AN INVESTMENT IN

YOUR COMPANY
YOUR EMPLOYEES
YOUR COMMUNITY
YOUR CHAMBER OF COMMERCE

A BENEFIT FROM
Sheridan County Chamber of Commerce
1517 E. 5th St.
P.O. Box 707
Sheridan, WY 82801
(307) 672-2485

Coordinated locally by
Laurie A. Ross, CLU, ChFC
203 S. Main St. – Ste. 2001
Sheridan, WY 82801
(307) 674-6973
The Wyoming Chambers Health Benefit Plan is a non-grandfathered benefit Plan under the Patient Protection and Affordable Care Act of 2010. This means the Plan includes the mandated coverage(s) as required in the law for the benefit of Plan participants.

For additional information regarding the benefits provided due to this legislation, as well as all other available coverage levels limitations, please refer to the Plan Declaration and the Summary Plan Document.

The Wyoming Chambers Health Benefit Plan is:

◆ A Welfare Benefit Plan established under Internal Revenue Service code as well as Department of Labor regulations.
◆ Plan contributions are held in a Trust that is directed by a Board of Trustees, chosen from the member participants of the Plan.
◆ The Wyoming Chambers Welfare Benefit Association Board, the Plan Sponsor, and its Board of Directors assign a Plan Administrator, retain a Legal Counsel, Accounting & Auditing Services and other Administrative Services as needed for the management of the Plan; all working for the benefit of the participants.
◆ Claims are paid by the contracted Claims Administrator (TPA) as directed by applicable State and Federal laws, the Trust Document, the Plan Declaration and the Summary Plan Description(s) of the benefit programs offered and administered by the Association. Full copies of these documents are available upon request.
◆ The Trust contracts with insurance and/or reinsurance companies in order to ensure the overall financial stability of the Trust and the benefits offered. These contracts may change from time to time and are voted upon and approved by the Association Board and the Trust Board or its designee.
◆ The benefits offered by the Benefit Plan are reviewed annually to determine their viability for the members and participants. The Wyoming Chambers Welfare Benefit Association, with available contracted counsel and advice, may alter these benefits, remove a plan of benefits completely and/or add new plans for consideration, without the consent of participating employers or participating employees.
◆ The Trust is participant-owned along with any surplus or deficits incurred. Participant employers are encouraged to review the applicable documents (Trust Document, Adoption Agreement and Plan Declaration) to ascertain applicable benefits and liability of becoming a participant prior to applying for coverage.

WYOMING CHAMBERS WELFARE BENEFIT ASSOCIATION
Julie Simon, President
Gail Lofing, Plan Administrator
Campbell County Chamber of Commerce
314 South Gillette Ave.
Gillette, WY 82716
(307) 682-3673
Program Objectives

☑ More stability in insurance premiums, now and in the future
☑ Broader accessibility to health insurance and coverage options within the community
☑ Creation of a community-wide wellness mind-set and culture
☑ Education about access to a broader range of choices to promote better healthcare decision making

Defined Contribution Healthcare

In a DEFINED CONTRIBUTION style plan, the employer chooses the amount of money to contribute toward a benefit plan...

From the menu of benefit programs and associated pricing, the employer decides how much of a premium to contribute per employee and/or employee with dependents. The choice by the employer does not have to increase annually nor increase at the same percentage increase as the plan – the premiums paid by the employer could be greater or smaller. The amount of the actual rate increase is not based on the individual employer’s loss ratio, but is based on the overall loss ratio to the Trust and each benefit plan.

Employees choose the plan that best fits their need...

From the same menu of benefit programs and associated pricing, the employee decides which benefit plan best meets his or her need. The employee’s applicable out-of-pocket premium cost is determined based on how much the employer contributes. If the employee chooses a plan which is more costly than the employer’s contribution, the difference is paid by the employee through payroll deduction. If the plan chosen by the employee is less costly than the employer’s contribution, the difference is contributed to a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA), depending on the benefit plan chosen and/or the Employer’s choices. The employee may choose a new/different benefit program every two years.

Defined Contribution Healthcare

For years, employers have provided benefits for employees and planned for those benefits to meet the needs of those employees and their families. The challenge for employers is that healthcare has become much more specialized and variable while benefit programs have adhered to a more “one-size-fits-all” model. Due to the evolving benefit needs of employees and their families, benefit choices must be available for employees to choose from to fit their individual needs.

Enrollment Requirements/Contingencies

◆ The employer must be a current member in good standing for at least 60 days, of at least one participating local Chamber of Commerce, prior to applying.
◆ Each employer must have a minimum of 75% of eligible employees participating for groups of 5 or more, and 100% participation for groups of 4 or less. Minimum group size is 2 employees (husband/wife teams have slightly higher premium).
◆ Completed Employee Enrollment/Waiver Applications are required from each employee in order to qualify. Following underwriting, the entire employer group will either be accepted or denied coverage.
◆ The PLAN’s renewal date is July 1st of each calendar year. Regardless of when enrollment is completed, any changes to the PLAN rates and/or benefits will take place on July 1st. Open enrollment (the ability to add employees who waived coverage or dependents which had previously waived) is the month of June of each year for each participating employer.
◆ Premium Contributions are made by the employer directly into the Trust Account and are used as described in the Trust Document, Summary Plan Description and Plan Declaration. The Trust is governed by a Board of Trustees, elected as described in the Trust Document.
◆ Employer must contribute a minimum of 50% of the employee’s premium, or equivalent if multiple plans are offered.
**Group Medical Plans**

**Notes:**
On Plan #4, the out-of-pocket shown does not include applicable deductible amounts

Plans 5 and 6 are Qualified High Deductible Plans, meaning they are qualified insurance Benefits for Health Savings Account rules and participation

Plans 5 and 6, the Rx Discount Card is where 100% of the discounted price applies to deductible and co-insurance

**All Plans Include**

- Mail Order Pharmacy
- Medically Necessary Ambulance Coverage (Air and Ground)
- Credit for Pre-Existing Conditions (with Proof of Prior Credible Coverage)
- $2,000,000 Annual Maximum (through 6/30/14) per insured / Unlimited Lifetime
- $150 Co-pay for Non-Emergent use of Emergency Room
- Out-of-Pocket Maximum = Deductible amount + Co-insurance amount
- Maternity Coverage Options
  - As “normal” coverage; or
  - Coverage following a $7,500 Deductible Amount (Groups of 14 full-time employees or less) (Deductible amount may be less in HSA Plans)
- Limited Chiropractic Benefits
- Credit for the amount of Prior Group Deductible (Transfer Credit)
- Dr. Office Co-Pay Limits (per visit)
  - 100% for Office Visits
  - 100% for approved Lab & X-ray to $1,000 per year per person
- Routine Wellness
  - 100% - Based on Physician Codes
  - Includes Annual Exams
  - Wellness Mammograms, Pap Tests, Wellness Colonoscopy and PSA Tests at 100%
- PPO Benefits provided
  - Non-network paid at the 90th percentile of Reasonable & Customary
- Mandatory Group Life Insurance with Matching AD&D ($15,000 per employee)

**PPO Networks:**
- Wyoming, Utah, Billing, MT
- Albany & Laramie Counties, WY
- Colorado
- Western South Dakota
- Rest of the nation

The Plan considers dependent children eligible for coverage up to age 26 in compliance with the Patient Protection and Affordable Care Act. Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to July 1, 2010. For additional information, please contact your agent or the Plan Administrator listed on Page 2.

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<table>
<thead>
<tr>
<th>Plan</th>
<th>Deductible Amount</th>
<th>Co-Insurance</th>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$500</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td>$1,000</td>
<td>$2,000</td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td>$500 to $6,000</td>
<td>80% to $12,500</td>
<td>50% to $7,000</td>
</tr>
<tr>
<td>Non-Network</td>
<td>$2,500</td>
<td>$4,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>PPO</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

Out of Pocket Amounts are cross accumulating

**Accident Benefit**
- 100% to $1,000 / person/year
- 100% to $1,000 / person/year
- 100% to $1,000 / person/year
- 100% to $1,000 / person/year
- 100% to $1,000 / person/year
- 100% to $1,000 / person/year

**Dr. Office Co-Pay**
- Primary Care
  - Ded & Coins: $30, $30, $30, $30, $30, $30, $30
- Specialist
  - Non-PPO: Ded & Coins: $125, $125, $125, $125, $125, $125, $125
  - PPO: Ded & Coins: $70, $70, $70, $70, $70, $70, $70

**Rx Card Co-Pay**
- Generic
  - Preferred: $7, $7, $7, $7, $7, $7, $7
  - Non-Preferred: $15, $15, $15, $15, $15, $15, $15

- Brand Name
  - Non-Preferred: $75, $75, $75, $75, $75, $75, $75

**Mandatory Group Life Insurance with Matching AD&D ($15,000 per employee)**
Dental Schedule of Benefits

<table>
<thead>
<tr>
<th>DENTAL BENEFITS</th>
<th>PATIENT’S LIABILITY</th>
<th>GENERAL PLAN LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PLAN 1</td>
<td>PLAN 2</td>
</tr>
<tr>
<td>Dental Deductible</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>(Per calendar year)</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>◆ Per Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◆ Per Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Benefits</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Benefits</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>&quot;Major Benefits</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>*Orthodontic Benefits</td>
<td>Not Covered</td>
<td>50%</td>
</tr>
<tr>
<td>(Under age 19)</td>
<td></td>
<td>Excludes Missed Visit Charges.</td>
</tr>
<tr>
<td>Lifetime Orthodontic Benefits</td>
<td>Not Covered</td>
<td>$1,000</td>
</tr>
<tr>
<td>Per Insured Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Per Insured Individual</td>
<td></td>
<td>Excludes Orthodontic Benefits.</td>
</tr>
</tbody>
</table>

*SIDE* of the only ways to maintain a “reasonable” outlook for the future of a benefit program is to be able to accurately assess the risks, and to assess those risks annually. The Wellness Initiative includes, for participating adults:

- A Health Risk Assessment
- Biometric Full Blood Panel Screening

Through this Initiative, participants receive, annually, an overview of their current health and a “score” that goes along with it. The reports and analysis may be used by the participant with their provider as well as the Care Managers with the Plan.

By participating in the Initiative, the rate charged to a participating employer group is reduced.

**Self-Audit Billing Credit**

The Plan offers an incentive credit to all participants to encourage examination and self-auditing of eligible medical bills to accurately reflect the services and supplies received by the participant or covered dependent. The participant is voluntarily asked to review all hospital and doctor bills and verify that he/she has received each itemized service and the bill does not represent either an overcharge or a charge for services never received regardless of the reason. The Benefit Services Administrator agrees to assist the employee (at his/her request) in determination of errors, and recovery attempts.

In the event a participant's self-audit results in elimination or reduction of charges, twenty-five percent (25%) of the amount eliminated or reduced will be paid directly to the participant (subject to a twenty dollar ($20) minimum savings), provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Benefit Services Administrator (e.g., A copy of the incorrect bill and a copy of the corrected billing.)

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the plan as well as the plan participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the plan member’s liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Maximum Allowable Fee, regardless of whether the charge is or is not reduced.

**Wellness Initiative**

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**Wellness Initiative**

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By participating in the Initiative, the rate charged to a participating employer group is reduced.
Benefits available...but NOT limited to:

- Acupuncture for anesthesia purposes
- Allergy tests and allergy injections
- Ambulatory/Outpatient Surgery Facility Care
- Anesthesia charges
- Assistant surgeon charges
- (if required due to the surgical aspects)
- Birthing Center
- Blood and blood related products
- Cardiac Rehabilitation
- Chemotherapy for treatment of a malignancy
- Chiropractic. Manipulation or adjustment of the spinal column
- Colonoscopy (Diagnostic)
- Diabetes Education. Equipment and supplies for persons with diabetes
- Durable medical equipment,
  purchase or rental up to the purchase price
- Elective Sterilization
- Emergency Room
- Hospital inpatient or outpatient services
- Laboratory Services
- Mastectomy due to diagnosed breast cancer
- Mental & Nervous Treatment
- Nursing Services
- Occupational Therapy
- Orthopedic braces
- Oxygen & the equipment for its administration
- Pathological Services
- Physical Therapy
- Prescription drugs requiring a prescription under federal law
- Professional ambulance service if medically necessary
  (includes air ambulance)
- Prosthetic Orthotics
- Radiation Therapy
- Respiratory/Inhalation Therapy
- Services of Physicians
  a. Hospital visits
  b. Doctor’s office calls
  c. Doctor’s office surgery
- Speech Therapy, but only to restore speech
  abilities lost due to illness or injury
- Surgery charges
- Vision Care following covered medical procedure to the eye
- Wig up to $300 lifetime (1 wig) due to Administration of cancer treatment
- X-Ray Services

This is a partial listing of the benefits provided under the medical plan and is NOT intended to provide complete details of benefits and limitations. Please refer to the Summary Plan Description (SPD) for details of benefits, limitations and the applicability of these benefits to each situation.

Benefits Exclusion:

- Abortion
- Acupuncture. Charges for acupuncture or acupressure therapy
- Adoption or surrogate expenses
- Behavioral Counseling expenses
- Biofeedback Therapy
- Blood handling and storage charges
- Cosmetic surgery
- Chelation Therapy, except for heavy metal poisoning
- Contraceptive Devices
- Corrective footwear
- Cosmetic services
- Court ordered treatment
- Custodial care
- Dental & Dental Implants
- Developmental delays
- Discounts. Preferred Provider discount amounts or “cash discounts”
- Educational or vocational testing
- Excess charges
- Exercise
- Experimental or investigational
- Eyelid and Eyebrow Surgery
- Failure to keep appointments
- Felony Acts. Charges resulting from or caused
  during the commission of a felony
- Food
- Foot care
- Foreign medical care or Government provided services
- Hair loss
- Hearing aids & exams
- Hypnotism
- Liposuction
- Mailing expenses
- Marital counseling
- Massage therapy
- No obligation to pay
- No physician recommendation
- Nonprescription items
- Not appropriate or not medically necessary
- Obesity
- Occupational
- Personal comfort of convenience items
- Providing medical information
- Relative giving services
- Riot
- Sales tax
- Self-Inflicted
- Services before or after coverage
- Sex changes
- Smoking cessation
- Substance Abuse / Addiction Treatment
- Surgical sterilization reversal
- Telephone consultations
- Third Party liability
- Travel or accommodations (unless Centers of Excellence)
- Unwanted hair
- Vision care. Visual training or orthoptics
- War or Acts of War
- Worker’s Compensation

This is a partial listing of limitations and exclusion. A complete listing, as well as supporting detail, is provided in the Summary Plan Description (SPD), supplied to each enrolled participant.

Section 125 - Section 125 of the Internal Revenue Code allows for the premiums paid by employees for employer provided group benefits to be withheld from employee pay on a pre-tax basis. The Wyoming Chamber Health Benefit Plan qualifies as an employer sponsored group benefit plan that could be offered under an employer’s Section 125 plan. However, before an employer can offer pre-tax premium payments for his or her employees, the employer must adopt a separate “Section 125 Plan” and allow employees the right to choose whether they wish to participate. The claims administrator for the Wyoming Chamber Health Benefit Plan has sample documents and/or administration options an employer may need, in order to adopt a pre-tax Section in consultation with the employer’s tax counsel. For clarification, please consult with your Agent or the Trust’s consultant.
There are hospitals and physicians who, through training and quality control measures, perform their services to the very best levels. Many of these providers also contract with benefit plans for very aggressive pricing. When care is sought at these facilities, for certain diagnosed conditions, the Plan will alter the structure of how benefits are paid and include a travel allowance for the participant and companion.

For additional details regarding the benefits and limitations of these programs, please consult the Summary Plan Description.
Submission Checklist

1. To apply for coverage with the Wyoming Chambers Health Benefit Plan and Trust, the following forms need to be submitted:

- **Employer Application**: Completed in full and dated no more than 60 days prior to the requested effective date.
- **Employee Applications**: Completed in full. Any employee corrections must be initiated by the employee. All medical questions must be answered, details given, and, if requested, a questionnaire asking additional details provided. Applications must be dated no more than 60 days from the requested effective date. Employee must complete waiver form for any eligible dependents who are not signing up for coverage.
- **Unemployment Report**: A copy of the employer’s most recent Quarterly Unemployment Report as filed for SUI, itemized by employee, **must be included**.

**ALL FORMS MUST BE COMPLETED AND SIGNED IN BLUE INK FOR ORIGINAL VERIFICATION.**

2. Once the application set is complete, it is forwarded to the Trust underwriter. The underwriter makes the decision whether the entire group is accepted into the Trust or declined. If employer is approved, the following forms and information are requested:

- **Acceptance Form**: This form shows that the group has been accepted along with the names of the employees who applied, the benefit plan chosen, the billed rates for that plan, and the group’s total premium per month. This form must be signed and returned by the employer within 1 week.
- **First Month’s Premium**: The first month’s premium must be submitted (check made out to the Trust). Available bill payment options are included (invoicing with either check payment, ACH payment or EFT payment).
- **Adoption Agreement**: This contract outlines the obligations of the Plan and the Employer, for the duration of the benefit plan. Two copies must be signed and returned. Both will be countersigned and one returned to the employer.

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**SUB CONTRACTORS**

- CLAIMS: CNIC Health Solutions
- RX: National Pharmaceutical
- ELIGIBILITY: Benefit Administrators
- CONSULTING: Covenant insurance Inc.
- AGENTS: As Assigned

**Reinsurance Policy**

- COMPANY: Life Summit RE

**Wyoming Chambers Welfare Benefit Association**

- BOARD OF DIRECTORS
  - PLAN ADMINISTRATOR

**Wyoming Chambers Health Benefit Plan**

- THE TRUST
  - BOARD OF TRUSTEES

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**The Plan Organization**

- LOCAL CHAMBER
- EMPLOYER – CHAMBER MEMBER
- WYOMING CHAMBERS WELFARE BENEFIT ASSOCIATION
- LOCAL CHAMBER
- EMPLOYER – CHAMBER MEMBER
- EMPLOYER – CHAMBER MEMBER
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