

Wyoming Welfare Benefit Plan

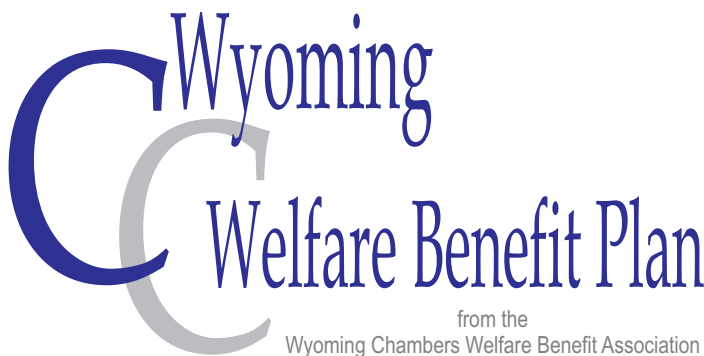
from the
Wyoming Chambers Welfare Benefit Association

An investment in:



Plan Description

- ✓ **A Summary of the Wyoming Chambers Welfare Benefit Plan**
- ✓ 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 assigns a Plan Administrator, retains 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 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 and Plan Declaration) to ascertain applicable benefits and liability of becoming a participant prior to applying for coverage.



Wyoming Chambers Welfare Benefit Association
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Participating Chambers:

Campbell County Chamber of Commerce
Sheridan County Chamber of Commerce
Douglas Chamber of Commerce
Powell Chamber of Commerce
Thermopolis Chamber of Commerce
Lander Area Chamber of Commerce
Casper Area Chamber of Commerce

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 mindset and culture
- ☑ Education about access to a broader range of choices to promote better healthcare decision making

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.

One benefit plan **DOES NOT** fit all employees’ healthcare needs!

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. In a DEFINED CONTRIBUTION style of plan ...

Employers **CHOOSE** the amount of money to contribute toward a benefit plan ...

... Employees **CHOOSE** the plan that best fits their need

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.

From that 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 an Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA), depending on the benefit plan chosen.

The employee may choose a new/different benefit program every 2 years.

Enrollment Requirements/Contingencies

- ★ The employer must be a current member in good standing, for at least 60 days prior to applying, of at least one participating Chamber of Commerce.
- ★ 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 fewer. Minimum group size is 2 employees (husband/wife teams are treated as 1 employee)
- ★ Completed Employee Enrollment / Waiver Applications are required from each employee in order to qualify. The entire employer group will either be accepted or denied coverage.
- ★ The TRUST renewal date is July 1st of each calendar year. Regardless of when enrollment is completed, any changes to the Trust rates and/or benefits will take place on July 1st. Open enrollment (the ability to add employees who waived coverage or dependents which had been 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

	Deductible		% Co-insurance	Out-of-Pocket		Accident Benefit	Doctor Office Co-pay		Rx Card Co-pay		
	Single	Family		Single	Family		Primary Physician	Specialist	Generic	Preferred Brand	Non-Preferred Brand
Plan 1	\$500	\$1,000	50% - \$4,000	\$2,500	\$5,000	100% to \$1,000/yr	ANC	ANC	\$10	\$25	\$60
Plan 2	\$1,000	2,000	80% - \$5,000	\$2,000	\$4,000	100% to \$1,000/yr	\$30	\$70	\$10	\$25	\$60
Plan 3	\$1,500	\$3,000	50% - \$5,000	\$4,000	\$8,000	100% to \$1,000/yr	\$30	\$70	\$10	\$25	\$60
Plan 4	\$200 / family / month		50% - \$5,000	\$2,500*	\$5,000*	100% to \$1,000/yr	ANC	ANC	\$10	\$25	\$60
Plan 5 - QHDP	\$2,500	\$5,000	90% - \$5,000	\$3,000	\$6,000	100% to \$1,000/yr	ANC	ANC	Discount Card		
Plan 6 - QHDP	\$5,000	\$10,000	100%	\$5,000	\$10,000	100% to \$1,000/yr	ANC	ANC	Discount Card		
Plan 7	\$2,500	\$5,000	50% - \$10,000	\$7,500	\$15,000	100% to \$1,000/yr	\$30	\$70	\$10	\$25	\$60

Notes: "ANC" = As Normal Care, meaning that eligible charges apply to deductible and co-insurance

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

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 (Wyoming Company)
- ** Medically Necessary Ambulance Coverage
- ** Credit for pre-existing conditions (with Proof of Credible Coverage)
- ** \$2,000,000 Lifetime Maximum per Insured
- ** \$150 Co-pay for Non-Emergency use of Emergency Room
- ** Out-of-Pocket Maximum = Deductible amount + co-insurance amount
- ** Maternity Coverage Options
 - As "normal" coverage
 - Coverage following a \$7,500 Deductible Amount

(Groups of 14 covered employees or less)

- ** Limited Chiropractic Benefits
- ** Credit for prior Group deductible amount met
- ** Dr. Office Co-Pay Limits (per visit)
 - \$200 - Primary Care Provider
 - \$500 - Specialist
- ** Routine Wellness (Annual Limits)
 - Age 0 to 2 - 100%
 - Ages 2 to 39 - 100% to \$300
 - Ages 40 to 49 - 100% to \$500
 - Ages 50 and up - 100% to \$750

DENTAL SCHEDULE OF BENEFITS

DENTAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS
	PLAN 1	PLAN 2	
Dental Deductible (per calendar year) - Per Individual - Per Family	\$50 \$150	\$50 \$150	Waived for Previous Benefits
	PLAN 1 PAYS	PLAN 2 PAYS	
Preventative Benefits	100%	100%	Deductible Waived Includes Routine treatment (for dependent children under age 14), oral exams, cleaning and x-rays.
Basic Benefits	80%	80%	Includes fillings, root canals and periodontic treatment.
Major Benefits	50%	50%	Includes Periodontal and Endodontics Care
*NOTE: Participants will be subject to a 6-month waiting period before benefits are covered.			
Orthodontic Benefits (Under age 19)	Not Covered	50%	Excludes Missed Visit charges
Lifetime Orthodontic Benefit Per Insured Individual	Not Covered	\$1,000	
*NOTE: Participants will be subject to a 12-month waiting period before benefits are covered.			
Calendar Year Maximum Benefit Per Insured Individual	\$1,000	\$1,000	Excludes Orthodontic Benefits

SELF-AUDIT BILLING CREDIT

The Plan offers an incentive credit to all participants to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider of health care services 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 (\$20.00) 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.



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 & Substance Abuse, to plan limits.
Nursing services.
Occupational therapy.
Orthopedic braces.
Oxygen and 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 for details of benefits, limitations and the applicability of these benefits to each situation.

Benefits Exclusions:

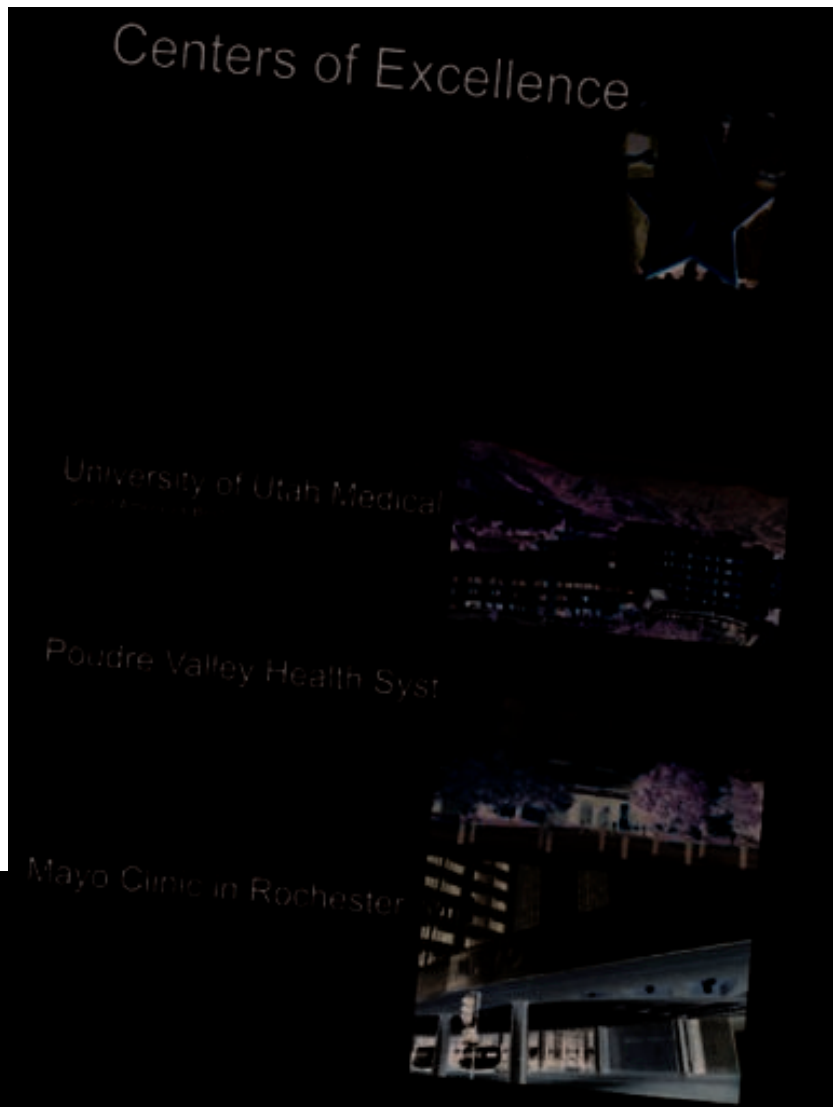
Abortion
Acupuncture. Charges for acupuncture or acupressure therapy.
Adoption or surrogate expenses.
Behavioral Counseling expenses.
Biofeedback therapy.
Blood handling and storage charges
Cosmetic surgery.
Chelation therapy, except for heavy metal poisoning.
Contraceptives Devices.
Corrective footwear.
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.

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.

Hair loss. Hearing aids and exams.
Hypnotism.
Infertility.
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 or convenience items.
Providing medical information.
Relative giving services.
Riot.
Sales tax.
Self-Inflicted.
Services before or after coverage.
Sex changes.
Smoking cessation.
Surgical sterilization reversal.
Telephone consultations.
Third party liability.
Travel or accommodations.
Unwanted hair.
Vision care, Visual Training or Orthoptics.
War or Acts of War.
Worker's Compensation.

Centers of Excellence

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.



TelaDoc

In an effort to provide participants with the very best access to quality medical advice, the TelaDoc program allows participants to speak with a licensed physician in their State of residence regarding certain diagnosis and health condition issues. The participant must pay a \$35 co-pay, then services are provided. Additional costs are born by the Plan.

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

Submission Checklist

To apply for coverage with the Wyoming Chambers 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.

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 is 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.

