Batteries of any kind
- Mouth Guards

H. Surgical Assistants

Covered

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

I. Transplants

Covered

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

Recipient Expenses – Recipient expenses directly related to the transplant procedure are Covered Services, including pre-operative and post-operative care, surgical, storage and transportation costs directly related to the donation of an organ used in a covered organ transplant procedure.

Hospital Services – Hospital services directly related to the covered transplant procedure, including pre-operative and post-operative care.

Physician Services – Recipient medical expenses directly related to the covered transplant procedure, including pre-operative and post-operative care.

Donor Expenses – Reasonable surgical costs, including pre-operative services up to thirty (30) days prior to and post-operative services up to sixty (60) days following a procedure directly related to the donation of an organ for an eligible Member are covered if all of the following conditions are true:

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

Not Covered

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

Limits

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

J. Urgent Healthcare Services

Covered

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

Facilities are listed in the provider directory. If a Member is unsure if symptoms require Urgent Healthcare Services, the Member can access the nurse line by calling WINhealth or the number on the Member's identification card. The nurse line personnel will review the symptoms and help the Member decide if a visit to the Urgent Care Facility is necessary.

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

Limits

- Urgent Healthcare Services 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 is not a Covered Service.

K. Routine Vision Services

Covered

- Only as listed above as part of the Schedule of Preventive Services. Benefit Plan Exclusions and Limitations

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

A. Experimental, investigational, unproven, unusual, or not customary treatments, procedures, devices, and/or drugs are excluded. Treatments, procedures, devices and/or medications/drugs shall be deemed excluded (not Covered Services) as Experimental, Investigational, Unproven, Unusual or Not Customary if:
   1) 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
   2) It is the subject of a current Investigational new drug or new device application on file with the FDA; or
   3) It is being provided pursuant to a Phase I, II, III, or IV as the Experimental or research arm of a Clinical Trial (except routine patient care costs and drugs approved by the FDA for the treatment of cancer or other life-threatening disease, provided in conjunction with a phase I, II, III, or IV study or clinical trial as required by Wyoming Statute § 26-20-301); or
   4) 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

5) It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by Federal Regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
6) The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; or
7) 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
8) It is Experimental, Investigational, Unproven, Unusual or not a generally acceptable medical practice in the predominant opinion of independent experts; or
9) 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.
10) A nationally recognized resource including, but not limited to, Hayes Inc. or Milliman Care Guidelines®, has deemed the Healthcare Services to be Experimental or Investigational.

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

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

D. Non-surgical treatment of TMJ is excluded including all work-up and treatment leading up to TMJ surgery. Invasive/incisional surgical treatment of TMJ is covered when preauthorized by WINhealth.

E. Charges or services for dental work or treatment which includes: Hospital or professional care in connection with an operation or treatment for the fitting or wearing of dentures, orthodontic care or dental treatment of malocclusion; and operations on or treatment to the teeth or supporting tissues of teeth are excluded, except for: a) removal of cysts or suspected malignant tumors, or b) treatment of

an Injury to natural teeth not caused by chewing if the injury occurs while the patient is insured. Refer to Section 6(1), *Dental Services*, for more information.

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

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

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

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

J. Service for orthomolecular therapy including nutrients, vitamins, and food supplements unless otherwise indicated in this Evidence of Coverage.

K. Charges or services incurred after the date of termination of the Member's Coverage.

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

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

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

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

P. Services for the reversal of sterilization.

Q. Termination of unwanted pregnancy is excluded..

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

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

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

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

V. Charges or services for hearing aids and supplies, tinnitus maskers, or examinations for the fitting of hearing aids, or cochlear implants, and follow up care for cochlear implants.

W. Charges or services for any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of an insured, or for the treatment of obesity, unless otherwise indicated in this Evidence of Coverage.

X. Charges or services for treatment of autistic disease, learning disabilities, behavioral problems or behavioral retardation.

Y. Counseling or treatment for ADD/ADHD, Asperger's syndrome or oppositional defiant disorder.

Z. Charges for services and supplies for, or related to, fertility testing, treatment of infertility and conception by artificial means, including but not limited to artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques.

AA. Charges or services for travel whether or not recommended by a Physician.

BB. Charges for private duty nursing are excluded.

CC. Charges or services for lifestyle improvements, including physical fitness programs.

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

EE. Court-ordered treatment.

FF. Emergency room services for non-emergent conditions.

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

HH. Services rendered at health fairs.

II. Lithotripsy of plantar fascia for plantar fasciitis.

JJ. Intradiscal Electrothermic Therapy (IDET) procedure.

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

LL. Breast augmentation and breast implants.

MM. Breast reduction and reduction mammoplasty.

NN. Labial reduction or reconstruction.

OO. Penile prostheses of any type, including any mechanical device used to treat erectile dysfunction.

PP. Surgical or chemical treatment of skin tags or common warts.

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

SECTION 7

Employee Contributions, Deductible, Copayments and Coinsurance

1. **EMPLOYEE CONTRIBUTIONS**

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

2. **DEDUCTIBLE, COPAYMENTS AND COINSURANCE**

A. Payment of Deductible, Copayments and Coinsurance

1) Member's Responsibility for Deductibles, Copayments and Coinsurance: Direct Benefits – Each Member who receives Direct Benefits under the health Plan shall pay any applicable Deductible, Copayment or Coinsurance for such Direct Benefits directly to the Participating Provider who provides the Direct Benefits. All charges for such Healthcare Services in excess of the Deductible, Copayment or Coinsurance specified in the Summary of Benefits and Coverage will be paid by WINhealth directly to the Participating Provider.

2) Member's Responsibility for Deductible, Copayments and Coinsurance: Reimbursement Benefits – When a Member is entitled to Reimbursement Benefits for Healthcare Services, reimbursement to the Member will be made in accordance with the Reasonable and Customary fee schedule as determined by WINhealth minus any applicable Deductible, Copayment and/or Coinsurance.

3) Amount of Deductible, Copayment and Coinsurance – The amount of the Deductible, Copayment or Coinsurance, if any, that applies to a specific Healthcare Service is listed in the Summary of Benefits and Coverage. The Member is responsible for paying all applicable Copayments or Coinsurance if more than one Copayment or Coinsurance applies to a particular Healthcare Service.

SECTION 8

Termination of Member's Coverage

Pursuant to the Plan Sponsor's election in the Master Group Contract, a Member's Coverage under the health Plan shall end on either (1) the date upon which one of the events below occurs; or (2) the last day of the monthly payment period during which one of the events below occurs:

A. Member ceases to be an Eligible Person or Eligible Dependent.

B. Member requests termination of Coverage in a written notice to the Plan Sponsor.

C. WINhealth provides written notice to the Member that Coverage is being terminated for one of the following reasons:
   1) The Member knowingly provided materially false information to WINhealth with regard to any person's eligibility for Coverage.
   2) The Member knowingly and without authorization from WINhealth used another Member's WINhealth identification card or permitted another person to use his or her WINhealth identification card.
   3) The Member failed to pay Premium when due and/or within required time frame.
   4) 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.

Any termination of Coverage under this Section 8 shall be effective as of 11:59 P.M. Mountain Time on the specified date.

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

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

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 seven (7) 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 fifteen (15) days from receipt of the original authorization request to provide the specified information. If the requested information is not provided within fifteen (15) days of the original authorization request, the request will be cancelled.

2) 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) demographic information of the member, requesting and performing providers;
   b) the requested service in both code form and word form;
   c) an explanation of why the service was denied in plain, easy to understand language;
   d) reference to the evidence-based guideline used to make the denial decision or from the benefit plan if it is a coverage limitation denial;
   e) a clear explanation of the member's right to appeal and how that may be done with address and phone number;
   f) Medical Management phone numbers for contact;
   g) Signature of the Medical Director;

3) Approval letters contain:
   a) demographic information of the member, requesting and performing providers
   b) the requested service in both code form and word form
   c) the date span for which the services is covered

d) a statement of any limitations (benefits, network, etc.) governing the approval
e) Medical Management phone numbers for contact
f) Signature of the Medical Director

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 at doi.wyo.gov.

SECTION 10

Continuation of Coverage

1. **CONTINUATION OF COVERAGE**

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

2. **COBRA**

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

1) The death of an Enrolled Eligible Person, with respect to loss of Coverage by such person's Enrolled Dependents.
2) The termination of an Enrolled Eligible Person's employment with the Plan Sponsor (other than for gross misconduct), or the reduction of the Enrolled Eligible Person's hours of work with the Plan Sponsor.
3) The divorce or legal separation of a Spouse from an Enrolled Eligible Person.
4) Entitlement of an Enrolled Eligible Person to Medicare benefits.
5) A Member ceasing to be a Child or Eligible Dependent.
   Note: In the event that the Plan Sponsor has elected to provide coverage for Domestic Partners as Eligible Dependents, the following information applies. Domestic Partners and their dependents who are not considered "qualified beneficiaries" under federal COBRA provisions will not be eligible to continue their coverage under COBRA after any event that would otherwise give rise to COBRA rights, such as termination of employment or the relationship. However, dependents who are not eligible for COBRA may be eligible for continuation coverage under Wyoming law or pursuant to the Plan Sponsor's voluntary provision of continuation coverage.
6) The Plan Sponsor's filing for bankruptcy under Title 11, United States Code, with respect to Coverage of an Enrolled Eligible Person who has retired from employment with the Plan Sponsor.

B. **Election of Coverage** – A Member may elect COBRA Continuation Coverage as follows:

1) The Plan Sponsor shall notify WINhealth of the occurrence of a Qualifying Event relating to death, termination of employment or reduction in hours of work, eligibility for Medicare, or certain bankruptcy proceedings. Such notification must be made within thirty (30) days of the event (described in subsections (A)(1), (2), (4) or (6) above).
2) The Member shall notify WINhealth of the occurrence of a Qualifying Event relating to divorce or to the non-eligibility of a Dependent for Coverage. Such notification must be made within sixty (60) days of the occurrence of the event (described in subsections (A)(3) or (5) above).

3) Within fourteen (14) days of the notice provided to WINhealth under subsections (B)(1) or (2) above, WINhealth will notify any Members who are entitled to COBRA Continuation Coverage.
4) A Member who is eligible for COBRA Continuation Coverage may elect such Coverage at any time within sixty (60) days after the occurrence of the Qualifying Event (or, if later, within sixty (60) days after notice is provided to the Member by WINhealth under subsection (B)(3) above) on forms that will be provided or approved by WINhealth.
5) A Member electing COBRA Continuation Coverage will receive the identical Plan benefits that he or she would have received had the Member's Coverage not terminated under Section 8.

C. **Duration of Coverage** – A Member's COBRA Continuation Coverage will continue from the date of the Qualifying Event until the earliest of the following:
1) The day after the end of the grace period for payment of the COBRA Continuation Coverage Premium, if such Premium has not been paid by the Member as required below.
2) The date the Member is covered under any other group health plan. If the other group health plan, however, excludes from coverage any Pre-Existing Condition of the Member, this subsection (2) shall not apply.
3) The date the Member becomes entitled to Medicare, except for Members entitled to COBRA Continuation Coverage as a result of a Qualifying Event described in subsection (A)(6) above).
4) Eighteen (18) months after a Qualifying Event relating to termination of employment or reduction in hours of work (described in subsection (A)(2) above) unless Coverage is extended under subsections (5), (6), or (7) below.
5) If a second Qualifying Event occurs during a Member's eighteen (18) month continuation period under subsection (C)(4), the Member shall be entitled to thirty-six (36) months of COBRA continuation Coverage, measured from the date of the first Qualifying Event.
6) When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA Continuation Coverage for Eligible Dependents other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement.
7) Twenty-nine (29) months after a Qualifying Event described in subsection (A)(2), if the Employee or any of his/her Enrolled Dependents is determined under Title II or Title XVI of the United States Social Security Act to be disabled within the first sixty (60) days of electing COBRA Continuation Coverage, written documentation of the disability must be provided to WINhealth no later than sixty (60) days after the date the Member is determined to be disabled. The Member must notify WINhealth within thirty (30) days of a final determination that he or she is no longer disabled. The extended Coverage under this paragraph will terminate on the last day of the payment period that begins more than thirty (30) days after the date the Member is determined not to be disabled, whether or not notice is given to WINhealth.

8) Thirty-six (36) months after a Qualifying Event not described in subsection (A)(2) or (6).
9) In the case of a Qualifying Event described in subsection (A)(6) (relating to bankruptcy proceedings), the date of the death of the Enrolled Eligible Person, or, in the case of the surviving Spouse or other Eligible Dependents of the Enrolled Eligible Person, thirty-six (36) months after the date the death of the Enrolled Eligible Personal.
    1) The date the Group Contract between the Plan Sponsor and WINhealth terminates, or in the case of an Employee, the date the Employer terminates his or her participation under the group policy. However, if the Employer replaces group Coverage with similar coverage under another group policy, the Member may become covered under that group policy for the balance of the period that the Member would have remained covered under the prior group policy in accordance with this paragraph had a termination described in this subparagraph not occurred.
    2) The date the Employer terminates coverage is the effective date of the COBRA termination.

D. **Coverage for Members of the Armed Services**
1) When an Employee is performing service in the uniformed services, he or she is entitled to continuing Coverage under the Plan for himself or herself and Eligible Dependents. Such Employee may elect to continue coverage for a period of twenty four (24) months, commencing when the Employee is absent for the purpose of performing service.
2) Employees performing service in the uniformed service for fewer than thirty-one (31) days will not be required to pay more than the regular employee share of Coverage under the Plan. Employees performing service in the uniformed service for thirty-one (31) or more days may be required to pay up to one-hundred-two percent (102%) of the full premium under the Plan.

E. **Payment of Premiums**
1) A Member electing COBRA Continuation Coverage must pay directly to WINhealth a monthly premium in an amount equal to one-hundred-two percent (102%) of the amount that would have been paid by the Plan Sponsor (including any Member contribution) had the Member's Coverage not terminated under Section 8. If the duration of the Member's COBRA Continuation Coverage has been extended to twenty-nine (29) months under Section 10(2)(C)(7) above due to a Member's disability, the Member must pay one-hundred-fifty percent (150%) of the premium that would have been paid by the Plan Sponsor (and not one hundred and two percent (102%)) beginning in the nineteenth (19th) month of COBRA Continuation Coverage.
2) The Member must pay all required premiums on the date that the Plan Sponsor would have been required to pay the Member's premiums had Coverage not terminated under Section 8 except that a thirty-one (31) day grace period shall apply. Notwithstanding the foregoing, the initial payment of premiums is not due until forty-five (45) days after the date the

Member elected COBRA Continuation Coverage, at which time the Member must pay all premiums due through that date.

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

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

3. **NON-COBRA CONTINUATION COVERAGE**

A. **Eligibility for Coverage** – For a Member who is not eligible for COBRA Continuation of Coverage under Section 10(2), the Member is entitled to continue his or her Hospital, surgical, and major medical insurance for him or herself, his or her Eligible Dependents or both, subject to the following conditions.

1) The Member must have been continuously insured under the group policy and for similar benefits under any group policy which it replaced, during the entire three (3) month period ending with the termination of eligibility;

2) The Member is not eligible if he or she is covered by Medicare or covered by any other insured or uninsured arrangement that provides Hospital, surgical, or medical Coverage for individuals in a group.

B. **Election of Non-COBRA Continuation Coverage** – A Member must notify WINhealth of the Qualifying Event related to eligibility of Non-COBRA Continuation Coverage. Such notice must be given, in writing, by the Member within the thirty-one (31) day period following the date of termination of Coverage.

C. **Payment of Premiums**

1) The Member electing Non-COBRA Continuation Coverage must pay directly to WINhealth a monthly Premium in an amount equal to one-hundred two percent (102%) of the Premium that would have been paid by the Plan Sponsor (including any member contribution) had the Member's Coverage not terminated under Section 8 (except that a thirty-one (31) grace period shall apply).

2) In addition to paying monthly Premiums, the Member must also pay any Copayment or Coinsurance applicable to a particular Healthcare Service received by the Member.

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

1) The Member fails to satisfy any of the preceding paragraphs in this Section 10(3);

2) The date twelve (12) months after the date the Member's insurance under the policy would otherwise have terminated because of termination of employment or membership;

3) The Member fails to make timely payment of a required contribution by the end of the period for which contributions were made;

4) The date the Group Contract between the Plan Sponsor and WINhealth terminates, or in the case of an Employee, the date the Employer terminates his or her participation under the group policy. However, if the

Employer replaces group Coverage with similar coverage under another group policy, the Member may become covered under that group policy for the balance of the period that the Member would have remained covered under the prior group policy in accordance with this paragraph had a termination described in this subparagraph not occurred.

5) The day after the end of the grace period for payment of the Non-COBRA Continuation of Coverage Premium, if such Premium has not been paid by the Member as required above.
6) The date the Employer terminates coverage.

SECTION 11

Conversion of Coverage

A Member whose Coverage has terminated under the Group Contract and whose Coverage was in place for at least three (3) months immediately prior to the termination may apply to convert his or her Coverage to an individual contract, provided the Member's Coverage has terminated for any reason except the Member's failure to make any payment required under the health plan. A Member may not be eligible to convert his or her Coverage if the Member is or could be covered by Medicare, or as may otherwise be specified in Wyoming Statutes Section 26-22-202.

A Member who wishes to convert his or her Coverage must apply directly to WINhealth if the Member continues to be employed in, or resides in the Service Area. The Member must apply to an insurance carrier that WINhealth may designate, if the Member is no longer employed in or residing in the Service Area. The Member is not required to furnish evidence of insurability. The individual conversion contract will be issued by WINhealth, or by the designated insurance carrier, effective as of the day following the date of termination of the Member's Coverage under the Group Contract, provided that the Member applies for the individual conversion contract and pays the initial Premium for such contract within thirty-one (31) days of the date of termination of the Member's Coverage.

SECTION 12

Coordination of Benefits

1. APPLICABILITY OF COORDINATION OF BENEFITS PROVISION

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

B. **Application** – This COB Provision applies to WINhealth when a Member has health care coverage under more than one (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 Section 12(4).

2. 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.

3. **ORDER OF BENEFIT DETERMINATION RULES**

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

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

4. **EFFECT ON WINHEALTH BENEFITS**

A. **Application of this Section** – When the Plan is a Secondary Plan, the benefits of the Plan may be reduced as provided under this section. Such

other Coverage Plan or Coverage Plans are referred to as "the Primary Plan" in subsection (B) below.

B. **Reduction in WINhealth's benefits** – The benefits of the Plan will be reduced when the benefits that would be payable for the Allowable Expenses in a Claim Determination Period under the Plan in the absence of this COB provision are less than or equal to the benefits that would be payable for the Allowable Expenses in the same Claim Determination Period under the Primary Plan. In that case, the benefits of the Plan will be reduced so that the benefits under the Plan, when added to the benefits payable under the Primary Plan, do not exceed the Allowable Expenses in the Claim Determination Period.

5. **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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).

6. **PAYMENTS MADE UNDER THE OTHER COVERAGE PLAN**

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

7. **WINHEALTH RIGHT OF RECOVERY**

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

SECTION 13

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 14

Service Area

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

SECTION 15

Miscellaneous Provisions

1. **Notices**

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

2. **Records and Information**

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

3. **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.

4. **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.

5. **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.

6. **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.

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

8. **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.

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

10. **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.

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

12. **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.

13. **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.

14. **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.

15. **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.

16. **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.

17. **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 16

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