THE WYOMING STATE EMPLOYEES' & OFFICIALS' GROUP PLAN ACTIVE EMPLOYEES 2008

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INTRODUCTION

■ Notices

■ Women's Health and Cancer Rights Act

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

■ Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under the federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, see page 18.

About This Plan

Great-West Life & Annuity Insurance Company (Great-West) processes the benefits for this Plan under the name of **Great-West Healthcare**.

This booklet describes the benefits available to ACTIVE EMPLOYEES ONLY. A separate booklet describes separate options available to ALL RETIREE EMPLOYEES.

THE STATE OF WYOMING (the Employer) has established an Employee Welfare Benefit Plan. This booklet, (effective JANUARY 1, 2008), replaces any prior booklet issued to THE STATE OF WYOMING. The benefits described in this booklet constitute the benefits available under the plan and are referred to collectively in this booklet as the "Employer's Plan." The Employer's Plan will be maintained pursuant to the terms of this booklet. The Employer's Plan may be amended from time to time. All prior plan descriptions established or maintained by the Employer are hereby revoked.

The benefits that form a part of the Employer's Plan and are described in this booklet are self-funded by the Employer.

This policy does not contain Comprehensive Adult Wellness Benefits as defined by the Wyoming Insurance Code. See the Table of Benefits for a complete description of this Plan's wellness benefits.

■ Self-Funded Benefits

The State of Wyoming is fully responsible for the self-funded benefits. Great-West Life & Annuity Insurance Company (Great-West) processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

The address of Great-West is 8505 E. Orchard Road, Greenwood Village, CO 80111.

■ Insurance Fraud

Fraud occurs when you knowingly lie to obtain some benefit or advantage to which you are not otherwise entitled. Examples of health insurance fraud are:

- Providing false information to obtain benefits under the plan; or
- Adding Dependent(s) to the plan who are ineligible based upon the Plan's definition of a Dependent. This can include claiming a Dependent is a full-time student when they would otherwise not be eligible for benefits or claiming someone as a legal spouse who does not meet the definition of legal spouse as defined by the Plan.

PPO MEDICAL BENEFITS SUMMARY

The following chart is a brief summary of the medical benefits offered by your Plan. Please read the Booklet for details about covered expenses, limitations and exclusions under the Plan.

See "Pre-Existing Conditions Limitation" in this booklet.

Summary of Medical Benefits	
CALENDAR YEAR DEDUCTIBLE	
For Option I, Option II and Option III, the calendar year deductible applies to all covered expenses except those payable at 100% and wellness services. For Option IV the calendar year deductible is waived for only the wellness services. If you have elected Option IV and have elected family coverage, the entire family calendar year deductible must be satisfied before any benefits are payable, except for wellness services. If you have elected Option IV and have elected family coverage, the entire family breakpoint maximum applies.	
• Medical Expenses – Option I	
– Individual	$350.00
– Family	$700.00
• Medical Expenses – Option II	
– Individual	$750.00
– Family	$1,500.00
• Medical Expenses – Option III	
– Individual	$2,500.00
– Family	$5,000.00
• Medical Expenses – Option IV	
– Individual (employee only single contract)	$1,500.00
– Family (employee plus one or more dependents)	$3,000.00
MEDICAL MANAGEMENT PENALTY FOR INPATIENT HOSPITAL EXPENSES	$250.00
MEDICAL MANAGEMENT PENALTY FOR OUTPATIENT SURGERY	$100.00
PERCENTAGE PAYABLE FOR COVERED SERVICES	
Cost-Effective Services	
• Wellness Benefit Maximum of $400.00 per member per calendar year.	100%
• Newborn Routine Benefit first year of life $600.00	100%
• Routine Colonoscopy (one every 5 years)	100%
• Home Health care – Option IV Deductible applies	100%
• Hospice Care – Option IV Deductible applies	100%
Inpatient and Outpatient Hospital Care	
• Wyoming Network Hospitals	85%
• Wyoming Non-Network Hospitals	80%
• Network Hospitals outside of Wyoming	80%
• Non-network Hospitals outside of Wyoming	60%
Physician charges for Surgery and Hospital Care	
• Wyoming Network Physicians	85%
• Wyoming Non-Network Physicians	80%
• Network Physicians outside of Wyoming	80%
• Non-network Physicians outside of Wyoming	60%

Office Visits	
• Wyoming Network Physicians	85%
• Wyoming Non-Network Physicians	80%
• Network Physicians outside of Wyoming	80%
• Non-network Physicians outside of Wyoming	60%
Emergency Room Treatment	
• Emergency Services	
* Wyoming Network Hospitals	85%
* Wyoming Network Physicians	85%
* Wyoming Non-Network Hospitals	80%
* Wyoming Non-Network Physicians	80%
* Network Hospitals outside of Wyoming	80%
* Network Physicians outside of Wyoming	80%
* Non-network Hospitals outside of Wyoming	80%
* Non-network Physicians outside of Wyoming	80%
Other Covered Expenses	80%
CALENDAR YEAR BREAKPOINT – NON-NETWORK PROVIDERS OUTSIDE OF WYOMING	
• Individual	$15,000.00
• Family	$30,000.00
CALENDAR YEAR BREAKPOINT – ALL OTHER PROVIDERS	
• Individual	$10,000.00
• Family	$20,000.00
BENEFIT MAXIMUMS	
• Lifetime inpatient mental/nervous	60 days
• Lifetime inpatient substance abuse	30 days
• Calendar year outpatient mental/nervous and substance abuse	50 visits
• Lifetime outpatient mental/nervous and substance abuse maximum	420 visits
• Calendar year home health care visits	100
• Calendar year skilled nursing facility days	180
• Hospice inpatient days	180
• Hospice bereavement	$300.00
• Outpatient Physical, Speech, Hearing, Occupational Therapy	
– Calendar year combined therapies maximum	$2,500.00
• Outpatient Spinal Adjustment Therapy	
– Calendar year Maximum	$1,125.00
• Air ambulance per trip	$10,000.00
• Organ transplant maximums	
• Lifetime organ transplant	$1,000,000.00
– Organ and tissue procurement per transplant benefit period	$35,000.00
– Transportation, lodging and meals per transplant benefit period	$10,000.00
* Covered lodging and meals per day	$200.00
– Private duty nursing care per transplant benefit period	$10,000.00
• Maximum Benefit for ALL covered expenses (per covered person)	$2,000,000.00

SUMMARY OF PRESCRIPTION DRUG BENEFITS – OPTION I, II, III AND IV

The following chart is a brief summary of the prescription drug benefits offered by your Plan. Please read the rest of this section for details above covered expenses, limitations and exclusions under the Plan.

Summary of Prescription Drug Retail and Mail Order Benefits OPTION 1, 11 & 111	
RETAIL PHARMACY Percentage Payable – 30 Day Supply	
• Generic Drugs	100% after $10.00 copay
• Brand Name Drugs	
– Preferred Drugs and Neutral Drugs	100% after $20.00 copay
– Non-Preferred Drugs	100% after $50.00 copay
MAIL ORDER PHARMACY Percentage Payable – 90 Day Supply	
• Generic Drugs	100% after $15.00 copay
• Brand Name Drugs	
– Preferred Drugs and Neutral Drugs	100% after $30.00 copay
– Non-Preferred Drugs	100% after $75.00 copay
SPECIALTY PHARMACY – 30 Day Supply	
• Specialty Pharmacy	100% after $80.00 copay

Summary of Med Pharmacy Program and Mail Order Benefits OPTION IV	
RETAIL PHARMACY	
• Generic Drugs	80% after deductible
• Brand Name Drugs	
– Preferred Drugs and Neutral Drugs	80% after deductible
– Non-Preferred Drugs	80% after deductible
MAIL ORDER PHARMACY Percentage Payable	
• Generic Drugs	80% after deductible
• Brand Name Drugs	
– Preferred Drugs and Neutral Drugs	80% after deductible
– Non-Preferred Drugs	80% after deductible
SPECIALTY PHARMACY – for certain high-cost drugs **The copay for Specialty drugs will mirror the Retail Network Pharmacy copays. See Specialty Pharmacy description in this booklet.**	

Who Is Eligible for Coverage?

To be eligible for coverage for yourself and your Dependents under your Employer's Plan you must:

- Be a resident of the United States or Puerto Rico.
- Be an Employee or position-sharing employee who regularly works at least 80 hours per calendar month.
- Retirees are covered under a separate Booklet.

You will be eligible on the first day of the month following the date your employment starts.

■ Pre-Tax Savings on Insurance Premiums

Please refer to the Flexible Benefits Plan Booklet for the specific written documentation required when enrolling. For more information please call: 1-800-891-9241 or 777-6835.

If you elect to participate in the Pre-tax Insurance Premium Payment (i.e., pay your insurance premium contributions on a pre-tax basis), you are locked into your insurance elections for the Flexible Benefit Plan Year. This means you may not drop health insurance coverage on yourself or your dependents unless you have a qualifying event or family status change that is consistent with your change in election as defined in the Flexible Benefits Plan Booklet.

■ Dependent

- Your legal spouse, as recognized by the State of Wyoming;
- Any unmarried child under the age of 19 until the last day of the month the child turns 19; or
- An unmarried child under the age of 25 if he or she is actively attending school as a full-time student until the earlier of the last day of the month the child turns 25 or is no longer an active full-time student. Before paying a claim, the Plan may require proof that this child is an active full-time student. If a student is a covered dependent under the plan in the spring of the year and completes the spring semester, they will remain covered until August 31st of the same year.

  For medical and prescription drug benefits, these age limits do not apply to a child who cannot support himself or herself due to a physical handicap or mental retardation. At reasonable intervals, but not more often than annually, the Plan requires a Physician's statement as proof of the child's handicap.

  Any eligible dependent child who is not self-supporting due to developmental disabilities or physical handicap must have been covered under the plan on the day before the date the child would otherwise lose dependent status due to reaching age 19. The developmental disability or physical handicap must have occurred prior to reaching age 19.

  The term "child" means your children. This includes any legal step-child, adopted child, foster child, or any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party. (See "Pre-Existing Conditions"). Legal documents must be provided at the time you enroll eligible children in one of these categories. Such statements will be legally binding and may have additional tax consequences. Statements concerning the legal responsibility for care cannot be made for limited purposes including but not limited to education and/or insurance purposes only.

For a child to be considered a Dependent, the child must be chiefly dependent upon you for financial support from age 19 to 25.

Student status must be verified every semester. Employees' Group Insurance sends out letters in July and November to update and verify eligibility of dependents age 19 to 25. Responding to these inquiries on a timely basis will avoid delays in claims processing and possible premium adjustments.

If a student status is not confirmed within the timeframe specified in the inquiry, the coverage for the applicable dependent will be terminated through the date that was last verified.

Who Is Eligible for Coverage? - Continued

The plan will allow coverage for a dependent child, if the employee has been appointed as permanent legal guardian and if the dependent child is a resident in the employee's home.

Your Dependents must live in the United States or Puerto Rico to be eligible for coverage.

A person who is covered under this Plan as an Employee may not be covered as both an "Employee" and a "Dependent". A child may not be covered as a "Dependent" of more than one Employee.

Individuals where both husband and wife, ***"with eligible dependents***", are employed by Covered Entities are required to enroll in the Split Premium Arrangement if they are electing to cover themselves and any children. Spouses must choose the same benefits under the Split Premium Arrangement (ie., same deductible health plan).

When Will My Coverage Begin?

See "Pre-Existing Conditions Limitation" in this booklet.

Although this Plan went into effect on August 1, 1990, this Plan of benefits is effective on January 1, 2008.

Your coverage remains in effect if:
- You were eligible before that date; and
- You pay the required contribution, if any.

If you become eligible on or after January 1, 2008, your coverage will begin on the first day of the month following the date your Service starts.

If an Employee, married to another Covered Entity Employee terminates employment and if they have been paying their premium through a split premium arrangement, then the remaining employee will automatically continue with Dependent coverage unless appropriate notification is made to the Employees' Group Insurance. The notification must be received by the Employees' Group Insurance within 31 days of the employee's termination date, if a pre-tax election had been made.

For coverage to start on the date described above, you must:
- Complete the appropriate application and give it to the Employees' Group Insurance within 31 days of the date you become eligible; and
- Pay the required contribution. The State provides a portion of your total contribution. For married employees without dependent children who both work for the entities covered under this plan, each employee shall enroll in single coverage. For married employees who both work for the entities covered under this plan and who would elect family coverage covering dependent children, a special arrangement called "Split Premium" is required for equitable contribution by entity/agency. See your Benefits Specialist for details.

If you do not apply for coverage within 31 days of the date you become eligible, you will be considered a late applicant. (See "What If I Don't Apply For Coverage When I'm First Eligible?".) Transferring from one State Agency to another is a continuation of your Service. Moving from one Covered Entity to another Covered Entity is a change in employment requiring re-enrollment to enroll in coverage.

If you were an At-Will Contract Employee and are then hired into a position that is eligible for benefits, you will be able to enroll in the Plan as if you are a new hire.

When Will My Retiree Coverage Begin?

Retirees must have medical coverage in effect under the Employer's plan for at least one year prior to retirement in order to be eligible for Retiree benefits.

When Will My Retiree Coverage Begin? - Continued

Retirees or spouses of Retirees who return to work for the State will be allowed to transfer coverage when your Service terminates again, and coverage under the Plan will be continuous upon enrollment as a retiree.

Your retiree coverage will start the day following loss of coverage as an active employee if:

- You were eligible for retiree coverage;
- You applied for retiree coverage and the application was received by Employees' Group Insurance within 31 days of loss of coverage due to retirement from a Covered Entity; and
- You pay the required contribution.

When Will My Dependent Coverage Begin?

If you want to cover any Dependents under this Plan, be sure to include them when filling out your application.

Your Dependent coverage will begin when your coverage begins unless you do not apply for Dependent coverage within 31 days of the date you become eligible. In this case, your Dependents will be considered late applicants. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

■ How Do I Add a New Dependent?

If you already have Dependent coverage, any new Dependents will be covered if appropriate documentation and written notification for the new Dependents is received by the Employees' Group Insurance within 31 days of the date you acquired them.

If you don't have Dependent coverage and acquire a new Dependent, you may apply for Dependent coverage. If you apply for Dependent coverage within 31 days of the date you acquired the new Dependent, coverage for that new Dependent will begin on the date you acquired the Dependent.

If you, as an employee, are planning to retire, your existing Dependents must be covered one year prior to your retirement date to be an eligible Dependent. If you, as an employee, acquire a new Dependent, you may add the newly acquired Dependent within 31 days of the date you acquired this new Dependent, and this newly acquired Dependent would be considered an eligible Dependent at retirement.

If your Employer receives a request to add your Dependent pursuant to a medical child support order, the Employer will determine whether the order is qualified. If the order is determined to be a Qualified Medical Child Support Order (QMCSO) and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing QMCSO.

■ What if I Have a Baby?

Newborn children will be covered for up to 31 days after their birth.

You must apply for Dependent coverage for the newborn child within 31 days of the date of birth and pay any required premium contributions to continue coverage uninterrupted. Applications must be received within 31 days of the birth. All applications to continue coverage for newborn children must be received within 31 days regardless of whether an employee has single or family coverage.

If you have other Dependents who were previously not covered and you wish to cover them, they may be added effective the first of the month following receipt of application. Application for other dependents must be received within 31 days of the birth. (See "What If I Don't Apply For Coverage When I'm First Eligible?".)

When Will My Dependent Coverage Begin? - Continued

■ What if I Adopt a Child?

Coverage will be provided under this Plan for any child you are in the process of legally adopting from the earlier of the following dates:

- the date the petition for adoption is filed; or
- the date the child enters the adoptive home;

except that when the child is in the custody of the state, coverage will be provided upon entry of a final decree of adoption.

The coverage for an adoptive child will terminate on the date on which the petition for adoption is dismissed or denied.

■ What if my Child Goes Back to School Full-Time?

If you have an unmarried Dependent child between the ages 19 and 25, who has experienced a gap of at least one semester (fall or spring) of school and enrolls in school as a full-time active student, the child may be enrolled in this Plan. You must apply for Dependent coverage for the active full-time student child within 31 days of the date that school starts. The student will be effective the first of the month following receipt of application or the date school starts whichever is later. The Plan may require proof that this child is an active full-time student.

What If I Don't Apply For Coverage When I'm First Eligible?

A person (you or your Dependent) will be considered a late applicant under this Plan if coverage is not applied for within 31 days of eligibility and you later want coverage. This does not apply to Special Enrollees, as described later in this section.

Late applicants can apply for coverage under this Plan during an Open Enrollment period. The Open Enrollment period is November 1 through November 30 of every odd-numbered plan year. Coverage will be effective on the following January 1. Your completed application must be received by November 30 in the Employees' Group Insurance.

The next Open Enrollment Period for the medical Plan will occur in 2009 for the plan year beginning on January 1, 2010.

For medical benefits, a late applicant will be subject to special limitations for pre-existing conditions. See the Pre-Existing Conditions Limitation described in this Plan.

■ Special Enrollee

For Medical and Prescription Drug Benefits under this Plan:

- A person (you or your Dependent) will be considered a special enrollee and not a late applicant and you may apply for coverage for such person under this Plan if you:
  - Did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under another health insurance plan or arrangement (other plan); and
  - Certified in writing, when you were first eligible, that you declined coverage under this Plan because of coverage under the other plan; and
  - Lost coverage under the other plan as a result of:
    - Exhausting the maximum period of COBRA coverage; or
    - Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of a spouse; or
    - Termination of employment or reduction in the number of hours of employment that affects eligibility for benefits; or
    - Termination of the employer's contribution for the other plan's coverage;
  - A significant change in benefits or premium that results in an additional cost of at least 35%.

  and

  - Request coverage under this Plan within 31 days of the date coverage is lost under the other plan.

What If I Don't Apply For Coverage When I'm First Eligible? - Continued

If you apply within 31 days after the date coverage is lost under the other plan, then coverage under this Plan will start on the first day of the calendar month beginning after the date the person's completed application for coverage is received by your Benefit Specialist or the Employees' Group Insurance.

- In the case of an Employee, you will ***not*** be considered a late applicant and you may apply for coverage for yourself under this Plan if you did not apply for coverage within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption.

  If you apply within 31 days after the date of marriage, birth or adoption, then your coverage under this Plan will start:

  - In the case of marriage, on the Date of Marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.
  - Other dependents, not previously covered, can be added on the first day of the calendar month after receipt of your application.

Will My Coverage Change While I'm Covered Under This Plan?

Two events may cause your coverage to change.

- First, your Employer may choose to amend this Plan. If the amounts or benefits provided are changed, your coverage will also change.
- Second, the family or work status under which you are covered may change.

■ When Will The Change In My Coverage Take Place?

- If the Plan is amended, changes will take place on the effective date of the amendment.
- If your family or work status changes, your coverage will begin under the new status on the first day of the month next following the date that your application is received by the Employees' Group Insurance.
- If your eligibility status changes which makes you ineligible for coverage, your coverage will end the last day of the month following the change.
- All claims will be based on the benefits in effect on the date the claim was incurred.

What If I Was Employed by a Covered Entity and Either Change Employment to Another Covered Entity or Have a Break In Service or Eligibility?

A Member who had coverage under this program through a Covered Entity and changes employment to another Covered Entity or experiences a break in employment service or eligibility will:

- Receive credit for any amounts already paid toward the calendar year medical deductible under prior enrollment in this plan to be applied to the current enrollment period in the same calendar year under this plan.
- Receive credit for any amounts already paid toward the calendar year medical breakpoints under prior enrollment in this plan to be applied to the current enrollment period in the same calendar year under this plan.

Any calendar year or lifetime maximum amounts reached during prior enrollment in this plan shall continue and accrue in subsequent enrollments under this plan.

Any breaks in coverage under this program may place restrictions in payments for pre-existing conditions. See "Special Benefits For Pre-Existing Conditions" for further information.

Note: Individuals who change employment from one Covered Entity to another Covered Entity must complete new applications to begin coverage with new Covered Entity. Coverage under this program with employment with your previous Covered Entity will end the first of the month following last day of employment.

When Will Coverage Under This Plan End?

■ Employee Coverage:

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The due date of the first contribution toward your coverage that you or your Employer fails to make.
- The date you are no longer eligible.
- The last day of the month in which your Service ends.

To voluntarily terminate coverage for yourself, you must send the appropriate completed form to the Employees' Group Insurance before the end of the month. Coverage will then terminate for the next month. Contact your Benefits Specialist for the appropriate form.

If you elect to participate in the Pre-tax Insurance Premium Payment (i.e.,pay your insurance premium contributions on a pre-tax basis), you are locked into your insurance elections for the Flexible Benefit Plan Year. This means you may not drop health insurance coverage on yourself or your dependents unless you have a qualifying event or family status change that is consistent with your change in election as defined in the Flexible Benefits Plan Booklet.

■ Dependent Coverage:

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends.
- The due date of the first contribution toward your Dependent coverage that you or your Employer fails to make; or
- The date your Dependent is no longer eligible for benefits.

To voluntarily terminate Dependent coverage, a completed form must be received by the Employees' Group Insurance by the end of the month. Coverage will then terminate for the next month. Contact your Benefits Specialist for the appropriate form.

If you elect to participate in the Pre-tax Insurance Premium Payment (i.e., pay your insurance premium contributions on a pre-tax basis), you are locked into your insurance elections for the Flexible Benefit Plan Year. This means you may not drop health insurance coverage on yourself or your dependents unless you have a qualifying event or family status change that is consistent with your change in election as defined in the Flexible Benefits Plan Booklet.

■ Disabled Employee

If you become eligible for Medicare because of your disability, you may continue your current level of health coverage by paying the appropriate premium on a timely basis.

■ Workers Comp Waiver of Premium

If your disability is covered by Worker's Compensation, your "Employing Agency" will pay the State's contribution towards your insurance for two (2) calendar months following the month in which the injury occurred. The following 4 calendar months, your "Employing Agency" will pay both the State's contribution and your contribution. Payment of your contribution will be continued until the end of the sixth (6th) calendar month following the month in which the injury occurred or until you return to work, whichever occurs first.

Can I Continue Benefits If I Become Ineligible For Coverage Under This Plan?

■ Continuation Coverage

If your Dependents' coverage ends because of your death, their health benefits will continue if they elect to continue coverage within 31 days of loss of coverage and make contributions.

Length of Time Continuation Coverage Provides Benefits (Medical & Prescription Drug Benefits)

<u>Loss of Coverage Due to Expiration of Contract</u>

Loss of Coverage Due to layoff of Contract will occur the earlier of the expiration of the contract or until eligible for other group insurance.

<u>Loss of Coverage Due to Layoff (Reduction In Force)</u>

Loss of Coverage Due to Layoff (Reduction In Force) will occur 6 months after the date your Service terminated or until eligible for other group insurance. You must enroll in COBRA within 60 days of loss of coverage and pay your contribution amount in order to maintain the 6 months of coverage due to Layoff (Reduction In Force).

Length of Time Continuation Coverage Provides Benefits Loss of Coverage Due to Your Death

<u>Dependents</u>

In the event of your death, your Dependents may be covered until your Dependent spouse remarries after your death.

In the event of your death, your Dependent child will be covered until the child no longer qualifies as a Dependent after your death. This coverage will also be provided to a child conceived before but born after your death who would have been covered as your Dependent if your coverage had stayed in force

Your continuation coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

■ Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ Retiree

An Employee who:

- has been retired from active Service with the Covered Entity; and
- has made application with the Employees' Group Insurance within 31 days of termination to continue coverage; and
- has had medical coverage in effect under the Covered Entity's plan for at least one year prior to retirement; and either
  - has attained at least age 50 on the date he/she retires; and
  - just prior to the date of his/her retirement had completed at least 4 years of Service for the Covered Entity and is eligible for
- State of Wyoming Retirement Benefits/TIAA CREF; or
  - is eligible for State of Wyoming Retirement Benefits/TIAA CREF; and
  - just prior to the date of his/her retirement had completed at least 20 years of Service with the Covered Entity.

An Employee who has previously retired from a Covered Entity and has returned to work with a Covered Entity who:

- has retired from active Service with the Covered Entity for at least a second time; and
- has made application with the Employees' Group Insurance within 31 days of termination to continue coverage; and
- has had medical coverage in effect under the Covered Entity's plan for at least one year just prior to retirement; and either
  - has attained at least age 50 on the date he/she retires; and

Can I Continue Benefits If I Become Ineligible For Coverage Under This Plan? - Continued

  - just prior to the date of his/her return to retirement has completed at least 4 years of continuous Service for the Covered Entity and is eligible for
- State of Wyoming Retirement Benefits/TIAA CREF; or
  - Maintained continuous retiree medical benefit coverage with the State's plan from previous retirement to the time of rehire with no break in coverage plus has had medical coverage in effect under the Covered Entity's plan since the retiree was rehired.

Retirees who qualify are eligible for Medical and Prescription Drug Benefits.

Employees who wish to continue their coverage under this Plan as a Retiree MUST apply for retiree coverage. New applications for retiree coverage must be received by the Employees' Group Insurance within 31 days of termination of active employment with a Covered Entity. Individuals who do not apply within the above 31 day window or who enroll and later drop their health coverage under the retiree Plan, cannot enroll in the retiree Plan at a later date.

Contact the Employees' Group Insurance for a retiree benefit booklet and packet.

Can I Convert My Coverage to Another Plan?

After continuation coverage, you also can receive coverage by converting to another plan.

Conversion of Medical Benefits

If your coverage ends for any reason except not making a required payment, you may be able to convert your group coverage to other coverage. You can apply for conversion coverage if:

- You had been covered under this Plan for at least 90 days just prior to the date your coverage ended; and
- You have elected and exhausted your COBRA coverage, if you are eligible for COBRA; and
- This Plan is still in force; or
- This Plan terminates, and is not replaced by similar group health coverage within 30 days.

Your spouse may convert coverage if you die or your marriage is annulled or ends in a divorce. Your Dependent children may convert their coverage if you die and have no surviving spouse or if their coverage ends only because they no longer meet the definition of Dependent.

A person who is entitled to Medicare Benefits may not convert coverage.

You must apply for medical conversion coverage within 31 days after your coverage ends.

Conversion coverage does not provide the same benefits as the Plan. If you are interested in converting your coverage, ask Great-West Healthcare for details.

Choice of Medical Plans

For employees other than Retirees, your Employer is offering you a choice of four medical plans: OPTION I Medical Plan, OPTION II Medical Plan, OPTION III Medical Plan and OPTION IV Medical Plan.

You can select a plan:

- When you first become eligible for medical benefits provided by your Employer, and
- During a plan transfer period. For Employees currently enrolled for medical benefits who wish to change plans, the plan transfer period begins on NOVEMBER 1 and ends on NOVEMBER 30. Enrollment forms must be received in the Employees' Group Insurance by November 30. Plan transfers take effect on JANUARY 1.

Employees who did not apply for medical coverage when first eligible must wait until the next Open Enrollment Period. See "What If I Don't Apply for Coverage When I'm First Eligible?" for details.

■ What Is the Difference Between the Four Plans?

- OPTION I - has an individual calendar year deductible of $350.00 and a family calendar year deductible of $700.00.
- OPTION II - has an individual calendar year deductible of $750.00 and a family calendar year deductible of $1,500.00.
- OPTION III - has an individual calendar year deductible of $2,500.00 and a family calendar year deductible of $5,000.00.
- OPTION IV - HSA -Qualified High Deductible Health Plan has an Employee only single contract calendar year deductible of $1,500.00 and an Employee plus one or more Dependents calendar year deductible of $3,000.00. Prescription Drug coverage is subject to the deductible and payable at 80%. Coverage that is not wellness based is subject to deductible requirements.

Employees and all of their family members must enroll in the same plan.

PPO MEDICAL BENEFITS

Your medical benefits provide you and your family comprehensive coverage for health care services.

- *Medical Management*- This is a utilization review program that applies to everyone except Retirees eligible for Medicare. If you need to be hospitalized or require surgery, your Physician must call Medical Management for pre-treatment authorization. The Medical Management program also provides Hospital discharge planning and identifies patients who might benefit from Great-West's Case Management Program.
- *A Nationwide Network of Hospitals and Physicians*- Your medical benefits are provided under a managed care program called Great-West PPO. This program offers you quality health care, lower out-of-pocket medical expenses, and a choice of Physicians. This provider network offers a large selection of Hospitals and Physicians across the United States. With Great-West PPO, you may use any Physician you wish, but you'll usually receive a higher level of benefits when you choose network providers.

These features help you receive appropriate, cost-effective care.

PPO MEDICAL BENEFITS - Continued

■ How Does the Plan Work?

The PPO plan includes a nationwide network of Hospitals and Doctors and a Medical Management Program. For the names of network providers, contact Member Services at the phone number or access the on-line directory at the website address shown on the Member ID card.

Benefits received from network providers are payable at a higher level than benefits received from non-network providers. Members are responsible for confirming that a provider is a network provider.

If a Member is traveling and needs care for a non-Emergency Medical Condition, contact Member Services for help in locating a network provider. Since the PPO network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits. If a Member is outside the PPO network area, benefits will be payable as shown in PPO MEDICAL BENEFITS SUMMARY.

Network providers will submit Members' claims and take care of getting Medical Management approval when necessary. When a non-network provider is used, the Member will need to file their own claim and make sure treatment is approved by Medical Management. See "Medical Management (MM) Program" for information about pretreatment authorization.

Supplemental Network

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in a supplemental network. This supplemental network is available to Members who choose a provider outside the primary network. Call Member Services for the names of providers who are participating in the program. Certain claims from non-network providers who are not in the supplemental network may, however, qualify for negotiation. Providers that participate in the supplemental network or agree to negotiate are considered non-network providers under the Plan. The Member is responsible for pretreatment authorization for all services and supplies that require pretreatment authorization.

Transitional Care for Members upon Termination of a Provider from the Network

If a Member's provider ceases to be a network provider for reasons other than quality-related reasons, fraud, or failure to adhere to Great-West's policies and procedures, coverage may continue for a specified period of time for treatment in progress for a Member who is:

- in her third trimester of pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or
- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Member's health; or
- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact Member Services to obtain a Transition of Care Request Form. The Transition of Care Request Form must be received by Great-West within 60 days of the provider's termination date. If your request is approved, care provided will be subject to the same copays, deductibles, coinsurance and limitations as care given by a network provider.

■ How Does Medical Management Work?

Medical Management (MM) Program

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services for Members covered under the Plan. Medical Management will also review the medical necessity of services that have already been provided.

Medical Management will determine the medical necessity of the care, the appropriate location for the care to be provided, and if admitted to a Hospital, the appropriate length of stay.

If a pretreatment request does not follow the Medical Management procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request.

Your Doctor must call Medical Management (MM) for pretreatment authorization. If a Member uses a non-network Doctor, the Member must make sure that treatment is approved by Medical Management.

Care received in an emergency room does not require pretreatment authorization. However, if hospitalization or surgery is required because of an emergency, the Member's Doctor must call MM within 48 hours after care is given.

Certain services require pretreatment authorization including, but not limited to, inpatient hospital care, surgery outside the Doctor's office and prescription drugs that exceed a recommended dosage or need to be reviewed for medical necessity based on recommendations from medical experts and the FDA.

For more information about services and supplies that require pretreatment authorization, contact Member Services at the phone number on the ID card.

Medical Management will review and render an authorization determination as described below.

- Urgent Care Requests

  For an urgent care request, MM will notify the Member and the provider of the authorization decision:

  - no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
  - no later than 72 hours after receipt of any other urgent care request.

  If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

  MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- Non-urgent Care Requests

  For a non-urgent care request, MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

  An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

  Medical Management will send the Member and the provider written notice of all authorization determinations.

PPO MEDICAL BENEFITS - Continued

If previously authorized benefits are reduced or terminated, MM will send notice of this decision ***prior*** to any reduction or termination of benefits.

If a Member receives notice of an adverse determination, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An "Authorized Representative" means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

"Adverse determination" means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

If the MM decision is an adverse determination, the Member will be sent written notice that will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the request and why the information is needed, the appeal procedures and time limits, including procedures and time limits for urgent care appeals.

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge; and
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Medical Management (MM) Non-Compliance Penalty

Network Physicians have agreed to contact the MM Program for pretreatment authorization. However, if a non-network Physician does not get pretreatment authorization or if a Member does not follow the recommended care plan, a non-compliance penalty will be applied to the claim.

For inpatient care: If you, your Physician or someone from your Physician's office does not obtain pre-treatment authorization from Medical Management, or you do not follow the Medical Management-recommended treatment plan, a $250.00 non-compliance penalty will be applied to your inpatient hospital expense claims.

For outpatient surgery: If you, your Physician or someone from your physician's office does not obtain pre-treatment authorization from Medical Management, or you do not follow the Medical Management-recommended treatment plan, a $100.00 non-compliance penalty will be applied to your outpatient surgery expense claims.

The non-compliance penalties cannot be applied toward the calendar year deductible or the breakpoint.

Appeal of Medical Management Decision

Appeal of a Medical Management decision should be requested within 180 days after receipt of an adverse determination. You have the right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all other appeals involving a MM adverse determination, before a Member may bring Grievance. The appeal review will consider written comments, documents and any other information submitted by the Member, Authorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

- **Level I Appeal**

  The first appeal level is an internal review by MM. Upon receipt of an initial appeal of a denied request for medical services, MM will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review and ***who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.***

  The Member and the provider or other Authorized Representative will be sent written notice of an appeal determination:

  - no later than 72 hours after receipt of an appeal involving urgent care; and
  - no later than 15 days after receipt of an appeal involving non-urgent care; and
  - no later than 30 days after receipt of an appeal involving services that have already been provided.

  If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

- **Level II Appeal**

  If the first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to Medical Management within 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to the Member.

  A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review.

  The Member and the provider will be sent a written notice of the external review determination:

  - no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
  - no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.

Medical Outreach Program

The Medical Outreach Program includes various initiatives to assist Members to manage their health concerns and to stay healthy. The Medical Outreach Program includes:

- A Disease Management Program;
- A Care Management Program; and
- A Wellness Program.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card for more information about these Programs.

Disease Management Program

This Plan participates in the Disease Management (DM) Program, Members have access to educational materials and individualized care plans designed to help a Member manage a chronic medical condition such as chronic pain, asthma, diabetes, coronary disease and chronic lung disease. The DM Program also provides services and support for Members with conditions classified as Oncology, End Stage Renal Disease (ESRD) and Neonatology. The DM Program is staffed by specially trained nurses who are available 24 hours a day, 7 days a week.

Members who may benefit from the DM Program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, preauthorization, physician referrals and self referrals. Each enrolled Member will receive tailored educational material depending on the Member's condition. The care managers in the DM Program will assist in setting clinical goals and monitor adherence to goals. Based on the severity of the condition, the care managers will schedule ongoing telephonic contact or home care visits by trained professionals. The Member's Doctor will be able to access the information provided to Members.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card to confirm that this Plan participates in the DM Program and to access the DM Program.

There are no additional participant out-of-pocket expenses for these services obtained through the DM Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the DM Program will be applied to the Maximum Benefit for All Covered Expenses.

Care Management Program

The Care Management (CM) Program manages the care of Members with serious Illnesses. Under the CM Program, if a Member requires inpatient care, such as surgery followed by long term medical care, a case manager who will work on behalf of the Member is assigned to the Member.

The case manager will help to coordinate and provide the most appropriate care in the most cost-effective manner. This includes handling the pretreatment authorization process, providing concurrent review for continued stay as an inpatient in a Hospital, discharge planning and post-discharge follow-up by the clinical staff to ensure that the Member is receiving proper care and support outside of a Hospital setting.

Members who may benefit from the CM Program are identified through a variety of means, such as the pretreatment authorization process and medical claims. Generally, Members may choose to participate in the CM Program.

If a Member chooses to participate in the CM Program and if a Member and the Member's Physician decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted.

Members with certain serious Illnesses must participate in the CM Program.

A Member may call the toll-free Member Services telephone number or access the website shown on his or her ID card to find out more about participation in the CM Program.

Wellness Program

The Wellness Program offers online health and wellness services, programs and other resources that enable Members to more easily and effectively obtain information about health-related topics and maintain healthy lifestyles. This includes a variety of information about fitness, nutrition, sleep deprivation and stress management. Participation in the Wellness Program is voluntary. A Member must take the Health Risk Assessment before they can enroll in the Wellness Program. Members who have taken the Health Risk Assessment may call the toll-free Member services telephone number or access the website shown on his or her ID card to participate in the Wellness Program. For Members who are assessed as high risk individuals, a nurse coach will contact the Member to work with them to set up an individualized program.

There are no additional participant out-of-pocket expenses for these services obtained through the Wellness Program.

■ What Should I Do When I Need Health Care?

When you need care, you may choose any Physician you wish. You are not required to see the same Physician each time.

You'll usually receive a higher level of benefits when you choose network Physicians.

- Your Great-West PPO provider directory lists the network Hospitals and Physicians in your area. The listing may change from time to time, so it's a good idea to check with Member Services or access the on-line directory at www.mygreatwest.com to confirm that a provider is still a network member. For a listing of providers in other cities, contact your Benefit Payment Office.
- Every time you go to a network Physician, show your Great-West PPO ID card. It identifies that your Employer has chosen Great-West PPO and provides important information used in billing for services.
- Network Physicians will submit your claims for you. They'll also take care of calling Medical Management whenever necessary. However, if you use non-network providers, you may have to file your own claims, and you will be responsible for making sure pre-treatment authorization requirements are met.
- To receive benefits at the network level, ask the Physician to refer you to a network specialist or Hospital if you need additional treatment or testing.

■ What Should I Do In Case Of An Emergency?

In case of a life-threatening emergency, go immediately to the nearest Hospital for treatment. In most cases, emergency room treatment is covered at 80%, regardless of the facility you choose. If you need to be hospitalized after receiving treatment in the emergency room, ask to be admitted to a Great-West PPO network Hospital. This way, your Hospital treatment will be covered at the higher benefit level.

Remember, if you are admitted to the Hospital, you, your Physician or someone from your Physician's office must call Medical Management within 48 hours after treatment begins, or on the next regular business day. If treatment is not authorized, the non-compliance coinsurance penalty of $250.00 will be applied to your claim. This non-compliance penalty cannot be used to satisfy the calendar year deductible or the breakpoint.

PPO MEDICAL BENEFITS - Continued

■ What If A Great-West PPO Provider Is Not Accessible To Me?

In certain circumstances, you may not be able to choose a Great-West PPO provider. If one of the following happens to you or a covered Dependent, non-Great-West PPO services will be payable at 80%.

- Treatment is a result of an emergency;
- Treatment is received outside the designated geographic area of Great-West PPO as defined in the current Great-West PPO directory; or
- Treatment cannot be performed by a PPO provider.

The term "emergency" means:

- An accidental injury that requires immediate treatment; or
- Life threatening Illness that requires immediate treatment. The Physician who attends the covered person must certify that the Illness was life threatening.

If the covered person was first confined in a Great-West PPO Hospital and later transfers to a non-Great-West PPO Hospital, benefits are payable at the non-network level (80% in Wyoming and 60% outside Wyoming) after the calendar year deductible.

■ How Can I Help Control My Health Care Costs?

Health care is like any other product or service you buy - you want to get the best value for every dollar. Great-West PPO is designed to help you control how your health care dollars are spent.

The following example illustrates the potential savings when you use Great-West PPO effectively. It is simplified, because a typical Hospital stay would include various Physician fees and pharmacy bills.

Potential Savings Within the State of Wyoming When You Use Great-West PPO OPTION I

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	-0-
Calendar Year Deductible	$350.00	$350.00
Balance	$2,850.00	$3,650.00
Plan Pays	$2,422.50 (85%)	$2,920.00 (80%)
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$777.50	$1,080.00

Potential Savings Within the State of Wyoming When You Use Great-West PPO OPTION II

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-
Calendar Year Deductible	$750.00	$750.00
Balance	$2,450.00	$3,250.00
Plan Pays	$2,082.50 (85%)	$2,600.00 (80%)
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$1,117.50	$1,400.00

Potential Savings Within the State of Wyoming When You Use Great-West PPO OPTION III

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-

PPO MEDICAL BENEFITS - Continued

Calendar Year Deductible	$2,500.00	$2,500.00
Balance	$700.00	$1,500.00
Plan Pays	$595.00 (85%)	$1,200.00 (80)
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$2,605.00	$2,800.00

Potential Savings Within the State of Wyoming When You Use Great-West PPO OPTION IV

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-
Calendar Year Deductible	$1,500.00	$1,500.00
Balance	$1,700.00	$2,500.00
Plan Pays	$1,445.00 (85%	$2,000.00 (80%)
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$1,755.00	$2,000.00

Potential Savings Outside the State of Wyoming When You Use Great-West PPO OPTION I

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$ -0-
Calendar Year Deductible	$350.00	$350.00
Balance	$2,850.00	$3,650.00
Plan Pays	$2,280.00 (80%	$2,190.00 (60%
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$920.00	$1,810.00

Potential Savings Outside the State of Wyoming When You Use Great-West PPO OPTION II

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-
Calendar Year Deductible	$750.00	$750.00
Balance	$2,450.00	$3,250.00
Plan Pays	$1,960.00 (80%	$1,950.00 (60%
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$1,240.00	$2,050.00

Potential Savings Outside the State of Wyoming When You Use Great-West PPO OPTION III

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-
Calendar Year Deductible	$2,500.00	$2,500.00
Balance	$700.00	$1,500.00
Plan Pays	$560.00 (80%	$900.00 (60%
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$2,640.00	$3,100.00

PPO MEDICAL BENEFITS - Continued

Potential Savings Outside the State of Wyoming When You Use Great-West PPO OPTION IV

	Network Provider	Non-network Provider
Hospital Bill (Room & Board)	$4,000.00	$4,000.00
Network Hospital Discount	$800.00	$-0-
Calendar Year Deductible	$1,500.00	$1,500.00
Balance	$1,700.00	$2,500.00
Plan Pays	$1,360.00 (80%)	$1,500.00 (60%)
Your Out-of-Pocket Cost (Co- payment plus deductibles)	$1,840.00	$2,500.00

■ Calendar Year Deductible

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Benefits that are payable at 100% are not subject to this deductible and cannot be used to satisfy it.

Your Plan's calendar year deductible is:

- $350.00 per person for Option I; or
- $750.00 per person for Option II.
- $2,500.00 per person for Option III.
- $1,500.00 if single coverage, $3,000.00 if two or more are covered for Option IV.

To limit your family's out-of-pocket expenses, the maximum deductible for you and all your covered Dependents is $700.00 for Option I, $1,500.00 for Option II, $5,000.00 for Option III and $3,000 for Option IV. No more than the individual deductible per person will be applied to the family deductible; except Option IV in which any family member may accumulate up to the $3,000 family deductible.

■ Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines. These guidelines help control medical plan costs by setting a limit on the amount covered for each medical procedure.

- When you see a provider who is not under contract with Great-West, the allowable covered expense will be determined by maximum allowable cost guidelines. The maximum allowable cost for each service or supply you receive will be the lesser of these two amounts:
  - The fee usually charged by your Physician for these services and supplies.
  - The maximum allowable cost for the same geographical area for these services and supplies.

  You are responsible for any amounts that are more than maximum allowable cost charges.
- Providers under contract with Great-West agree to a set fee schedule for people enrolled in Great-West PPO. When you see a Great-West PPO Network provider, or any other provider who is under contract with Great-West, the allowable covered expense will be the lesser of the actual billed amount and the amount allowed for the service under the negotiated fee schedule. The provider cannot bill you for any expenses in excess of the scheduled amount.

■ Maternity Coverage

The Plan includes a Maternity Assessment Program. Within the first 12 weeks of pregnancy, call the toll free number on the ID card to talk with a registered nurse trained in maternal and child health care.

Your maternity nurse will answer any questions you may have. You'll also receive educational materials which address proper diet, exercise, rest and the importance of receiving medical care during pregnancy.

Your maternity coverage includes prenatal care, childbirth, and post-natal care.

This Plan provides coverage for:

- a 48-hour Hospital stay for you and your baby, if dependent coverage is elected following a normal vaginal delivery.
- a 96-hour Hospital stay for you and your baby, if dependent coverage is elected following a cesarean section.

When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission.

A Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for an early discharge is made by the attending Physician in consultation with the mother.

Pre-authorization is not required for the 48/96 hour Hospital stay as described above. However, you or your Physician should still contact Member Services as soon as you find out that you are pregnant so they can help you identify and avoid risks during your pregnancy, obtain the prenatal care you need and direct you to appropriate facilities. Authorization is needed for a longer stay than as described above.

In the event your newborn child has been diagnosed with any illness that will require additional hospitalization than normally required for a well newborn, you or your Physician should contact Member Services as soon as possible. Pre-authorization is required for additional hospital days and treatment for a sick newborn.

■ Post-Mastectomy Coverage

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for similar treatment covered under the Plan.

■ Reconstructive Services and Surgery

The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn childrens' congenital defects and birth abnormalities, when the reconstruction meets **one** of the following primary purposes:

- When the primary purpose is to restore large skin defects due to a port wine stain.
- When the primary purpose is to relieve severe physical pain caused by an abnormal body structure.
- When the primary purpose is reconstruction following a mastectomy. See "Post-Mastectomy Coverage".
- When the primary purpose is to:
  - treat a functional impairment caused by an abnormal body structure; or
  - restore the Member's normal appearance, regardless of whether a functional impairment exists;

  when the abnormality results from a documented Illness that occurred within the preceding 12 months.

  Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness.

"Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

Certain types of reconstructive services and surgeries may not be covered under the Plan. See BENEFIT LIMITATIONS.

OPTION IV - HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Option IV is a high deductible health plan (HDHP) as defined by the HSA law (Tax Code Sec. 223). While you are enrolled in this plan, you may be eligible to contribute to a Health Savings Account (HSA).

Please note that you are not eligible for an HSA if you are enrolled under Medicare, can be claimed as a tax dependent in another person's tax return or are covered by another health plan that is not a high deductible health plan.

A Health Savings Account is a tax-advantaged account for individuals covered under a high deductible health plan. Funds in the account may be used to pay for qualified medical expenses. These are expenses for "medical care" as determined by the IRS that are paid by you, your spouse or your tax dependents which aren't paid or payable by any health plan coverage. The expenses must be incurred after you have opened an HSA. For a detailed list of qualified health expenses, please refer to the IRS web site at www.treas.gov. Some examples include:

- copayments, deductibles, and coinsurance for medical and dental care;
- vision care expenses;
- prescription and some over-the-counter medications;
- smoking cessation treatment and prescriptions; and
- some insurance premiums, such as long-term care, COBRA, and health care coverage premiums while you are receiving unemployment compensation.

You will have to pay income tax and a penalty tax if HSA money is used for expenses that are not considered medical care, such as air purifiers, cosmetic surgery, and related expenses, illegal treatments, massages (for general well-being), vitamins and nutritional supplements, or other non-medical expenses.

A Health Savings Account is separate and apart from the PPO plan. Even if your employer elects to contribute to your HSA, the HSA is not an employer-provided health or welfare benefit plan. An HSA, once opened, is yours to keep. You can continue to contribute to and use your HSA even after you move your coverage from this PPO plan to a different HDHP. However, if you are no longer enrolled in a HDHP, you may only continue to access your money in the HSA but may no longer contribute additional money until such time that you are enrolled in another HDHP.

Your employer has arranged with Mellon Trust of New England, N.A. to serve as your HSA custodian and HSA service provider. Mellon will provide you with HSA enrollment forms, related materials and information. To open your HSA, you must complete and submit any necessary HSA forms required by the HSA custodian and be found to meet the HSA requirements. You also have an option of opening your HSA with another HSA custodian of your own choosing. Further information about the HSA is available on the IRS website at www.treas.gov.

What Medical Expenses Are Covered Under All Plans?

This Plan pays benefits for the covered expenses listed below.

The Plan will pay a percentage of covered expenses after any deductible. If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible. You are also responsible for any amount over the allowable covered expense limit described in the Plan provision "Allowable Covered Expenses".

The Summary of Benefits earlier in this booklet shows the payment percentage and deductible amounts applicable to various covered expenses.

What Medical Expenses Are Covered Under All Plans? - Continued

Services must be Medically Necessary as defined in the GLOSSARY. Unless otherwise noted for a particular service, services must be required as a result of symptoms of Illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

■ Cost-Effective Services

Inpatient Hospital stays are among the most expensive types of medical treatment. Fortunately, many unnecessary Hospital days can be avoided by using certain types of medical treatment we call cost-effective services. If you follow the guidelines set out below, these cost-effective services are payable at 100%, and you do ***not*** have to satisfy the calendar year deductible before the Plan begins paying benefits.

- Wellness Benefit first $400 per person per calendar year
- Newborn Routine Benefit first year of life $600 per calendar year
- Routine Colonoscopy covered once every five years (routine diagnosis and procedure)*
- Home Health Care (Deductible applies for Option IV Medical Plan)
- Hospice Care (Deductible applies for Option IV Medical Plan)

* If any tissue or polyp is removed during the course of a Colonoscopy, the procedure changes from a routine procedure to a surgical procedure subject to deductible and coinsurance requirements.

■ Wellness Care

This benefit is designed to prevent more serious and costly Illnesses by providing coverage for routine health care.

The Plan will cover 100% up to $400.00 per member per calendar year. Any amount exceeding $400.00 is not covered and is the patient's liability. The calendar year deductible does not apply to Wellness Care visits. For a comparison of the wellness benefits provided by the Plan with those defined by the state statutes as comprehensive adult wellness benefits, contact the Employees' Group Insurance.

The Plan covers periodic physical exams by a Physician for a member who is at least eight days of age. This includes x-ray and lab services, if part of the annual physical exam, necessary immunizations and booster shots.

Annual pelvic exams, Pap smears and mammograms are included in the $400.00 calendar year wellness care benefit.

Newborn Routine benefit is covered up to $600.00 for the first year of life (365 days).

■ Home Health Care

There are many instances in which a patient might prefer home health care to an inpatient Hospital stay. Such patients typically need a certain level of medical care, but not the full-time supervision of a Hospital staff.

When prescribed as an alternative or as a follow-up to inpatient Hospital care, medical services provided in the home by a certified home health care agency are covered as cost-effective service.

The Plan will pay for home health care visits, up to 100 home health care visits each calendar year. Each four hours of service for home health care aide equals one home health care visit. Each visit in person by any other member of the home health care agency equals one home health care visit.

What Medical Expenses Are Covered Under All Plans? - Continued

■ Hospice Care

Hospice care can provide the physical, psychological, spiritual or social support needed to help terminally ill patients cope with their Illnesses. Hospice care includes services provided by a hospice care program in the patient's home. If Hospice care is provided in a Hospital the maximum the plan allows is 180 days. Hospice care provided on an out patient basis is not subject to the 180 in hospital limit. These services are covered as long as they are prescribed by a Physician, and the covered person's life expectancy is six months or less.

This Plan will also pay up to $300.00 for bereavement expenses incurred by the covered person's family (his or her legal spouse, children, parents, grandparents, and brothers and sisters) for supportive services provided to them after the death of the covered person.

Hospice care program means a formal program directed by a Physician to help care for a person with a life expectancy of six months or less. This program is through either:

- a centrally-administered and nurse-coordinated program which:
  - provides a coherent system primarily of home care;
  - is available 24 hours a day, seven days a week; and
  - provides bereavement services; or
- confinement in a hospice.

The hospice care program must meet the standards set by the National Hospice Organization. If such program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a hospice care program.

Hospice care is payable at 100% and is not subject to the calendar year deductible. Pretreatment authorization is not required prior to receiving care in an emergency room.

■ Care Received in a Hospital

Covered expenses for care received in a Hospital include charges for room and board as well as other inpatient and outpatient services and supplies.

- For room and board, the covered expense for each day of confinement is limited to
  - the Hospital's usual charge for semi-private care; or
  - 90% of the Hospital's lowest charge for private care if there are no semi-private rooms.
- For confinement in an intensive care unit, the covered expense for each day is limited to the Hospital's usual charge for confinement in an intensive care unit.

Benefits for emergency room treatment are described later in this booklet. (See "Treatment in An Emergency Room".)

<u>Things You Can Do To Help Control The Cost Of Your Hospital Treatment</u>

Most Hospital treatment is planned. Since you know about this treatment in advance, you have the opportunity to plan carefully and see that you receive the best coverage. There are two things to consider:

- Can you use a Great-West PPO Hospital? You'll usually receive a higher level of benefits and will have less paperwork to worry about if you do.
- Is your Physician a Great-West PPO provider? If the answer is yes, your Physician will call Medical Management when required. If the answer is no, make sure you receive pre-treatment authorization prior to receiving care. (See "How Does Medical Management Work?")

All care received in a Hospital is subject to the calendar year deductible. However, you'll usually receive a higher level of benefits when you use Great-West PPO Hospitals.

What Medical Expenses Are Covered Under All Plans? - Continued

■ Skilled Nursing Facility Expenses

If you no longer need the level of care provided in the Hospital but are not yet well enough to go home, you may be admitted to a skilled nursing facility.

- The total covered expense for each day in a skilled nursing facility is limited to the usual charge of the facility for semi-private care. This daily covered amount includes room and board and all other services; and
- This covered daily amount will not be more than 1.5 times the amount covered for room and board in the last Hospital in which the patient was confined.

The Plan will pay for up to 180 days of care in a skilled nursing facility each calendar year.

To receive skilled nursing facility benefits, you must be sure that the skilled nursing facility you choose is licensed by the state as a skilled nursing facility. In addition, confinement in a skilled nursing facility must:

- Start within seven days after the end of a Hospital confinement. The Hospital confinement must have lasted at least three days.
- Be necessary for treatment of the same condition that caused the Hospital confinement. This must be certified by the patient's Physician.
- Not be chiefly for custodial care. "Custodial Care" means the kind of care that helps a person perform the activities of daily living.

■ Physician Charges for Surgery or Hospital Care

If you are admitted to a Hospital, you may incur Physician or surgeon charges that are separate from your Hospital bill. These fees - along with charges for surgeries performed in a Physician's office - are covered under this category of benefits.

When medically necessary, the Assistant Surgeon's expenses will be paid at 20% of the surgeon charges or at 20% of maximum allowable cost whichever is less.

If outpatient surgery is performed in a surgical center or in the outpatient department of a Hospital, it is also covered under this category of benefits.

Once again, the provider you choose will impact the level of benefits you receive.

■ Office Visits

Covered expenses for office visits include expenses for most services and supplies (x-rays, lab tests, drugs) provided in the Physician's office. Office visits do not include surgeries performed in a Physician's office.

■ Family Planning

This Plan covers:

- Infertility testing. This includes only the actual testing for the initial diagnosis of infertility and any surgical procedures that will correct the condition. Any outside intervention procedures (such as artificial insemination, in vitro fertilization) are not covered under this family planning benefit. Drug therapy is not covered under this benefit.
- Tubal ligations; and
- Vasectomies.

■ Well Newborn Care

Babies who are born with medical problems are covered as any other Dependent under this Plan. But even healthy babies may receive medical care, so this Plan also includes benefits to give your healthy baby a good start in life. Covered expenses for well newborn care include Hospital and Physician charges for infant care through the first seven days of life.

What Medical Expenses Are Covered Under All Plans? - Continued

■ Treatment of TMJ and Related Disorders

This Plan covers treatment of craniofacial muscle disorders and temporomandibular disorders.

This treatment is limited to surgical treatment and surgical preparation, including:
- exams and diagnostic x-rays;
- muscle injections;
- nerve block injections; and
- manipulation under anesthesia.

NOTE: No amount will be paid for the following treatment, services or supplies when related to TMJ:
- grinding the surface of the teeth;
- splints and appliances;
- orthodontic treatment (such as braces or wires);
- change of vertical dimension (including crowns);
- any other treatment, services or supplies which are not shown as a Dental Covered Expenses.

■ Oral Surgery

This Plan covers treatment of a fractured jaw or accidental injuries to sound natural teeth within 12 months after the Accident. The Accident must have occurred while you were covered under this Plan.

This Plan covers dental implants due to
- congenital defect or developmental malformation which interferes with function, or
- an accidental injury to sound natural teeth that occurs after the date coverage starts within twelve months after the Accident. Chewing injuries are not considered accidental injuries.

This treatment includes the cost and placement of the implants, but does not include charges for the cost or placement of required precision attachments and bridgework. This Plan does not cover single tooth implants.

The Plan covers Dental Implants in conjunction with the loss of sound natural teeth due to oral cancer which interferes with function. In order to be eligible, the loss of teeth must have occurred while covered under the Plan and replacement must occur within 24 months of the loss of natural teeth.

IMPORTANT: Dental implant services must be pre-authorized, or benefits will not be paid. A written request must be sent by the provider to Great-West Healthcare Benefit Payment Office, P. O. Box 12018, Cheyenne, WY 82003-1234.

■ Treatment Of Mental/Nervous Conditions and Substance Abuse

Advance approval is required for all Hospital stays. Call 1-800-685-1060.

The mental/nervous and substance abuse benefit provides coverage for mental health services, including treatment for alcoholism, drug addiction and other substance abuse, regardless of the origin of the condition. A mental/nervous or substance abuse condition is a condition that is classified by the International Classification of Diseases as a psychiatric condition. This benefit includes coverage for both inpatient and outpatient treatment.

<u>Inpatient Mental/Nervous Treatment</u>

The Plan will pay up to 60 days during the entire time the person is covered under this medical Plan.

<u>Inpatient Substance Abuse Treatment</u>

The Plan will pay up to 30 days during the entire time the person is covered under this medical Plan.

What Medical Expenses Are Covered Under All Plans? - Continued

Outpatient Treatment

The Plan will pay up to 50 visits in any calendar year and 420 visits during the entire time the person is covered under this medical Plan.

■ Specified Therapies

This Plan covers the following specified outpatient therapies:

- physiotherapy;
- speech and hearing therapy;
- occupational therapy; and
- manual manipulation of the musculo-skeletal system.

Spinal Adjustment Therapy benefits, which can include Chiropractic care, will be paid on a maximum allowable cost basis, subject to the calendar year deductible, based on Network or Non-Network provider with a calendar year maximum of $1,125.00 per member.

Charges for Acupuncture are not subject to the Specified Therapies maximum. Acupuncture expenses rendered by a physician are paid based on medical necessity subject to the overall maximum of the plan.

Physical therapy, speech and hearing therapies, occupational therapy will be paid on a maximum allowable cost basis, subject to the calendar year deductible, based on Network or Non-Network provider with a calendar year (combined) maximum of $2,500.00 per member.

No benefits are payable for massage.

Therapy provided during an inpatient Hospital stay is payable on the same basis as other inpatient Hospital care.

■ Prescription Drugs - Option IV High Deductible Health Plan

The Medical Plan covers outpatient prescription drugs.

The prescription drug benefits are provided through various programs. The Med Pharmacy Program uses a nationwide network of participating retail pharmacies. The Mail Order Drug Program offers one mail order pharmacy that can dispense up to a 90-day supply of medication. The Specialty Drug Program uses a small pharmacy network referred to as the Specialty Pharmacy Network (SPN). The SPN covers certain drugs commonly referred to as ***high-cost specialty drugs***.

Covered drugs require the written prescription of a Doctor and approval by the Food and Drug Administration (FDA). Drugs must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of Illness, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee of your Plan's pharmacy benefit management company. Oversight and final decisions are made by the Great-West Healthcare Pharmacy Committee.

Some drugs may have dispensing limits that are primarily based on FDA recommendations. Additionally, some drugs are subject to prior authorization. Coverage for these drugs is dependent upon satisfying Medically Necessary requirements.

Med Pharmacy Program

The Med Pharmacy Program covers charges for prescription drugs, insulin and diabetic supplies, except as specifically excluded under the Plan. Refer to "Medical Benefit Limitations."

The Med Pharmacy Program covers a 30-day supply received in any one purchase at the pharmacy. Up to a 90 day supply may be purchased at the retail pharmacy upon request.

Mail Order Drug Program

What Medical Expenses Are Covered Under All Plans? - Continued

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of Illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for diabetic supplies and insulin.

With this program, a Member may buy through the mail up to a 90-day supply of diabetic supplies,insulin and covered maintenance prescription drugs.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local participating pharmacy. The second prescription should be mailed to the Mail Order Drug Program.

Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as ***high-cost specialty drugs***. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. Specialty Pharmacy Program is limited to a 30 day supply.

With a new Specialty Pharmacy prescription, the Member may contact Member Services, or access www.mygreatwest.com, to identify the drugs contained on the Specialty Pharmacy list. Members may also access the website or contact Member Services for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

Enteral Nutrition

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when ***all*** of the following conditions are met:

- It is necessary to sustain life or health;
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
- It requires ongoing evaluation and management by a Physician; and
- It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Coverage ***does not*** include:

- Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products:
  - Prescribed without a diagnosis requiring such foods;
  - Used for convenience purposes;
  - That have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - Used as a substitute for acceptable standard dietary intervention; or
  - Used exclusively for nutritional supplementation.

What Medical Expenses Are Covered Under All Plans? - Continued

Clinical Trials

Services and supplies, such as medications, provided as part of clinical trials are generally not covered under the Plan because they are Experimental, Investigational or Unproven.

However, the Plan covers clinical services, as defined in this provision, when a Member participates in a phase III or IV clinical trial that has been preauthorized by Medical Management for treatment of cancer or other life-threatening Illness, if all of the following criteria are met:

- the Member has a current diagnosis that will likely be terminal in less than two years under generally accepted treatment options in the absence of the clinical trial; and
- standard therapies have not been effective in significantly improving the condition or standard therapies are not medically appropriate; and
- the Member must be enrolled in the clinical trial and not be treated off protocol; and
- treatment is provided in a clinical trial that meets certain criteria established by Great-West Healthcare. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

All Plan provisions, including but not limited to pretreatment authorization and Medical Management review, apply to a Member's participation in a clinical trial.

For the purpose of this provision, "clinical services" mean services and supplies that are:

- necessary to administer the service or supply that is the focus of the clinical trial.
- necessary for management of the patient's health within the clinical trial.
- required for the clinically appropriate monitoring of the effects of the focus of the clinical trial (example: blood tests to measure tumor markers).
- required for the prevention, diagnosis or treatment of complications that result from the clinical trial treatment.

Clinical services do not include:

- services and supplies that:
  - are excluded from coverage under the Plan in absence of an approved clinical trial.
  - are customarily provided by the trial sponsor at no cost to the patient.
  - are provided solely to determine trial eligibility.
  - are provided solely to satisfy the trial's data collection needs (examples: monthly CT scans for a condition that usually requires a single scan, protocol induced costs).
- costs that are funded by other agencies or research sponsors.
- expenses such as travel, housing, companion expenses that may result from a Member's participation in a clinical trial.
- administrative services (example: statistical analysis).
- charges related to covered services or supplies that have not or cannot be separated from costs related to non-covered services or supplies.

■ Other Covered Medical Expenses

Other Medical Services and Supplies

Medical services and supplies include:

- Nursing services.
- Medical equipment.
  - insulin syringe and clinitest covered under OPTION IV Plan.
  - rental of a wheelchair, bed rail, hospital bed or iron lung.

What Medical Expenses Are Covered Under All Plans? - Continued

- splints, trusses, orthopedic braces, crutches, casts, artificial eyes.
- purchase, repair and replacement of artificial limbs. That part of the charge which exceeds the cost of the least expensive functional limb available will not be considered a covered expense.
- prosthetic appliances to replace an organ, excluding artificial hearts.
- prosthetic, custom-made shoes necessitated by deformity, injury, or surgical procedures.

• Ambulance services. Up to $10,000.00 for air ambulance services to the nearest treatment center with adequate available facilities is payable per trip.
• Wigs or hairpieces required as a result of radiation therapy, chemotherapy, head injury, or surgery. The Plan will pay up to $125.00 during the entire time the person is covered under this medical Plan.
• One hearing aid per ear during the first six years of life for a child with a congenital hearing defect.
• When required as a result of a mastectomy, reconstructive surgery (payable on the same basis as any other surgery) and any prosthetic device. Benefits are payable in accordance with Plan provisions for reconstructive surgery following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

■ Alternate Care and Treatment

Hospital confinement is not always the best environment for treating an Illness. For a patient who needs significant long-term medical supervision, Medical Management may recommend alternative care and treatment.

The Case Management (CM) program helps patients with catastrophic Illnesses manage their health care. The goal of the CM program is to develop alternative treatment plans that will help these patients obtain the type of care they need ***outside*** of a Hospital setting. A patient who chooses to participate in this program is assigned a case manager, who will help coordinate the patient's care.

As a part of the pre-treatment authorization or catastrophic claims management (CM) program, Great-West may recommend alternate treatment plans or facilities that:

• Are not included in this medical Plan; or
• Are included in this medical Plan, but on a basis that differs from the care and treatment being recommended by Great-West.

If you and your Physician decide that the recommended alternative treatment plan is right for you, these expenses are payable on the same basis as the care and treatment for which they are substituted.

Great-West may authorize coverage for such alternate forms of care and treatment without obtaining prior consent from your Employer.

Am I Covered for Organ Transplants?

Your medical benefits provide you and your family coverage for organ transplants which are described below. This provision overrides everything else in this Plan, except for benefit exclusions (See "What's Not Covered?") and the overall lifetime maximum (See "Is There A Limit On The Amount Of Medical Benefits I Can Receive?").

■ What Organ Transplants are Covered?

The following human to human organ or tissue transplants are covered:

• bone marrow,
• heart,
• heart/lung,
• liver,
• lung, or

Am I Covered for Organ Transplants? - Continued

- pancreas.

Charges for Medically Necessary organ or tissue transplants during a transplant benefit period will be payable at 100% up to $1,000,000.00 during the entire time the person is covered under this medical Plan. You do ***not*** have to meet the calendar year deductible before you receive these benefits.

Your Physician and the medical professionals at Medical Management will determine if the organ transplant is Medically Necessary. If disagreement exists, the normal appeal and grievance process would be followed.

■ What Services are Covered with Organ Transplants?

The following services are covered:
- Organ and tissue procurement, including removal, preservation, and transportation of the donated organ, up to a maximum of $35,000.00 in a transplant benefit period.
- Transportation of the recipient and one companion to and from the site of the transplant surgery. If the recipient is a minor, transportation of two persons who travel with the minor will be included. Reasonable and necessary lodging and meal costs incurred in the interim by such companions will also be included, up to a maximum of $200.00 per day. An overall maximum of $10,000.00 for transportation, lodging, and meals applies to each transplant benefit period.
- Hospital room and board, and medical services and supplies.
- Services of a Physician, including diagnosis, treatment, and surgery.
- Services of registered and licensed practical nurses. Private duty nursing care is covered to a maximum of $10,000.00 in any one transplant benefit period.
- Rental of wheel chairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medication, x-rays, and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy.
- Surgical dressings and supplies.
- Home health care expenses incurred as a result of the transplant procedure. There is no maximum number of home health care visits under the organ transplant benefit.

If a covered transplant procedure is not performed as scheduled due to the poor medical condition or death of the intended recipient, benefits will be payable for any of the eligible services actually performed.

■ Transplant Benefit Period

An organ or tissue transplant benefit period lasts from five days before the date of the organ or tissue transplant and ends 18 months after the organ or tissue transplant. Transplants will be considered to be in the same transplant benefit period unless
- they are due to wholly different causes;
- for an active Employee, you return to work; or
- for a Retiree or a Dependent, the transplant benefit periods are separated by 3 continuous months.

What's Not Covered?

■ Pre-Existing Conditions Limitation

This section will ***not*** apply to a child placed with you for adoption or to a newborn child.

A pre-existing condition is an Illness or any related condition for which you or your Dependent received services, supplies or medication during the 3 months before the enrollment date for you or your Dependent under this medical Plan.

A pre-existing condition is not:

What's Not Covered? - Continued

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received after 12 months following the enrollment date for you and your Dependent.

Up to $1,000.00 of benefits for services, supplies and medication:

- received for the pre-existing condition after the date you or a Dependent became covered under this medical Plan; and
- which would otherwise be excluded by this limitation;

will be considered covered expenses. This Plan will ***not*** pay benefits for expenses incurred during a period of Hospital confinement which began before the person's coverage took effect.

If you are a late applicant as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 12 months after your enrollment date.

"Enrollment date" means:

- for an Employee who applies for coverage for himself or herself during the 31-day period after first becoming eligible to do so (the Employee's initial application period), the first day of the Employee's Service with the Employer.
- for an eligible Dependent for whom application for coverage is made during the Employee's 31-day initial application period, the first day of the Employee's Service with the Employer.
- for a late applicant or special enrollee (as described in the section, "What If I Don't Apply For Coverage When I'm First Eligible?"), or for any newly acquired Dependent, the date the person becomes covered under this Plan. Late applicants must wait for the Open Enrollment Period of November 1 to November 30 of any odd-numbered year.

<u>Portability of Coverage</u>

A person (you or your Dependent) will receive credit toward satisfaction of the Pre-Existing Condition Limitation described in this section for the time he was covered under another health plan, but only if the person was covered under another health plan that meets the definition of "Creditable Coverage" within the 90-day period just before his or her enrollment date under this Plan.

Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 90-day period.

If the person was covered for a period of time under Creditable Coverage that is:

- greater than or equal to the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- less than the time periods referred to in the Pre-Existing Conditions Limitation described in this section, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

  However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

"Creditable Coverage" is defined as coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

What's Not Covered? - Continued

■ General Benefit Limitations

The following limitations apply to all medical treatment you receive.

Benefits are payable only if the medical expenses are for treatment that is:

- Medically Necessary; and
- Except for well newborn care and wellness care, required as a result of symptoms of Illness; and
- Recommended, performed or prescribed by a Physician; and
- The least expensive, medically acceptable service or supply, as determined by Great-West; and
- Incurred while you or your Dependent is covered for these medical benefits. Treatment is considered to be incurred on the date the service is rendered or the supply is provided. No benefits are payable for expenses incurred after termination of coverage.

No amount will be payable for:

- Services provided in a state, whereby the provider is a non-licensed provider. For services to be covered, the provider must be operating within the scope of his license.
- An accidental injury or sickness for which the person on whom the claim is presented is entitled to indemnity under the terms of any Worker's Compensation or similar law. This applies whether or not such person has declined participation under the law.
- Services or supplies:
  - Provided by any government health plan; or
  - For which there would be no cost to the covered person if he or she did not have coverage.

  Benefits payable under this medical Plan will not be reduced or denied because the covered person is entitled to benefits under a state-sponsored medical assistance program. Any amount the Plan pays:
  - Will be considered benefits paid under this medical Plan; and
  - Will constitute a full discharge of the Plan's liability to the extent of the payment.

  For care received in a Veterans Administration facility for nonservice connected disabilities, benefits will be considered payable by Medicare and the Plan will coordinate benefits on the same basis as if the services had been received in a facility for which Medicare would have paid benefits.
- Expenses that are incurred:
  - For treatment provided by your spouse, children, brothers, sisters, parents or grandparents; or
  - For treatment provided by your spouse's children, brothers, sisters, parents or grandparents.
- Cosmetic surgery and all expenses related to the surgery, unless the operation is performed or the treatment is rendered to correct:
  - Deformities that result from Illness; or
  - Congenital defects that interfere with bodily but not psychological function; or
  - Any congenital defect of a newborn child.
- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT).
- Experimental, Investigational or Unproven services and supplies. Any service or supply that is integral or linked to an Experimental, Investigational or Unproven service or supply that, in the absence of the Experimental, Investigational or Unproven service or supply, would not be Medically Necessary, is also not covered.
- Custodial care. "Custodial care" means the kind of care that helps you perform the activities of daily living, such as, but not limited to:
  - Help in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet.
  - Preparation of special diets.
  - Housekeeping.

What's Not Covered? - Continued

  - Supervision of medication which:
    * Does not need the continuing attention of trained medical or paramedical personnel; and
    * Can usually be administered by yourself, a member of your family, or any other person who has not had formal medical training.
- Radial keratotomy, laser surgery or Lasik surgery.
- The reversal of any sterilization procedure.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Hearing aids or the fitting of hearing aids, except for one hearing aid per ear during the first six years of life for a child with a congenital hearing defect.
- Dental services other than
  - dental implants;
  - treatment of accidental injuries to sound natural teeth within twelve months after the Accident. Chewing injuries are not considered accidental injuries.
- Routine physicals for adults or children based on usual & customary medical practices.
- Services and supplies received for an Illness that is a result of war, declared or undeclared.
- Non-prescription drugs or medicines, or drugs or medicines that are not approved under the United States Food and Drug Act or its successor(s).
- Vitamins, minerals and dietary supplements except for prescription prenatal vitamins for pregnancy and B-12 for pernicious anemia.
- Anti-obesity drugs and formulas.
- Special nursing services if those same services are provided by the regular nursing staff of any Hospital in which the patient is confined.
- Charges by a Physician for any phone call or interview during which the patient is not examined.
- Normal maternity expenses for Dependent children.
- Abortions, unless the life of the mother would be endangered if the fetus were carried to term. Complications that arise from the abortion will be covered.
- Biomicroscopy, field charting, or aniseikonic investigation.
- Orthoptic or visual training.
- Testing, except for diagnostic purposes, or training for educational purposes.
- Rehabilitative care unless the institution is defined as one that provides physical therapy and is not an institution established for old age or custodial care.
- Non-emergency weekend hospital admissions.
- Sex change operations.
- Residential care.
- Smoking cessation programs and medications.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except as specifically provided in the Enteral Nutrition benefits provision.
- Clinical trials, except as provided in the Clinical Trials benefit provision.
- For OPTIONS 1, 11 and III, prescription drugs, medicines or insulin which are received as an outpatient and diabetic supplies (see Prescription Drug Provision). Note: OPTION IV - High Deductible Health Plan, prescription drugs are covered under the Med Pharmacy Benefit under the medical plan.

What's Not Covered? - Continued

- For Option IV High Deductible Health Plan - Over-the-counter drugs and supplies, infertility drugs, anti-obesity drugs and formulas.

Do I Have Protection Against High Out-of-Pocket Expenses?

To help protect you and your family against high health care expenses, your Employer has set breakpoints for your Plan. A breakpoint is the level of covered expenses at which you will receive 100% benefits.

Non-network Providers outside of Wyoming Option I, II and III

Your Plan's calendar year breakpoint is $15,000.00 for Non-network providers outside of Wyoming. This means that if covered expenses incurred for Non-network providers outside of Wyoming for you or one of your Dependents reach $15,000.00 in any one calendar year, all other covered expenses incurred for Non-network providers outside of Wyoming for that person during the rest of that calendar year will be payable at 100%.

To limit your family's out-of-pocket expenses, the maximum breakpoint for you and all your covered Dependents for Non-network providers outside of Wyoming is $30,000.00. No more than $15,000.00 per individual will be applied to the family breakpoint for Non-network providers outside of Wyoming.

Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse will ***not*** be payable at 100% even if you have reached your breakpoint.

The Non-network Providers outside of Wyoming Calendar Year Breakpoint and the All Other Providers Calendar Year Breakpoint will be cross-accumulated for claims processing purposes.

Non-network Providers outside of Wyoming Option IV

Your Plan's calendar year breakpoint is $15,000.00 for Non-network providers outside of Wyoming. If Employee only coverage has been elected, and in any one calendar year, the deductible and coinsurance a Member pays for all services reaches the individual breakpoint maximum of $15,000.00, all other covered expenses for the Member during the rest of that calendar year will be payable at 100%.

If Family coverage has been elected, and in any one calendar year, the deductible and coinsurance a Member pays for all services on behalf of all covered family Members reaches the family breakpoint of $30,000.00, all other covered expenses for the covered family Members during the rest of that calendar year will be payable at 100%.

Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse will ***not*** be payable at 100% even if you have reached your breakpoint.

The Non-network Providers outside of Wyoming Calendar Year Breakpoint and the All Other Providers Calendar Year Breakpoint will be cross-accumulated for claims processing purposes.

Network & Wyoming Providers - Option I, II & III

Your Plan's calendar year breakpoint is $10,000.00.

This means that if covered expenses incurred for all other providers for you or one of your Dependents reach the breakpoint amount in any one calendar year, all other covered expenses incurred for any other provider for that person during the rest of that calendar year will be payable at 100%.

To limit your family's out-of-pocket expenses, the maximum breakpoint for you and all your covered Dependents for all other providers is $20,000.00.

No more than the individual breakpoint for all other providers will be applied to the family breakpoint for all other providers. No more than $10,000.00 per individual will be applied to the family breakpoint.

Do I Have Protection Against High Out-of-Pocket Expenses? - Continued

Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse will ***not*** be payable at 100% even if you have reached your breakpoint.

The Non-network Providers outside of Wyoming Calendar Year Breakpoint and the All Other Providers Calendar Year Breakpoint will be cross-accumulated for claims processing purposes.

Network & Wyoming Providers Option IV

Your Plan's calendar year breakpoint is $10,000.00.

If Employee only coverage has been elected, and in any one calendar year, the deductible and coinsurance a Member pays for all services reaches the individual breakpoint maximum of $10,000.00, all other covered expenses for the Member during the rest of that calendar year will be payable at 100%.

If Family coverage has been elected, and in any one calendar year, the deductible and coinsurance a Member pays for all services on behalf of all covered family Members reaches the family breakpoint of $20,000.00, all other covered expenses for the covered family members during the rest of that calendar year will be payable at 100%.

Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse will ***not*** be payable at 100% even if you have reached your breakpoint.

The Non-network Providers outside of Wyoming Calendar Year Breakpoint and the All Other Providers Calendar Year Breakpoint will be cross-accumulated for claims processing purposes.

■ Expenses That Do Not Count Toward the Breakpoint

The following medical expenses will not be used to satisfy your individual or family breakpoint:

- Covered expenses used to satisfy any deductible amount.
- Covered expenses for outpatient treatment of mental/nervous conditions and substance abuse.
- Covered expenses that are payable at 100%.
- Expenses for services and supplies not covered under this Plan.
- Medical Management penalties.
- Prescription co-pays.

Is There A Limit On The Amount Of Medical Benefits I Can Receive?

The provisions entitled "What Medical Expenses Are Covered?" and "Am I Covered for Organ Transplants?" describes the calendar year and lifetime benefit maximums that apply to specific types of covered expenses. This medical Plan also includes an overall maximum benefit that applies to all covered expenses.

The maximum amount payable for any one person is $2,000,000.00 during the entire time he or she is covered under this medical Plan.

How Will Benefits Be Affected By Medicare?

If you or your Dependents become eligible for Medicare due to age or disability, you and your covered Dependents will continue to continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare.

If you are an active Employee and you or your spouse choose Medicare as your primary coverage, you will lose all coverage under this medical Plan. See your Benefits Specialist for details.

How Will Benefits Be Affected By Medicare? - Continued

■ If You Are An Active Employee or a Spouse Age 65 or Over

If you or your covered spouse becomes eligible for Medicare due to age, your coverage under this medical Plan will be considered your primary coverage, and Medicare will be considered your secondary coverage.

■ If You Are An Active Employee and Your Dependents Are Disabled

If your covered Dependents become eligible for Medicare due to disability, your Dependent's coverage under this medical Plan will be considered your primary coverage, and Medicare will be considered your secondary coverage.

■ If You Or A Covered Dependent Become Eligible for Medicare Due To End-Stage Renal Disease

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
  - the Member's refusal of Medicare coverage;
  - the Member's voluntary termination of Medicare coverage; or
  - the Member's failure to apply for Medicare coverage.

■ If You Are A Retiree

If you are a Retiree age 65 or over or Medicare eligible, then any medical benefits payable under this Plan for you (and for your spouse if he or she is age 65 or over) will be directly coordinated with Medicare. This means Medicare will pay their benefits first and will be known as the primary payer of benefits. You and your Medicare age spouse will be considered to be enrolled under Medicare whether or not you are actually enrolled. For purposes of this provision, if you elect a plan option available under Medicare Part C, the Plan will coordinate benefits based on the amounts that would have been payable if you had enrolled in Parts A and B of Medicare. If you enter into a private contracting arrangement with your Physician outside the Medicare system, no benefits will be coordinated or payable by the Plan.

How Do My Prescription Drug Benefits Work For Option I, II & III?

For OPTION I, OPTION II AND OPTION III, your prescription drug benefits are provided through the Performance Pharmacy Program. This program uses a nationwide network of participating pharmacies. You can obtain information about network pharmacies by calling Great-West's toll-free Member Services number on your I.D. card. Prescription drug expenses are not applied to deductibles or breakpoints under the Medical benefit.

Your Performance Pharmacy Program does not coordinate drug coverage with other drug programs. If you or your dependents use another drug program for benefits, no payment will be made under this plan.

■ Summary of Prescription Drug Benefits - OPTION I, II AND III

Below is a brief summary of the prescription drug benefits offered by your Plan. Please read the Prescription Drug description for details about covered expenses, limitations and exclusions under the Plan.

Summary of Prescription Drug Retail and Mail Order Benefits

RETAIL PHARMACY Percentage Payable - 30 Day Supply	
Generic Drugs	100% after $10.00 co-pay
Brand Name Drugs	
- Preferred Drugs and Neutral Drugs	100% after $20.00 co-pay
- Non-Preferred Drugs	100% after $50.00 co-pay
MAIL ORDER PHARMACY Percentage Payable - 90 Day Supply	
Generic Drugs	100% after $15.00 co-pay
Brand Name Drugs	
- Preferred Drugs and Neutral Drugs	100% after $30.00 co-pay
- Non-Preferred Drugs	100% after $75.00 co-pay
SPECIALTY DRUGS - 30 Day Supply	100% after $80.00 co-pay

How Do I Use the Performance Pharmacy Program?

The Performance Pharmacy program uses a nationwide network of pharmacies. These pharmacies are linked electronically to a computer system that contains information about drugs you have received while covered under this Plan. Each time you present a prescription to be filled, this system is checked for:

- Drug interactions.
- Therapeutic duplications.
- Early refill and excessive use.
- Excessive/insufficient drug doses.
- Drug/disease, drug/age and drug/pregnancy interactions.

Because these pharmacies have access to your Plan information, they know exactly how much you should pay for each prescription. Processing claims electronically at the time of purchase eliminates claim forms, which means you don't have to wait for reimbursement.

Your ID card is the key to fast, convenient claims service and low out-of-pocket costs.

- Present your ID card when purchasing drugs at any network pharmacy.
- The pharmacy will ask you to sign a claim voucher, which lets them process your claim.

How Do I Use the Performance Pharmacy Program? - Continued

- Pay the pharmacist your co-pay for each 30-day supply of a prescription or prescription refill. You may purchase up to a 90 day supply of a prescription at one time, but you will be charged a separate copay for each 30 day supply. Your co-pay is based on the category of drug:
  - Generic drugs.
  - Preferred brand name drugs. You will be provided a Performance Drug List (PDL). Each category on the PDL contains preferred and non-preferred drugs. You may also contact the toll-free number printed on your ID card or look up the list at www.mygreatwest.com.
  - Neutral drugs. These are brand name drugs which are not found on the PDL and are not considered preferred or non-preferred.
  - Non-preferred brand name drugs.

■ What If I Don't Have My ID card with Me?

If you don't have your ID card with you when you fill a prescription at a network pharmacy, you will pay the full price for the prescription and must file a claim to be reimbursed.

■ What If I Buy a Prescription Drug at a Non-Network Pharmacy?

<u>If the Pharmacy Is a Participating Pharmacy</u>

If you present your ID card at a non-network participating pharmacy, you must pay the pharmacist your co-pay for each prescription or prescription refill.

<u>If the Pharmacy Is Not a Participating Pharmacy, or If You Don't Have Your ID card with You</u>

When you purchase drugs at a non-network pharmacy that is ***not*** a participating pharmacy, or if the pharmacy ***is*** a participating pharmacy but you do not bring your ID card, you must pay the full price of the prescription and file a claim to be reimbursed.

- Ask your Benefits Specialist for a Prescription Drug Claim form.
- Complete this claim form, attach your prescription drug receipt, and mail it to the address printed on the form.
- The reimbursement will be sent directly to you.

After the co-pay, the amount of your reimbursement will be the remainder of the covered charges for the prescription drug.

What Prescription Drug Expenses Are Covered?

Covered expenses include charges for:

- Drugs and medicines that:
  - Require the written prescription of a Physician; and
  - Are purchased from a licensed pharmacist or from a Physician who is licensed to dispense drugs; and
  - Are required in the treatment of Illness.
- Insulin.
- Diabetic Supplies.
- Oral contraceptives and contraceptive devices.

What Prescription Drug Expenses Are Covered? - Continued

■ The Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as ***high-cost specialty drugs***. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis. Specialty Pharmacy Program is limited to a 30 day supply.

With a new Specialty Pharmacy prescription, the Member may contact Member Services, or access www.mygreatwest.com, to identify the drugs contained on the Specialty Pharmacy list. Members may also access the website or contact Member Services for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

What's Not Covered?

■ General Benefit Limitations

The following limitations apply to all prescription drugs you receive. Some drugs may have dispensing limits which are primarily based on FDA recommendations.

Benefits will be payable only if the covered prescription drugs are:

- Received while you or your Dependent is covered for these prescription drug benefits; and
- Recommended and prescribed by a Doctor.

No amount will be payable for:

- That part of a single purchase of any drug or medicine that exceeds a 90-day supply.
- More than one purchase of a drug, medicine, diabetic supply or insulin during the dosage period recommended by the prescribing Doctor.
- Drugs, medicines, diabetic supplies or insulin that:
  - Are not approved under the United States Food and Drug Act;
  - Are dispensed in a quantity or an amount in excess of that specified by the prescribing Doctor;
  - Are dispensed more than one year after the date on which the drug, medicine, or insulin was ordered by the prescribing Doctor;
  - Are consumed or used or administered while the covered person is confined to a Hospital or similar institution that has on its own premises a facility for dispensing pharmaceuticals.
- Therapeutic devices and appliances, immunization agents, biological serums, blood or blood plasma.
- The administration of drugs, medicines, or insulin.
- Over-the-counter drugs and supplies.
- Vitamins, minerals and dietary supplements except for prescription prenatal vitamins for pregnancy and B-12 for pernicious anemia.
- Anti-obesity drugs and formulas.
- Allergy serums.
- Smoking cessation medications.

What's Not Covered? - Continued

- Drugs for treatment of infertility.

Mail Order Drugs

Covered expenses for prescription drugs are payable at 100% after your co-pay. Covered expenses include costs for home delivery and expenses for:

- Prescription maintenance drugs. "Prescription maintenance drugs" means drugs prescribed by your Physician on an ongoing basis. The mail service prescription drug program covers drugs required for treatment of Illness.

How Do I Use the Mail Service Prescription Drug Program?

The mail service prescription drug program is for people who require maintenance prescription drugs on a long-term basis. With this program you may buy through the mail up to a 90-day supply of insulin and other covered prescriptions.

Medications are distributed by a mail order service program. The drugs you receive through this program are the same name brands or generic equivalents that you would otherwise purchase in a pharmacy. When you purchase drugs through this program, you pay a co-pay for a generic drug, or a co-pay for a preferred brand name drug or a co-pay for a non-preferred brand name drug. Your co-pays are shown in the Summary of Prescription Drug Benefits.

Ask your Physician to prescribe needed medications for a 90 day supply, plus refills. If you are presently taking medications, ask your Physician for a new prescription.

Ask your Employer for a mail service program form. Complete the member profile form with your first order only. Be sure to answer all the questions for yourself and your Dependents. Make certain you include your ID card Number on the form.

Send the completed member profile form, your original prescription(s) and the co-pay for each prescription to the mail order service program.

The mail order service program will process your order and return your medications to you by First Class Mail or UPS, along with re-order instructions for future prescriptions and/or refills. Allow 14 days for delivery.

■ How Do I Order Refills?

- With your original prescription medication, you will receive a notice showing the number of times it may be refilled.
- Simply mail this notice, along with your co-pay, to the mail order service program in the pre-addressed order envelope.
- To avoid the risk of running out, order your refills at least two weeks before you need them.
- You may also request refills by calling the Customer Service Toll Free Number printed on the member profile form.

■ What If I Need Medication Immediately?

Obviously, there will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local participating pharmacy. Be sure to use your ID card.

If you need medication immediately, but will be taking it on an ongoing basis, ask your Physician for two prescriptions.

- The first should be for a 14-day supply that you can have filled at a local participating pharmacy.
- The second prescription should be for the balance, up to a 60-day supply. Send it, with your co-pay, to the mail order service program immediately.

What Prescription Drug Expenses Are Covered?

- Drugs and medicines that:
  - Require the written prescription of a Physician; and
  - Are purchased from a licensed pharmacist or from a Physician who is licensed to dispense drugs; and

What Prescription Drug Expenses Are Covered? - Continued

- Are required in the treatment of Illness.
- Insulin.
- Diabetic Supplies.
- Oral contraceptives and contraceptive devices.

What's Not Covered?

■ General Benefit Limitations

The following limitations apply to all prescription drugs you receive. Some drugs may have dispensing limits which are primarily based on FDA recommendations.

Benefits will be payable only if the covered prescription drugs are:

- Received while you or your Dependent is covered for these prescription drug benefits; and
- Recommended and prescribed by a Physician.

No amount will be payable for:

- that part of a single purchase of a prescription maintenance drug or insulin that exceeds a 90-day supply.
- More than one purchase of a drug, medicine or insulin during the dosage period recommended by the prescribing Physician.
- Drugs, medicines, diabetic supplies or insulin that:
  - Are not approved under the United States Food and Drug Act;
  - Are dispensed in a quantity or an amount in excess of that specified by the prescribing Physician;
  - Are dispensed more than one year after the date ordered by the prescribing Physician;
  - Are consumed or used or administered while the covered person is confined to a Hospital or similar institution that has on its own premises a facility for dispensing pharmaceuticals.
- Therapeutic devices and appliances (except as specifically provided under the Plan), immunization agents, biological serums, blood or blood plasma.
- The administration of drugs, medicines, or insulin.
- Over-the-counter drugs and supplies.
- Anti-obesity drugs and formulas.
- Allergy serums.
- Smoking cessation medications.
- Drugs for treatment of infertility.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An ***Authorized Representative*** means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Benefit Specialist or go to www.mygreatwest.com to print a copy of a claim form. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

- Medical Benefits

  Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill the Company for the balance.

  For other services Members must file a claim. Sign the completed form, attach the itemized bill and mail both to the Benefit Payment office listed on the Member's ID card.

  Claims should be sent to:

  - GREAT WEST HEALTHCARE
  - WYOMING BENEFIT PAYMENT OFFICE
  - P.O. BOX 12018
  - CHEYENNE, WYOMING 82003-1234

  An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

  If You Incur Expenses Outside the United States

  If you incur expenses outside the United States, you must pay the bill and file a claim to be reimbursed.

  - The claim must be translated into English.
  - The charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount of U.S. dollars.
  - Along with the claim, you must send a receipt showing that you have paid the bill.
  - You must use an address within the U.S. on your claim form. Payments can only be made to an address within the United States.

- Prescription Drug Benefits

  For employees under OPTION IV HIGH DEDUCTIBLE HEALTH PLAN, out-patient prescriptions are covered under the medical plan. If you purchase drugs at a participating pharmacy and present your ID card, you will receive preferred pricing from the pharmacy. You will pay the pharmacist the preferred price for the drug and the pharmacy will then file the claim electronically. An Explanation of Benefits (EOB) will be sent to you showing how the claim was paid. A check for any amount payable to you will be attached to the EOB.

  For employees under OPTION I, II AND III, a prescription given to a pharmacist is not a claim for benefits under the Plan. A Member may submit a claim for Prescription Drug Benefits if:

- a copay amount was charged that the Member believes to be incorrect; or
- all or a portion of the cost of a prescription drug or supply is paid by the Member at the time the drug or supply is dispensed and the Member wants to request reimbursement for the amount paid; or
- prescription drugs or supplies are purchased at a pharmacy that is ***not*** a participating pharmacy.

Claim forms are available from Member Services and from the Benefits Specialist. If a Member decides to pay full price to purchase a drug or supply, the Member should submit a claim to the prescription drug benefits manager for processing. Benefits will be processed subject to the provisions of the Plan. This includes any deductible, copayment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form. Ask the Employer for a copy of this form.

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and
- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

What If My Claim Is Denied?

■ Notice of Denial Of Claim

If any benefits are denied, you will be sent a written notice of the denial. This notice will include:

- Specific reason or reasons for the denial;
- Specific reference to the plan provisions on which the denial is based;
- An explanation of additional material or information needed to complete the claim.

You must be given notice of claim denial within 90 days after the claim is filed. If special circumstances require more than 90 days to act on the claim, another 90 days will be allowed. If such an extension is needed, you will be notified before the end of the initial 90-day period.

■ Appeal Of A Claim Denial

If you have any questions about a claim payment, contact the Benefit Payment Office listed on your ID card. If you disagree with the reasons for a claim denial, you can initiate a claim review procedure by giving written notice to the Benefit Payment Office within 60 days after you receive the written claim denial. You or anyone authorized to act on your behalf may ask for a review of the claim and examination of any pertinent documents. Submit in writing the reasons why you believe that the claim should not have been denied, as well as any other information, questions or appropriate comments.

What If My Claim Is Denied? - Continued

■ Claims Processing Appeal

The claims processing appeal is an internal review by the claims processing center concerning the accuracy of the denied claim. The Member will be sent written notice of an appeal determination no later than 60 days after receipt of a claim denial appeal. The claims processing center may initiate a Level I Medical Management Appeal on appeals dealing with medical necessity. Appeals of claims denials concerning Plan exclusions and maximums are limited to claims processing appeals.

- **Level I Appeal**

  The first appeal level is an internal review by Medical Management. Upon receipt of an initial appeal of a denied claim, Medical Management will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review. The Member will be sent written notice of an appeal determination no later than 60 days after receipt of a claim denial appeal involving services that have already been provided.

  If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II.

- **Level II Appeal**

  If the first level internal review upholds the claims denial, in whole or in part, a second level Medical Management review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to Medical Management within 60 days after receipt of the first level appeal determination.

  A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review. The Member will be sent a written notice of the external review determination within 60 days after receipt of the second level appeal request.

Members will be sent written notice upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- The reason(s) for the determination;
- The reference to the Plan provision(s) on which the determination is based;
- The Member's right to review and request copies of all relevant documents, free of charge;
- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;
- That an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

■ Decision on Review

You will be notified of the final decision within 60 days after receipt of a request for review. If special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, a further 60 days will be allowed.

■ Grievance Procedure

If you are not satisfied with how a claim has been settled, you may file a grievance with the State Employees' and Officials' Group Plan. You must exhaust your Great-West appeals process before filing a grievance. A proceeding against the Plan shall be initiated by the filing of a statement by the claimant with the Employee's Group Insurance Department. Said statement shall be filed within one (1) year of the date upon which occurred the event forming the basis of the grievance. Certain steps must be followed:

- You must file a brief statement with the Plan explaining the situation. This statement must contain the following information:
  - your name, address, social security number and place of employment;
  - a description of the situation that includes a one paragraph summary;
  - copies of all pertinent documents, including bills;

What If My Claim Is Denied? - Continued

  - all information received from the Benefit Payments Office; and
  - the specific response or actions requested from the Plan.
- You must send a copy of your statement to:

GREAT-WEST HEALTHCARE

WYOMING BENEFIT PAYMENT OFFICE

P.O. BOX 12018

CHEYENNE, WYOMING 82003-1234

Indicate in your statement to the Plan the date you sent a copy to Great-West.

- The hearing officer will ask for a response from the Plan. Great-West will be a witness for the Plan.
- The grievance will then be heard by the grievance hearing officer. You will be given notice of the time and date of the hearing. You do not need to be represented by an attorney to present your grievance, but you may retain counsel if you wish.
- The hearing officer will present a proposed final order to the director of A&I or his/her designee who will issue a decision regarding the grievance. The decision shall be binding on both the Participant and the Plan. Any appeal from a final order shall be pursuant to Section 16-3-101 through 16-3-115 of the Wyoming statutes and Rule 12 of the Wyoming Rules of Appellate procedure.

This is only a summary of the Grievance Procedure. Please contact the Plan's office for a complete copy of the Grievance Rules.

What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

This COB provision does not apply to your Prescription Drug Benefits.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group health plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but

What If a Member Has Other Health Coverage? - Continued

- if both parents have the same birthday, the plan that covered the parent longer will be primary.

However:

- If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
  * first, the plan of the parent with custody of the child will pay its benefits;
  * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
  * finally, the plan of the parent not having custody of the child will pay its benefits.

  However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

  If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
  - a laid-off or retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

  will determine its benefits after the benefits of any other plan covering that person as an employee.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and

What If a Member Has Other Health Coverage? - Continued

- only the reduced amount will be charged against any benefit limits under this Plan.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

What If a Member Has Other Health Coverage? - Continued

The following example illustrates how coordination of benefits works under this Plan.

Coordination of Benefits

Total Allowable expenses	$2,000.00
Calendar year deductible under this Plan	$350.00
Percentage payable under this Plan after deductible	80%
Calendar year deductible under other Plan	$300.00
Percentage payable under other Plan after deductible	80%

If This Plan is Primary

Total Allowable expenses	$2,000.00
Calendar year deductible under this Plan	$350.00
Balance after deductible	$1,650.00
This Plan pays	$1,320.00 (80%)

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and
- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

Coordination of Benefits

If This Plan is Secondary

Total Allowable expenses	$2,000.00
Calendar year deductible under other Plan	$300.00
Balance after deductible	$1,700.00
Other plan pays	$1,360.00 (80%)
Balance of allowable expenses after other plan paid	$640.00
Amount this Plan would pay if there were no COB	$1,320.00 (80%)
Amount this Plan pays after COB	$640.00

What If a Member Has Other Health Coverage? - Continued

■ Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Great-West may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Great-West any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Great-West in asserting its subrogation and recovery rights. The Covered Person will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision.

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Great-West for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to exclude, the Benefits provided by the Plan.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Great-West for the amount of the benefits paid under this Plan; and
- Great-West may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

Great-West's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on

What If a Member Has Other Health Coverage? - Continued

behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

Other Information a Member Needs to Know

■ Payments in Error

If a payment is made in error, the provider of service or the person to whom the incorrect payment was made will be requested to refund the amount paid in error. In some instances, recovery of amounts paid in error may be made by, but not necessarily limited to, deducting overpayments against subsequent benefits which may become payable. If necessary, legal action will be taken to recover amounts paid in error.

■ Incontestability

After this Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums.

During the first 2 years your coverage under this Plan is in force, only a written statement signed by you can be used to contest the validity of your coverage. After your coverage has been in force for 2 years during your lifetime, no statement made by you can be used to contest the validity of your coverage.

■ Interpretation of Plan

Benefit Specialists and other State personnel are not authorized to furnish any information respecting the Plan's benefits or eligibility requirements and any such unauthorized representations will not be binding on the State. Any questions pertaining to eligibility or benefits must be directed to the Great-West Life & Annuity Insurance Company, Wyoming Benefit Payment Office or to the Employee's Group Insurance.

■ Notice of Claim

Great-West must receive written notice of claim within 20 days after the date of the loss or as soon as is reasonably possible. Notice can be given at Great-West's Executive Offices or to one of its authorized agents. Notice should include your name and the group policy or plan number.

■ Proofs of Claim

Written proof of claim must be given to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of claim, unless the claimant was legally incapable of doing so.

■ Time Of Payment Of Claims

Benefits payable under this Plan will be paid as soon as written proof of loss is received. Benefits are paid in the order of receipt by the Great-West Benefit Payment Office of written proof of the claim and all necessary supporting evidence.

■ Payment of Claims

Benefits will be paid to you, if living. If not, benefits will be paid to your estate. If any benefit is payable to:

- your estate; or
- a person who cannot give a valid release;

then Great-West can pay up to $1,000.00 to any relative it considers to be entitled to such payment. The Plan will be discharged to the extent of such payment made in good faith.

You may request in writing that payments under this Plan be made directly to the person providing the services.

■ Legal Actions

You may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan. You must exhaust all administrative remedies before you may bring a legal action to recover under the Plan.

■ Physical Examinations

Great-West at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

Great-West may also have an autopsy performed unless prohibited by law.

<u>Relationship Between Great-West and Network Providers</u>

Providers under contract with Great-West are independent contractors. Network providers are neither agents nor employees of Great-West, nor is Great-West, or any employee of Great-West, an agent or employee of Network providers. Great-West will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

Other Information a Member Needs to Know - Continued

General Information

Name of Plan

Health and Welfare Plan for Employees of THE WYOMING STATE EMPLOYEES' AND OFFICIALS' GROUP INSURANCE PLAN.

Policyholder/Employer

THE STATE OF WYOMING

EMERSON BUILDING #106

CHEYENNE, WYOMING 82002-0430

Type of Plan

Medical and Prescription Drug Benefits (52665)

Funding

See the section, "About This Plan."

Type of Administration

Contract Administration

Plan Administrator

The Plan is administered by THE WYOMING STATE EMPLOYEES' AND OFFICIALS' GROUP INSURANCE PROGRAM.

Written correspondence should be forwarded to:

THE WYOMING STATE EMPLOYEES' AND OFFICIALS' GROUP INSURANCE PROGRAM

EMERSON BUILDING #106

CHEYENNE, WYOMING 82002

■ Plan Administrator's Authority

For self-funded benefits, the Plan Administrator has complete authority to control and manage the Employer's Plan and has full discretion to determine eligibility, to interpret the Employer's Plan and to determine whether a claim should be paid or denied, according to the provisions of the Employer's Plan as set forth in this booklet.

■ Plan Modification/Termination

The Employer intends to provide benefits under the Plan indefinitely. However, the Employer may at any time:

- change the contributions you must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If your Employer, through the Wyoming State Employees' and Officials' Group Insurance Plan, decides that the Plan of benefits should be amended or the Plan terminated for any reason, a designated representative of the Employer will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the Employer gives authority to amend or terminate Plan benefits. The notice will be given to you within the time allowed by the appropriate law.

If the Plan is amended or terminated it will not affect the payment of any claims for expenses incurred prior to the time the change is made.

General Information - Continued

■ Premium Deduction Adjustments

Premium adjustments will reflect a period of up to 36 months regardless if the time period in question exceeds this amount.

Agent for Service of Legal Process

ATTORNEY GENERAL'S OFFICE

STATE OF WYOMING

CAPITOL BUILDING

CHEYENNE, WYOMING

82002

Service of legal process may also be made upon the Plan Trustee or the Plan Administrator.

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

The Sources of Contributions to the Plan

Employee Coverages:	
Medical Benefits:	Employer/Employee
Dependent Coverages:	
Medical Benefits:	Employer/Employee

Claims

Procedures to be followed in presenting claims for benefits and remedies for the redress of claims which are denied in whole or in part are described in this booklet.

Claims-related issues are to be sent to:

GREAT WEST HEALTHCARE

WYOMING BENEFIT PAYMENT OFFICE

P.O. BOX 12018

CHEYENNE, WYOMING 82003-1234

TELEPHONE NO. 1-800-685-1060

Eligibility and Benefit Questions- Eligibility and benefit questions are to be sent to:

THE WYOMING STATE EMPLOYEES' AND OFFICIALS' GROUP INSURANCE PROGRAM

EMERSON BUILDING #106

CHEYENNE, WYOMING 82002

TELEPHONE NO. 1-800-891-9241 OR 1-(307) 777-6835

GLOSSARY/DEFINED TERMS

The following defined terms have a special meaning with respect to the benefits outlined in this booklet. On each page where they appear throughout this booklet, they are capitalized.

■ Accident

A sudden and unforeseen event that:

- Causes injury to the physical structure of the body; and
- Results from an external agent or trauma; and
- Is definite as to time and place; and
- Happens involuntarily or, if it is the result of a voluntary act, entails unforeseen consequences.

It does not include harm resulting from disease.

■ Active Full Time Student

An unmarried child between the ages of 19 and 25 actively attending an accredited school on a regular and full time basis. Full time is considered not less than 12 credit semester hours or what the school determines as full time. The full time student must be chiefly dependent upon you for financial support.

■ Adult and Dependent Contract

Coverage where the employee and spouse **or** employee and child(ren) are enrolled in this program.

■ Certificate of Creditable Coverage

A document provided by a health program which documents the amount of previous qualified health coverage. Certificates are used to provide coverage credit for health insurance pre-existing condition clauses.

■ Contract Administration

An arrangement in which a plan hires a third party to handle administrative services such as claims processing while the plan bears the risk for the claims. Great West Health Care is contracted under an Administrative Services Only contract for the State of Wyoming.

■ Covered Entity

An employer who is required by statute to participate in the State of Wyoming for the Employees' and Officials' Group Insurance Program. Covered Entities include, but not limited to, the State of Wyoming, University of Wyoming, Wyoming Business Council, and the Wyoming Community Colleges.

■ Creditable Coverage

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools, the Federal Employee Health Benefit Plan (FEHBP) or a State Children's Health Insurance Program (S-CHIP).

■ Creditable Health Care

Under HIPAA, health care coverage without a significant break in coverage (a period of 63 consecutive days), which may be credited towards pre-existing waiting periods.

■ Dentist

A person licensed to practice dentistry.

■ Dependent

- Your legal spouse, as recognized by the State of Wyoming;
- Any unmarried child under the age of 19 until the last day of the month the child turns 19; or
- An unmarried child under the age of 25 if he or she is a full-time student until the earlier of the last day of the month the child turns 25 or is no longer a full-time student. Before paying a claim, the Plan may require proof that this child is a full-time student. If a student is a covered dependent under the plan in the spring of the year, they will remain covered until August 31st of the same year.

  For medical and prescription drug benefits, these age limits do not apply to a child who cannot support himself or herself due to a physical handicap or mental retardation. At reasonable intervals, but not more often than annually, the Plan requires a Physician's statement as proof of the child's handicap.

  Any eligible dependent child who is not self-supporting due to developmental disabilities or physical handicap must have been covered under the plan on the day before the date the child would otherwise lose dependent status due to reaching age 19. The developmental disability or physical handicap must have occurred prior to reaching age 19.

  The term "child" means your children. This includes any legal step-child, adopted child, foster child, or any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party. (See Section C "Pre-Existing Conditions"). Legal documents must be provided at the time you enroll eligible children in one of these categories. Such statements will be legally binding and may have additional tax consequences. Statements concerning the legal responsibility for care cannot be made for limited purposes including but not limited to education and/or insurance purposes only.

For a child to be considered a Dependent, the child must be chiefly dependent upon you for financial support from age 19 to 25.

The plan will allow coverage for a dependent child, if the employee has been appointed as permanent legal guardian and if the dependent child is a resident in the employee's home.

Your Dependents must live in the United States or Puerto Rico to be eligible for coverage.

A person who is covered under this Plan as an Employee may not be covered as a "Dependent". A child may not be covered as a "Dependent" of more than one Employee.

■ Emergency Medical Condition

The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to believe that immediate medical care is required and that lack of such care could reasonably be expected to result in:

- placing the patient's life in serious jeopardy;
- serious Injury or impairment of bodily functions; or
- serious or permanent dysfunction of any bodily organ or part;
- with respect to a pregnant woman, placing the woman's health, or that of her unborn child, in serious jeopardy.

■ Employee

A person in the Service of the Employer.

This includes a Retired Employee as defined later in this section.

"Employee" only includes a person who is a resident of the United States or Puerto Rico.

Employee Contributions

The amount an employee is required to pay in premiums to participate in a plan.

Employer

- THE STATE OF WYOMING

Employer Contributions

The amount an employer contributes towards premium on behalf of an eligible participant of a plan.

Experimental Investigational or Unproven

A service or supply, such as medication, that meets any of the following criteria:

- For a service or supply that is subject to Food and Drug Administration (FDA) approval:
  - it does not have FDA approval; or
  - it has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.

  An accepted off-label use is a use that is:
  - established based on reliable evidence as defined in this provision; or
  - is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Medical Management, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or
- Is being provided pursuant to phase I, II, III or IV clinical trials, unless in the case of phase III or phase IV clinical trials is provided in accordance with the clinical trials coverage described in the Plan ; or
- Is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
- Is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as experimental, investigational, unproven or for research; or
- 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 Department of Health & Human Services (HHS) and the FDA; or
- Based upon review and analysis of the published peer-reviewed medical literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
  - is substantially confined to use in research settings; or
  - is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
  - is experimental, investigational, unproven; or
- Is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
- Is not currently the subject of active investigation because prior investigations and/or studies have failed to established proven efficacy and/or safety.

In making the determination whether a service or supply is Experimental, Investigational or Unproven, Medical Management reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, "reliable evidence" means evidence of all of the following:

- There are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
- The published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
- The investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.

■ Family Contract

Coverage where the employee, spouse and child(ren) are enrolled in this program.

■ Hospital

Any of the following:

- An institution that meets all of the requirements shown below. It must:
  - Be legally established as a hospital.
  - Be open at all times.
  - Be operated chiefly for the care of sick and injured persons as in-patients.
  - Have a Physician available at all times.
  - Have a registered nurse on duty at all times.
  - Have organized facilities for diagnosis and major surgery. For treatment of mental illness an institution that does not have surgical facilities will still qualify as a hospital if it satisfies the definition of a "Hospital" in all other respects.
  - Satisfy requirements, other than those above, specified by the law of the state where the covered person lives.
  - Not be chiefly:
    * A clinic.
    * A nursing home.
    * A rest home.
    * A convalescent home or similar place.
    * A place for treatment of alcoholism or substance abuse, unless required by state law.
    * A place for the kind of care that helps a person meet the activities of daily living.
- If state law so requires, an institution that meets all of the requirements shown below. It must:
  - Provide treatment for a specific condition.
  - Be licensed by the state licensing body or approved by the department responsible for such facilities in the geographical area in which it is located.
  - Provide recognized treatment for the condition for which it is licensed or approved to operate.

■ Illness

- An accidental bodily injury; or
- A bodily disorder; or
- A mental/nervous or substance abuse condition; or
- Pregnancy.

Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

A mental/nervous or substance abuse condition is a condition that is classified by the International Classification of Diseases as a psychiatric condition.

What is considered an "Illness" will be determined by Great-West.

Illness will include any congenital defect of a newborn child.

Treatment of weight loss will not be considered treatment of an Illness unless the covered person is morbidly obese. Morbid obesity will be determined by Great-West.

Family history will not be considered an Illness.

■ Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

■ Insurance Fraud

Fraud occurs when you knowingly lie to obtain some benefit or advantage to which you are not otherwise entitled. Examples of health insurance fraud are:

- Providing false information to obtain benefits under the plan; or
- Adding Dependent(s) to the plan who are ineligible based upon the Plan's definition of a Dependent. This can include claiming a Dependent is a full-time student when they would otherwise not be eligible for benefits or claiming someone as a legal spouse who does not meet the definition of legal spouse as defined by the Plan.

■ Medically Necessary/Medical Necessity

Health care services and supplies, such as medication, that a Physician, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and
- Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and
- Specifically allowed by the licensing statutes which apply to the Physician who provides the service or supply; and
- At least as medically effective as any standard care and treatment; and
- Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician or other health care provider; and
- Not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" mean the:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Recommendations of an American Medical Association-recognized Physician specialty society;
- Prevalent practices of Physicians in the relevant clinical area; or
- Any other relevant factors.

Medical Management may require satisfactory proof in writing that any type of Treatment, service or supply received is Medically Necessary. Medical Necessity will be determined solely by Medical Management, in accordance with the definition above.

The fact that a Physician may prescribe, order, recommend or approve a service does not, in itself, make such service or supply Medically Necessary.

Medical necessity does not include any:

- Experimental treatment, service or supply; or
- Service or supply that is for the psychological support, education or vocational training of the covered person; or
- Implant of any artificial organ for any reason whatsoever.

■ Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

■ Member

An Employee/Retiree and any covered Dependent.

■ Physician

A person licensed to practice medicine or osteopathy. Physician also includes any other practitioner of the healing arts if he or she performs a service:

- Within the scope of his or her license; and
- For which this Plan provides coverage.

This includes a Christian Science Practitioner who is listed in the current Christian Science Journal.

■ Plan

THE STATE OF WYOMING (the Employer) has established an Employee Welfare Benefit Plan. The benefits described in this booklet constitute benefits available under the plan and are referred to collectively in this booklet as "the Plan."

■ Qualifying Event

An occurrence that may entitle a person to make changes to their benefit elections. Examples include termination of employment, reduction in hours, death of employee, divorce, a dependent child's loss of dependent status, a significant change in benefits or premium that results in an additional cost of at least 35%, etc.

■ Reserves

Funds set aside by a self-funded plan to assure the fulfillment of commitments for future claims. These funds are designed to pay for the estimated liability for unpaid insurance claims (losses) that have occurred as of a given date. The estimated liability includes losses incurred but not reported (IBNR), claims being adjusted and amounts to be payable in the future. Reserves also protect a Plan from fluctuations in claims payments where higher than anticipated claims are incurred and paid.

■ Retiree

An Employee who:

- has been retired from active Service with the Covered Entity; and
- has made application with the Employees' Group Insurance within 31 days of termination to continue coverage; and
- has had medical coverage in effect under the Covered Entity's plan for at least one year prior to retirement; and either
  - has attained at least age 50 on the date he retires; and
  - just prior to the date of his retirement had completed at least 4 years of Service for the Covered Entity and is eligible for State of Wyoming Retirement Benefits/TIAA CREF; or
  - is eligible for State of Wyoming Retirement Benefits/TIAA CREF; and
  - just prior to the date of his retirement had completed at least 20 years of Service with the Covered Entity.

Retirees are eligible for Medical and Prescription Drug benefits.

■ Self-Insurance

A self insured plan is where the employer is acting as an insurance company. The employer pays claims with the money ordinarily earmarked for premiums. The State of Wyoming health program is a self funded medical plan which means that the State is the "insurance company" for our healthcare. This allows the State to minimize our costs while maximizing the money available to pay your medical claims which lowers our medical premium rates.

■ Service

Work with the Employer:

- on an active, regular basis; and
  - for at least 80 hours per calendar month; or
  - be classified as a position sharing Employee.

If you are a Retiree, "Service" means the period during which you are retired according to the definition of "Retiree" in this section.

■ Significant Break in Coverage

Under HIPAA, a period of 63 consecutive days during which an individual does not have any creditable health care.

■ Single Contract

Coverage where only the employee is enrolled in this program.

■ Split Contract

Coverage where both husband and wife, ***with eligible dependents***, are employed by Covered Entities and covered under this Plan.

■ Totally Disabled and Total Disability

Being under the care of a Doctor and prevented by Illness or injury:

- In your case, from performing your regular work; and
- In the case of your Dependent, from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

■ You and Your

An Employee.

Security Regulations

The Plan will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160,162, and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained, or transmitted on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, of (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan shall, in accordance with the Security Regulations:

Security Regulations - Continued

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits.
- Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan will use ePHI only for Plan administration activities and not for employment-related actions of for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.
- Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measure to protect the information.
- Report any Security Incident of which it becomes aware.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the medical and prescription drug coverage that you (the Employee) had in effect for yourself and your Dependents.

"Uniformed Service" means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Medical and Prescription Drug Coverage

Under USERRA, you are eligible to elect continued medical and prescription drug coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued medical and prescription drug coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer's reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

For medical coverage, a pre-existing condition limitation may be imposed on an Illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Administrator for details.

Continuation of Coverage During Family and Medical Care Leave

Eligible Employees are any Employees who:
- Have been employed for at least 12 months by the Employer; and
- Have worked for at least 1,250 hours with the Employer during the previous 12 months; and
- Are covered for benefits under this Plan.

If you have to attend to any of the following family needs:
- The birth or adoption of your child; or
- Placement of a child in your custody for foster care; or
- To care for your spouse, child, or parent with a serious health condition; or
- Your serious Illness that makes you unable to perform the functions of your job;

then you may be eligible for unpaid Family and Medical Care Leave, for up to a maximum period of 12 work weeks during any 12-month period. This period will include any period of family or medical leave provided under any state or local law.

Coverage for the benefits provided under this Plan will be continued for you and your eligible Dependents while you are on Family and Medical Care Leave. Coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his/her eligible Dependents on the date of your leave.

Your Employer may grant a Family and Medical Care Leave request and continue contributions for your coverage under appropriate personnel rules. If you do not return to employment following a Family Medical Care Leave, your Employer may request a refund of employer contributions made on your behalf in accordance with appropriate personnel rules.

Your Employer may refuse to grant a Family and Medical Care Leave request under certain circumstances.

Should you have any questions about Family and Medical Care Leave, see your Plan Administrator for details.

CONTINUATION OF COVERAGE - COBRA

This provision generally explains COBRA continuation coverage, when it may become available to a Member and what a Member needs to do to protect the right to receive it. COBRA continuation coverage, is a temporary extension of coverage under the Plan, and was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In some circumstances, COBRA requires that Members who lose group Medical and Prescription Drug plan coverage to be given an opportunity to continue that coverage when there is a "qualifying event" that would result in a loss of coverage under the Plan. A "qualified beneficiary" is a person who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, qualified beneficiaries can include the Employee and/or the Employee's spouse or Dependent children. COBRA continuation coverage must be offered to each qualified beneficiary and the coverage is the same coverage that other Members under the Plan who have not had a qualifying event have. Each qualified beneficiary will have the same rights under the Plan as other Members, including open enrollment and special enrollment rights.

Right to COBRA Continuation Coverage

- As an Employee, you have a right to choose COBRA continuation coverage, if you lose your coverage due to a reduction in your hours of employment, or due to voluntary or involuntary termination of your employment, for any reason except gross misconduct.
- As a Dependent spouse, you have the right to to choose COBRA continuation coverage, if you lose your coverage due to the Employee's death, or the Employee's termination of employment or reduction in hours of employment, as stated above, or due to your divorce or legal separation. If the Employee cancels your coverage in anticipation of your divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you have lost coverage earlier.
- Your Dependent Child, including alternate recipients under QMCSO have the right to choose COBRA continuation coverage if the Dependent Child loses coverage due to the reasons stated above or ceases to be an eligible Dependent under the terms of the Plan.
- As a retired Employee, in addition to COBRA continuation rights as stated above, you have a right to choose COBRA continuation coverage, if you lose your coverage due to and within one year before or after the Employer's filing a proceeding in bankruptcy under Chapter 11 of the Bankruptcy Code. Your eligible Dependents will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Length of COBRA Continuation Coverage

Generally:

- In the case of loss of coverage due to termination of employment or reduction in hours of Service, coverage may be continued for those who elect continuation coverage, for up to 18 months from the date of the qualifying event.
- In the case of loss of coverage due to your death, divorce or legal separation, or a Dependent Child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for those who elect continuation coverage, for up to 36 months from the date of such event.
- If an Employee becomes entitled to Medicare and later has a qualifying event, which is a termination of employment or reduction of hours, within 18 months of entitlement to Medicare, then the maximum coverage period for the Dependent spouse and children will be 36 months which begins from the date the Employee becomes entitled to Medicare.
- With respect to Members qualified for COBRA continuation coverage due to the Employer's bankruptcy filing as described above, those who lose coverage may elect continuation coverage. The coverage will continue for up to:
  - the date of your death, if you are retired; or
  - the date of the surviving spouse's death; or
  - 36 months after your death if your Dependent elected COBRA continuation coverage.
- If, after the occurrence of any event described in the Right to COBRA Continuation Coverage above, the Member is allowed to continue coverage under the Plan (whether or not contributions are required) beyond the Plan's termination of coverage provision for any reason other than to comply with the federal law (i.e. state laws mandating continuation coverage or the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this provision.

CONTINUATION OF COVERAGE - COBRA - Continued

Extension of COBRA Continuation Coverage

- *Disability Extension* - If you lose coverage because of termination of your employment or reduction in your hours of employment, and if anyone in your family unit is determined under Title II or XVI of the Social Security Act to have been Totally Disabled at any time during the first 60 days of COBRA continuation coverage, then the Totally Disabled Member and other qualified beneficiaries who are entitled to COBRA continuation coverage may extend the continuation for 11 additional months.
- *Second Qualifying Event* - If your Dependent:
  - is covered under COBRA because of termination of your employment or reduction in your hours of employment; and
  - while covered under COBRA experiences a second qualifying event, such as a divorce or legal separation or ceasing to be an eligible Dependent;

  then such qualified beneficiaries are entitled to up to a maximum of 36 months of COBRA coverage from the date of the first qualifying event.

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Employer or the representative of the Employer has been timely notified that a qualifying event has occurred.

When the qualifying event is termination of employment, reduction of hours of employment, death of the Employee or commencement of a proceeding in bankruptcy (applicable only to covered Retired Employees and their Dependents), the Plan Administrator will notify the Employee within 44 days of the later of the date of the qualifying event or the date coverage ends.

Dependents - If your spouse or Dependent children become eligible for COBRA continuation coverage due to divorce or legal separation or end of dependency status, or upon occurrence of a second qualifying event, the Plan Administrator or the representative of the Employer must be notified within 60 days of the first or the second qualifying event. The notice must be provided following Reasonable Notice Procedures, as described below.

If the notice is not provided within 60 days of the qualifying event, your spouse or Dependent children will lose the right to such coverage.

If you have a child or adopt a child while covered under COBRA, and you decide to add the child to your COBRA continuation coverage, then you must notify the Plan Administrator or the representative of the Employer of the birth or adoption within the 30 days of birth, adoption or placement for adoption in order for the child to be considered a COBRA qualified beneficiary. The notice must be provided following Reasonable Notice Procedures, as described below.

Disability Extension - A Member who wishes to continue COBRA continuation coverage under the Disability Extension must notify the Plan Administrator or the representative of the Employer of the Social Security Administration's disability determination within 60 days of such determination and before the end of the initial 18-month COBRA coverage period. If the notice is not provided within the specified timeframe, the qualified beneficiary and the members of the family unit will lose the right to extend COBRA coverage under the Disability Extension.

If the Social Security Administration determines that the qualified beneficiary's disability ceases to exist, then the qualified beneficiary must notify the Plan Administrator or the representative of the Employer of this information within 30 days of such determination.

The notice must be provided following the Reasonable Notice Procedures, as described below.

Reasonable Notice Procedures

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. The qualified beneficiary must mail the notice to the contact person at the address specified below:

THE WYOMING STATE EMPLOYEES'
AND OFFICIALS' GROUP INSURANCE PLAN
EMERSON BUILDING, #106
CHEYENNE, WY
82002-0430

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries, the qualifying event and the date of the qualifying event. If a qualifying event is a divorce, the notice must include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary, spouse or parent, if applicable, or by an authorized representative of the qualified beneficiary.

Election of COBRA Continuation Coverage

When a qualifying event occurs, the Employer or a representative of the Employer must give the qualified beneficiary the necessary COBRA election form. The qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice or the date the qualified beneficiary would lose coverage, whichever is later. To elect coverage, the qualified beneficiary must follow the procedures specified in the Election Form. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If the qualified beneficiary does not elect coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The qualified beneficiary has the right to change a prior rejection of COBRA continuation coverage anytime within the 60-day election period by following the procedures specified in the Election Form. Failure to continue this coverage will affect future rights under federal law, such as the right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion.

Cost of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the applicable group rate.

If a qualified beneficiary elects to continue coverage, the qualified beneficiary must make the first payment for continuation within 45 days of the election. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the qualified beneficiary fails to make the first payment, they will lose the continuation coverage rights under the Plan. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the qualified beneficiary makes the first payment for continuation coverage, they will be required to pay for continuing the coverage for each subsequent month of coverage; they will be given a grace period of 30 days to make each periodic payment. The coverage will be continued as long as payment for that period is made before the end of the grace period.

The Plan may require payments of up to 150% of the applicable group rate if coverage is extended under the ***Disability Extension***.

Termination of COBRA Continuation Coverage

The COBRA continuation coverage may terminate before the maximum period of continuation runs out if:

- The required contribution is not paid; or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (except for a person whose continuation coverage right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code); or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition limitation for a pre-existing condition of a qualified beneficiary; or
- After the date the qualified beneficiary qualifies under the ***Disability Extension***, the beneficiary is no longer disabled; or
- All of Employer's group health plans are terminated.

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under another group health plan or that the beneficiary is no longer disabled within 30 days of the event. The notice must comply with the Reasonable Notice Procedures, described above. The Employer or its representative will notify the qualified beneficiary of the termination of coverage if it happens prior to the maximum period of COBRA continuation coverage.

For more information about COBRA continuation of coverage, a Member may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

In order to protect your rights and your Dependent's rights, you should keep the Plan Administrator informed of any changes in the address of family members.

The Trade Act of 2002

The Trade Act of 2002 created special second COBRA election period for certain displaced workers receiving Trade Adjustment Assistance (TAA) under the Trade Act of 1974. A Member who did not elect COBRA continuation coverage during the initial 60-day election period that was a direct consequence of the TAA-related loss of coverage, may elect COBRA continuation coverage during a second 60-day period that begins on the first day of the month in which the Member is determined to be "TAA-Eligible". The election must be made within 6 months after the date of the TAA-related loss of coverage.

Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.