
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
9634
WYOMING LAWYERS HEALTH BENEFIT PLAN**

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INTRODUCTION

This document is a description of Wyoming Lawyers Health Benefit Plan (the Plan). **No oral interpretations can change this Plan.** The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. **This Plan is effective September 1, 2010**

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Plan Sponsor fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Health Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Responsibilities for Plan Administration, ERISA, HIPAA and General Plan Information. Explains requirements for plan administration, including ERISA requirements and information privacy and security.

SCHEDULE OF BENEFITS

Verification of Eligibility 307-426-5500 or 800-246-4622

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

- Inpatient Hospitalizations**
- Inpatient / Partial Hospitalization Mental Disorder Treatments**
- Hospitalizations**
- Substance Abuse/Mental Disorder treatments**
- Skilled Nursing Facility stays**
- Home Health Care**
- Hospice Care**
- Outpatient surgical procedures**
- Chemotherapy and Radiation**
- Clinical Trials**

Pre-certification:

Mountain States Review
888-304-3804 or 307-426-5500

Please see the Health Management section in this booklet for details.

PRIOR APPROVAL / PRE-AUTHORIZATION:

This Plan requires prior approval before the participant receives certain services, supplies, or procedures. The participant or his or her health care provider must request prior approval from the Claims Administrator at **800-246-4622**. Prior approval determines whether a proposed treatment plan is an eligible expense under the Plan. Without prior approval for certain services, a proposed treatment plan may not be a covered benefit.

Note: The following is a list of services for which prior approval is required:

- Breast or other Reconstructive surgery**
- Home Health Care**
- Dental Procedures for non-dental reasons**
- Morbid Obesity surgery**
- Organ Transplants**
- Hospice Care**
- Nursing Facility**

Please note: An inpatient admission for an approved procedure will also require Pre-Certification notification 888-304-3804.

At the participant's request, his or her health care provider will request prior approval by submitting the

appropriate information. Unless otherwise required by law, the Claims Administrator will determine if the requested service is a covered expense under the Plan from the written information provided by the participant's health care provider. After reviewing the participant's request, the Claims Administrator will notify the participant and his or her health care provider of the decision within seventy-two (72) hours if his or her request involves a medically urgent situation or within maximum of fifteen (15) days in a non-medically urgent situation, unless additional information is needed.

- if the participant's request is approved, he or she knows his or her Plan covers the specific services or procedures. **Please note:** An inpatient admission for the approved procedure will then require Utilization Review; or
- if benefits are denied, the participant will receive written notice in which the reason(s) for denial will be listed. The notice will be mailed to the most current addresses we have on record for the participant and his or her health care provider.

Certain factors may alter or impact whether the participant receives approval. These factors include benefit limitations, continued Plan participation, and the date he or she receives services. If the participant request for prior approval is denied in whole or in part, the participant may appeal the benefit denial or reduction as explained in How to Submit a Claim. See page 61 How to Submit a Claim.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

ALTERNATE TREATMENT UNDER CASE MANAGEMENT

In cases where a covered person's condition is expected to be or is of a serious nature, the Claims Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Claims Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of the patient's care.

PREFERRED PROVIDERS

Your medical bills can be reduced if you use physicians, clinics and/or hospitals that are network members of the following Preferred Provider Organizations:

Mountain Benefit Associates www.mba-national.com

Amera-Net www.aghealth123.com

Health InfoNet www.healthinfonetmt.com

Multiplan www.multipan.com

You can determine who the member providers of these PPO's are by:

1. Asking your physicians office or facility billing office; or
2. Calling MBA or your employer and have them review the directories of medical providers; or
3. Visit the MBA website at www.mba-national.com and click on *Members* then click on *PPO's*.

The physicians and facilities that have contracted with these PPO's have agreed to accept discounts for their services. In turn, your overall bills are reduced and your individual out-of-pocket expense will be less each time you have the opportunity of using one of these PPO's.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge

reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

(Applies to HDHP Plans 1 & 2 only)

High Deductible Health Plan A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Deductibles and certain Copayments are payable by Plan Participants.

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Plan Year per Covered Person or Family Unit. Each **September 1st**, a new deductible amount is required. For family coverage, the deductible must be met as a Family Unit, without regard to which family member incurred the expenses. For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge.

Billing Error Incentive: If you find an error in your medical bill (where the provider has charged you for items or services you did not receive), the plan will compensate you 25% of the amount saved (subject to a twenty dollar (\$20.00) Minimum savings), after the corrected bill has been received by Mountain Benefits Associates.

The Cost Sharing Provisions are only a summary. All other Policy maximums, limits and exclusions apply.

Benefit Description	Basic Plan	Value Plan	Standard Plan	Premium Plan	HDHP Plan 1	HDHP Plan 2
Deductible per Insured.	\$2,000	\$1,500	\$1,000	\$500	\$2,500	\$5,000
Deductible per covered family.	\$4,000	\$3,000	\$2,000	\$1,000	\$5,000	\$10,000
Out-of-Pocket Maximum.	\$4,000	\$3,500	\$3,000	\$1,000	\$2,500	\$5,000
Out-of-Pocket Maximum per covered family.	\$8,000	\$7,000	\$6,000	\$2,000	\$5,000	\$10,000
Lifetime Maximum for all causes.	None	None	None	None	None	None
Physician office visit. The Co-payment applies only to those charges for evaluation and management that are performed in an office by the provider.	\$30 copay (first 4 visits), then deductible and coinsurance applies	\$30 copay (first 4 visits) then deductible and coinsurance applies	\$30 copay, deductible waived	\$20 copay, deductible waived	100% after deductible	100% after deductible
Coinsurance In-Network	60%	80%	80%	80%	100%	100%
Coinsurance Out-of-Network	50%	60%	60%	60%	100%	100%
Preventive services :	100% of the first \$500	100% of first \$500	100% of the first \$500	100% of first \$500	100%	100%

MAXIMUMS AND LIMITATIONS:

See also the Policy for the section on Medical Benefits. That section contains a more complete explanation of the covered services listed below.

ACCIDENTAL INJURY BENEFIT

Deductible	Waived
Benefit Percentage.....	100%
Maximum Benefit per Accident.....	\$500

The Accidental Injury Benefit is not available for HDHP Options

ALCOHOLISM, AND / OR CHEMICAL DEPENDENCY

Benefits for **Alcoholism and Chemical Dependency** are paid the same as any other medical condition, and are subject to the same annual or lifetime maximum limits

CHIROPRACTIC CARE

Maximum Number of Treatments per Benefit Period	35
Maximum Benefit per Treatment	\$25
Maximum Benefit for Diagnostic X-rays per Benefit Period	\$100

"Treatment" includes all services provided during a calendar day, except for X-rays.

DIABETIC EDUCATION BENEFIT

Outpatient Expenses

Maximum Benefit per Benefit Period	\$250
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"Outpatient Expenses" means any outpatient self-management training and education for the treatment of diabetes. Such training and education must be provided by a **Provider** with expertise in diabetes.

HOME HEALTH CARE

Maximum Number of Visits per Benefit Period	180
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HOSPITAL LIMITATIONS

Hospital Room and Board Limitation	Average Semi-private
Intensive Care Unit Limitation.....	Maximum Eligible Expense

SEVERE MENTAL ILLNESS

Benefits for **Severe Mental Illness** are paid the same as any other medical condition. They will not be subject to any annual or lifetime limits for **Mental Illness**.

MENTAL ILLNESS

Benefits for **Mental Illness** are paid the same as any other medical condition, and are subject to the same annual or lifetime maximum limits

MAMMOGRAMS

Deductible Waived, Benefit Percentage	100%
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PREVENTIVE CARE

Routine **Outpatient** Well-child Care (birth through 2 years of age).

Deductible Waived, Benefit Percentage	100%
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Immunizations (CDC Recommended).

Deductible Waived, Benefit Percentage	100%
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Routine Prostate Specific Antigen (PSA) Test

Deductible Waived, Benefit Percentage	100%
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Routine Office Visit See Cost Sharing Provisions.

ORTHOTIC SUPPLY

Maximum Benefit Per **Benefit Period**\$350
Maximum Benefit per Lifetime \$700

DURABLE MEDICAL EQUIPMENT ("DME")

Maximum Benefit per **Benefit Period** \$15,000
Maximum Benefit per Lifetime \$30,000

PROSTHETIC APPLIANCE

Maximum Benefit per **Benefit Period**\$15,000
Maximum Benefit per Lifetime \$30,000

REHABILITATION THERAPY

Maximum Benefit per **Lifetime** - Inpatient..... \$100,000
Maximum Benefit per **Benefit Period** - Outpatient..... \$5,000

Physical Therapy

Maximum Benefit per **Benefit Period**\$5,000

Speech Therapy

Maximum Benefit per **Benefit Period**\$5,000

Occupational Therapy

Maximum Benefit per **Benefit Period**\$5,000

HOSPICE CARE

Maximum Benefit per **Benefit Period**\$10,000
Maximum Benefit per Lifetime \$20,000

ORGAN AND TISSUE TRANSPLANT SERVICES

Deductible applies, **Benefit Percentage**..... Applies

PRESCRIPTION DRUG BENEFITS

Basic Plan	Value Plan	Standard Plan	Premium Plan	HDHP Plan 1	HDHP Plan 2
Generic Insured pays the first \$20 of cost on covered generic drugs	Generic Insured pays the first \$10 of cost on covered generic drugs	Generic Insured pays the first \$10 of cost on covered generic drugs	Generic Insured pays the first \$10 of cost on covered generic drugs	Covered under medical plan with prescription discount card, including specialty prescriptions	Covered under medical plan with prescription discount card, including specialty prescriptions
Preferred Brand Insured pays the first \$100 prescription drug deductible on formulary drugs, then the greater of \$20 or 30% of cost on covered formulary drugs.	Preferred Brand Insured pays the first \$100 prescription drug deductible on formulary drugs, then the greater of \$10 or 20% of cost on covered formulary drugs.	Preferred Brand Insured pays the first \$100 prescription drug deductible on formulary drugs, then the greater of \$10 or 20% of cost on covered formulary drugs.	Preferred Brand Insured pays the first \$100 prescription drug deductible on formulary drugs, then the greater of \$10 or 20% of cost on covered formulary drugs		
Brand Non-Preferred Insured pays the first \$100 prescription drug deductible on non-formulary drugs, then \$40 plus 50% on non-preferred drugs	Brand Non-Preferred Insured pays the first \$100 prescription drug deductible on non-formulary drugs, then \$20 plus 50% on non-preferred drugs	Brand Non-Preferred Insured pays the first \$100 prescription drug deductible on non-formulary drugs, then \$20 plus 50% on non-preferred drugs	Brand Non-Preferred Insured pays the first \$100 prescription drug deductible on non-formulary drugs, then \$20 plus 50% on non-preferred drugs		
Mail Order Mail order co-pay= 2 x retail co-pay	Mail Order Mail order co-pay= 2 x retail co-pay	Mail Order Mail order co-pay= 2 x retail co-pay	Mail Order Mail order co-pay= 2 x retail co-pay		
Specialty Drugs Insured pays 30% of cost; deductible waived.	Specialty Drugs Insured pays 30% of cost; deductible waived.	Specialty Drugs Insured pays 30% of cost; deductible waived.	Specialty Drugs Insured pays 30% of cost; deductible waived.		
Annual out-of-pocket max of \$2,500 per member	Annual out-of-pocket max of \$2,500 per member	Annual out-of-pocket max of \$2,500 per member	Annual out-of-pocket max of \$2,500 per member		

**The Insured is responsible for payment of charges that exceed the Policy's benefits.
Unless otherwise indicated in the Policy, the Deductible and Benefit Percentage above apply to all benefits.**

VISION CARE BENEFIT SCHEDULE

COVERED CHARGES	BENEFIT
Eye Exam per Covered Person in a 12 month period.	100% up to \$50
Frame-type Lenses per pair, in a 24 month period. 1 Set Frames and Lenses or 1 Set Contact Lenses or 1 year supply of Disposable Contacts	\$150 maximum benefit per 24 month Benefit Period

Additional information on Vision Care can be found in the Vision Care Benefits section of this document.

DENTAL CARE BENEFIT SCHEDULE

DENTAL CARE DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	\$50
Calendar Year Deductible applies to these classes of services: Class B Services - Basic, Class C Services - Major and Class D Services - Orthodontia	
MAXIMUM BENEFIT AMOUNT	BENEFIT
For Class A - Preventive, Class B - Basic and Class C - Major Services Per Covered Person per Calendar Year	\$1000
For Class D - Orthodontia (benefit available for Dependents under age Dependent Children only) Lifetime maximum per Covered Person	\$1500
COVERED CHARGES	
Dental Percentage Payable	
Class A Services - Preventive	100%
Class B Services - Basic	80%
Class C Services - Major	50%
Class D Services - Orthodontia	50%

Additional information on Dental Care can be found in the Dental Benefits section of this document.

SUPPLEMENTARY ACCIDENT CHARGE BENEFIT

The Accidental Injury Benefit is not available for HDHP options.

(Expenses not eligible under this benefit may be considered under the Medical Benefits of this Plan)

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

- (1) the Injury is sustained while the person is covered for these benefits; and
- (2) the charge is for a service delivered within 90 days of the date of the accident; and
- (3) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits.

ACCIDENT CHARGE

An accident charge is a Usual and Customary Charge incurred for the following:

- (1) Physician services
- (2) Hospital care and treatment.
- (3) Diagnostic x-rays and lab tests.
- (4) Local professional ambulance service.
- (5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.
- (6) Nursing service.
- (7) Anesthesia.
- (8) Covered Prescription Drugs – paid only under guidelines of the Prescription Drug Benefit.
- (9) Use of a Physician's office or clinic operating room.

Chiropractic Care Services are specifically excluded under this benefit.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of participating Employers.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is an Active Employee of a participating Employer who works at least twenty (20), twenty-five (25), or thirty (30) hours per week (as designated by the Employer) and is on the regular payroll of the Employer for that work. Notwithstanding a designated minimum hours, an Employee granted a paid or unpaid sabbatical or maternity leave of no more than one year will remain eligible for Employee coverage if the participating Employer elects in the Plan Adoption Agreement to include such Employees as Plan Eligible Employees.
- (2) Is in a class eligible for coverage.
- (3) completes the employment Waiting Period. A "Waiting Period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective. Waiting period means the period that must pass before coverage for and employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and children from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children, Foster Children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be under the limiting age of 26.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

NOTE: Retired Employees are not eligible for coverage.

NOTE: Eligible Employees age sixty-five (65) and over have a choice of either:

- Retaining coverage under the Plan as their primary coverage while the federal Medicare program serves as secondary coverage; or
- Choosing the federal Medicare program as their primary coverage, in which case coverage for both the Employee and all covered Dependents under this Plan will terminate.

FUNDING

Cost of the Plan. This is a plan sponsor self-funded healthcare plan where participating Employer and covered Employee contributions are held in a welfare benefit trust fund. Participating Employers and the Plan Sponsor assume the financial risk of healthcare coverage for Plan participants. Healthcare costs are paid to the healthcare provider from the welfare benefit trust fund, rather than by an insurance company.

Contributions made to this Plan are used to pay claims and associated expenses of this Plan. The Plan Administrator and Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the required combined participating Employer and covered Employee contributions for the offered benefit options.

If Employer and covered Employee contributions are inadequate to fund this Plan, the Participant may be financially responsible for any incurred and unpaid claims. The Claims Administrator assumes no financial liability. The level of covered Employee contributions are set by each participating Employer after taking into consideration the minimum required Employer contributions set by the Plan Sponsor.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator:

Mountain Benefit Associates
P.O. Box 98 – 809 South Railway Avenue
Worland, Wyoming 82401
800-246-4622 or 307-426-5500

Covered Charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred **12 consecutive months, or 18 months if a Late Enrollee** after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within **six months** prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under any Creditable Coverage. A child has Creditable Coverage within 31 days if the child's expenses are covered under the parent's coverage during that period, either under this

Plan or another plan, whether or not the child is ever enrolled in that Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first **63-consecutive day** period during all of which the individual was not covered under any Creditable Coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also. When applying Creditable Coverage to the Pre-Existing Condition limitation, the Plan is not required to take into account any days of Creditable Coverage that precede a break in coverage of **63 days** or more.

Enrollment Requirements for Newborn Children.

Hospital charges incurred by a healthy newborn during the initial period of hospital confinement, will be covered as charges of the mother, provided the newborn is discharged prior to or on the same day as the mother and the mother was covered for the pregnancy. Baby's **routine** delivery charges will be covered as charges of the mother only if the newborn is a **well** baby. Beginning seven (7) days after their dates of birth, eligible newborn children become subject to their own individual deductible for each calendar year. If the newborn is ill, suffers an injury, or requires care other than routine care, the baby's charges will not be covered as charges of the mother.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than **31 days** after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. **Coverage begins on September 1,**

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within **31 days** after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within **31 days** after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator:

Mountain Benefit Associates
PO Box 98 or 809 S Railway Ave.
Worland, WY 82401
307-426-5500 or 800-246-4622

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:
 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

- (e) This Plan will also permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current employee or dependent lost eligibility under Medicaid or CHIP.

The current employee must request enrollment into this Plan not later than **60 days** after the event, as described above. For an eligible current employee or dependent who has met the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within the required days from loss of coverage.

- (2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:
 - (a) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
 - (b) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
 - (c) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

- (3) **Dependent beneficiaries.** If:
 - (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
 - (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of **31 days** and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this **31 day** period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
 - (b) in the case of a Dependent's birth, as of the date of birth; or
 - (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (4) **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:
- (a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within **60 days** after such Medicaid or CHIP coverage is terminated.
 - (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within **60 days** after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (5) The date the covered Employee's Eligible Class is eliminated.
- (6) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: From the first day of disability until the end of that month in which Disability coverage was in effect.

For leave of absence or layoff only: From the first day of the leave of absence or layoff until the end of that month in which leave of absence or layoff coverage was in effect.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Claims Administrator:

Mountain Benefit Associates
PO Box 98 or 809 S Railway
Worland, WY 82401
307-426-5500 or 800-246-4622

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every **August 1st through August 31st**, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective **September 1st** and remain in effect until **September 1st** of the following year unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **September 1st**. A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage. Plan Participants will receive detailed information regarding open enrollment from their Employer.

A plan participant who failed to make an election during open enrollment will retain their current coverage.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

CO-PAY

A Co-pay is the predetermined amount paid by the participant or covered dependent on a per item or per service basis. Co-pays will never increase to 100% or accumulate toward satisfaction of the deductible, coinsurance or coinsurance limit.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to all plans and benefit options offered under the Wyoming Lawyers Health Benefit Plan, including the ones described in this document.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Group health plans generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage of Pregnancy for a Dependent child.

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
- (a) the patient is confined as a bed patient in the facility; and
 - (b) the confinement starts within 14 days of a Hospital confinement of at least 3 days; and
 - (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
 - (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Charge that is allowed for the

primary procedures; 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures. If bi-lateral or multiple procedures through separate incisions are performed, no more than 75% of Usual and Customary will be allowed. If the procedure being performed is exempt from "multiple procedure guidelines" according to the CPT guidelines, procedures will be payable at the normal rate based on Usual and Customary Charges.

- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed 125% of the Usual and Customary percentage allowed for that procedure. Each surgeon will receive 50% of the 125% allowed.
 - (c) If for Tubal Ligation performed at the same time as a cesarean section, the procedure will be allowed at 50% of the Usual and Customary fee allowance, payable as allowed in the Schedule of Benefits.
 - (d) For tubal ligation performed at the same time as a vaginal delivery, the procedure will be allowed at 100% of the Usual and Customary fee allowance, payable as allowed in the Schedule of Benefits.
 - (e) If an M.D. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 25% of the surgeon's Usual and Customary allowance.
 - (f) If a P.A., R.N. or N.P. Assistant surgeon is required; the assistant surgeon's covered charge will not exceed 10% of the surgeon's Usual and Customary allowance.
- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:
- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Prior approval is required.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as

being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits. **Prior approval is required.**

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

- (8) **Diabetes Education and Training.** Charges for outpatient self-management training and education for diabetes are covered if prescribed by a health care professional. Outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. Covered outpatient self-management training and education shall be limited to a one-time evaluation and training program when medically necessary, within one year of diagnosis. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition or treatment. This additional training shall be limited to three hours per year.
- (9) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
- (a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
 - (b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
 - (c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
 - (d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
 - (e) Initial **contact lenses** or glasses required following cataract surgery.
 - (f) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
 - (g) Care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of **infertility**.
 - (h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.
 - (i) Treatment of **Mental Disorders and Substance Abuse.** For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate

lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Biofeedback charges are **not** covered under this plan.

- (j) **Breast Reduction Surgery.** Charges for breast reduction surgery will be covered if breast size is contributing to documented physical health conditions and a minimum of 350 grams per breast is removed. **Prior approval is required.**
- (k) **Pre-Admission Testing.** Charges for diagnostic tests performed on an outpatient basis prior to a scheduled non-emergency hospital admission, for reasons other than pregnancy are covered.
- (l) **Second & Third Surgical Opinion.** Expenses for a second surgical opinion for a surgical procedure are covered. If the second surgeon disagrees with the recommendation of your physician, a third surgical opinion will be covered.

If two of the three surgical opinions agree surgery is unnecessary and the patient proceeds with the surgical operation, the surgeon's fee, as well as the hospital charges, will be covered at fifty percent (50%) of the scheduled allowance.

- (m) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (n) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Charges for Occupational therapy are subject to the limits as described in the Schedule of Benefits.

- (o) **Transplants:** Services and supplies provided for the transplant procedure are subject to the following conditions:

Any charges associated with a transplant that is not performed through a United Resource Network (URN) contracted facility will be considered ineligible under this Plan. In order to find out which facilities are contracted with United Resource Network (URN), you may contact Mountain Benefit Associates at 800-246-4622 or Mountain States Review at 888-304-3804. Precertification is required for all transplants.

DONOR EXPENSES

- (i) If the donor is a Covered Person under this Plan, his covered Expenses are covered under this benefit.
- (ii) If the recipient is a Covered Person under this Plan, his Covered Expenses are covered under this benefit.
- (iii) If the donor is not a Covered Person under this Plan but the recipient is, the donor's expenses will be covered if:
 - 1. The donor's expenses would not be covered by any other Plan (as that term is defined in the Duplication of Benefits section) in the absence of this Plan; and
 - 2. The expenses would be Covered Expenses (assuming that they were incurred by a Covered Person).

Benefits paid for the donor under this paragraph are treated as though they were paid for the recipient for purposes of Deductible, Co-payment percentages, Plan Benefit Maximum, etc.
- (iv) Covered Expenses include the cost of securing an organ from a cadaver or tissue bank, the surgeon's charges for removal of the organ and a Hospital's charge for storage or transportation of the organ.

RECIPIENT EXPENSES

- (i) Reasonable transportation costs to and from the site of the covered organ transplant for the covered person and one close relative.

- (ii) Reasonable necessary lodging and meal expenses incurred at the site of the covered organ transplant, up to a daily maximum as stated in the Schedule of Benefits, by the individual accompanying the covered recipient.

TYPE I: The following procedures are covered as any other illness:

1. Artery or vein transplants
2. Cornea transplants
3. Heart valve replacements
4. Implantable prosthetic lenses in connection with cataracts
5. Joint replacements
6. Kidney transplants
7. Prosthetic by-pass or replacement vessels

TYPE II: The following major human organ transplants are covered per the Schedule of Benefits. Charges related to but which are not direct procedures of the transplant will be covered under those benefits available elsewhere in the Plan:

1. Bone marrow transplants*
2. Heart transplants (mechanical, artificial or other than human heart transplants not covered)
3. Heart and lung transplants
4. Liver transplants
5. Lung transplants
6. Pancreas transplants

*Bone Marrow Transplants to include Limited Benefits for Allogeneic Bone Marrow Transplant and Autologous Bone Marrow Transplant. This provides benefits for Allogeneic Bone Marrow Transplant and Autologous Bone Marrow Transplant only for certain diseases or conditions and specifically excludes benefits for those procedures for all other diseases or conditions. The limited benefits provided for Allogeneic Bone Marrow Transplant and for Autologous Bone Marrow Transplant are an exception to the exclusion for Experimental or Investigative procedures. The exception of these procedures in limited circumstances from the exclusion for Experimental or Investigative procedures is not intended to, and does not operate as, a waiver for the exclusion for Experimental or Investigative procedures. The limited benefit provided for Allogeneic Bone Marrow Transplant and Autologous Bone Marrow Transplant is subject to all of the other conditions and provisions of the plan including, without limitation, the requirement that the procedure be medically necessary.

Benefits will be provided for Medically Necessary Allogeneic Bone Marrow Transplant only when prescribed for:

1. Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia;
2. Advanced stage Hodgkin's disease;
3. Advanced stage intermediate grade or high grade non-Hodgkin's lymphoma;
4. Advance stage neuroblastoma;
5. Severe aplastic anemia;
6. Chronic myelogenous leukemia which is in blast crisis or chronic phase;
7. Infantile malignant osteopetrosis;
8. Severe combined immunodeficiency syndrome;
9. Homologous beta-thalassemia;
10. Wiskott-Aldrich syndrome;
11. Myelodysplastic syndrome;
12. Lysosomal storage diseases;

13. Multiple myeloma;
14. Wilms' tumor; or
15. Gonadal germ cell tumors.

Benefits will be provided for Medically Necessary Autologous Bone Marrow Transplant only when prescribed for:

1. Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia;
2. Advanced stage Hodgkin's disease;
3. Advanced stage intermediate grade or high grade non-Hodgkin's
4. Advanced stage neuroblastoma;
5. Multiple myeloma;
6. Breast cancer;
7. Wilms' tumor; or
8. Gonadal germ cell tumors.

No benefits will be provided for any other use or application of Allogeneic or Autologous Bone Marrow Transplants.

- (p) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
- (q) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Charges for Physical therapy are subject to the limits as described in the Schedule of Benefits.

- (r) **Rehabilitation Center:** Expenses for a covered person incurred for a sickness or injury that results in the need for rehabilitation services as provided or offered in a rehabilitation hospital or centers are covered up to the maximum in the Schedule of Benefits. The Covered Person must be under the care of a physician for any benefits to be payable.

"Rehabilitation services" means a formal program of treatment that:

- (i) is provided to those individuals who have severe disabling impairments of recent onset or recent progression or persons who have not had prior exposure to these services and who require an identifiable intensity of services; and
- (ii) is performed in a rehabilitation hospital or center either as an inpatient or an outpatient; and
- (iii) is prescribed by a physician as medically necessary and is periodically reviewed; and
- (iv) is prescribed in place of a stay in the acute setting of a hospital or is an extension of a hospital stay; and
- (v) is provided in a hospital or facility that is licensed and qualified to render rehabilitation services.

Covered expenses are charges, not to exceed the Usual and Customary charges that are made for physical, speech, and occupational therapy services. Alcohol and drug rehabilitation expenses are not covered under this benefit.

- (s) **Prescription Drugs** (as defined).
- (t) Routine **Preventive Care**. Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.
- (u) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (v) **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:
 - (i) reconstruction of the breast on which a mastectomy has been performed,
 - (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,
in a manner determined in consultation with the attending Physician and the patient.
- (w) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

Charges for Speech therapy are subject to the limits as described in the Schedule of Benefits.
- (x) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (y) **Sterilization** procedures. The Plan pays for certain Elective Sterilization procedures such as tubal ligation and vasectomies. These procedures shall be considered the same as any other illness only for:
 - (a) covered participants;
 - (b) covered dependent spouse.
- (z) **Self-Inflicted. When related to Mental Illness**
 - (aa) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
 - (bb) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first 14 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for routine pediatric care for the first 14 days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(cc) Diagnostic x-rays.

HEALTH MANAGEMENT SERVICES

Health Management Services Phone Number

Mountain States Review
888-304-3804 or 307-347-7979

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 24 hours after an emergency.

By calling the Health Management Service to pre-certify does not guarantee payment of benefits. In order to verify benefits payable, you will need to call Mountain Benefit Associates at the number listed under “Verification of Benefits” section of this plan.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - Hospitalizations
 - Substance Abuse/Mental Disorder treatments
 - Skilled Nursing Facility stays
 - Home Health Care
 - Hospice Care
 - Outpatient surgical procedures
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. For Benefit Payment or Eligibility questions, please call Mountain Benefit Associates at **800-246-4622** or in the Worland area **307-426-5500**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 24 hours or 1 working day of the first business** day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

COORDINATION / FACILITATION CARE SERVICES

Health Management. Professional RN Case Managers will coordinate and implement programs by providing guidance and information on available resources and suggesting the most appropriate treatment plan. They will assist to integrate and promote efficient use of health care resources for quality outcomes. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Case Management. A case manager may consult with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

The Claims Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Claims Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and families choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Life Care Management. Life Care Management is a proactive approach to medical management with emphasis on education and compliance with plan of care. This service works with clients to ensure maximizing health lifestyle opportunities to maintain and control on-going wellness management. The disease management program, as an example, may address chronic illnesses such as diabetes and hypertension.

Stop Loss / Reinsurance Coordination. A service that provides RN assessment / analysis consultation for Plan operation purposes to secure stop loss / reinsurance. This may include contacting health care providers and patients regarding information about current treatment, medical status and management.

DISCOUNT NEGOTIATION SERVICES

Discount Negotiation. Patients and their family are often unaware of health care options and because of this may be paying a higher than necessary cost. Mountain States Review has a professional nursing staff to assist in finding lower cost health services without compromising the quality of treatment. Whenever possible negotiations are made with the health care agencies or vendors.

AUDIT / REVIEW SERVICES

Claim Audit Review

1. Coordinators familiar with the case from its beginning in pre-certification as well as local facility procedures seek to identify inaccurate or unnecessary charges. Claims are analyzed for accuracy. The claim and discharge or operative summaries may be analytically compared. The applicability of facility services may be reviewed in light of the patient's diagnosis, treatment, and discharge planning.
2. Cases are also reviewed to determine:
 - a. if hospitalization was necessary
 - b. if the treatment received was appropriate and customary for the diagnosis,
 - c. if the frequency or duration of the treatment was appropriate, and
 - d. whether alternative settings might have been utilized.

Facility Audit / Review

Auditing services begin with facility claim review. This may be a desk review or an on-site review. If an on-site audit is indicated, it is conducted with a patient's complete medical records, where discrepancies can be addressed with facility personnel to reach a fair and honest agreement between the facility and the auditor. The audit is approved and accepted by the facility with the appropriate reductions agreed upon by the facility staff and the nurse auditor.

HEALTH MANAGEMENT SERVICES: Coordination / Facilitation Care Services, Discount Negotiation Services and Audit Review Services are payable at 100% deductible waived under this Plan.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis. Active Employees will include an Employee granted a paid or unpaid sabbatical or maternity leave of no more than one year if the participating Employer elects in the Plan Adoption Agreement to include such Employees as Plan Eligible Employees.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Business Associate The term "Business Associate" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right.

Calendar Year means January 1st through December 31st of the same year.

Claim Administrator The person or group providing administrative services to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Benefit Services Administrator for this Plan is MBA.

Close Relative means the spouse, mother, father, sister, brother, child or in-laws of the patient.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Procedure means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of a bodily function.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Developmental Delays means the lack of normal physiological development in motor, language, social, adaptive and/or cognitive function.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is an employer member of the Wyoming State Bar who has adopted the Plan and is participating in the Plan.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

HIPAA means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify

the types of measures required to protect the security and privacy of personally identifiable health care information.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Eligible expenses for **INPATIENT** hospice care will mean confinement in a free-standing, hospital-affiliated hospice facility.

Eligible expenses for **OUTPATIENT** hospice care will mean a centrally administered, medically directed and nurse-coordinated program which: is available twenty-four (24) hours a day, seven (7) days a week; uses a hospice team, and provides a regular program primarily of home care.

A hospice team will mean professional and volunteer workers who provide care to : reduce or abate pain or other symptoms of mental or physical distress; and meet special needs arising out of the stresses of the terminal illness, dying and bereavement, The team must consist of at least a doctor and registered nurse. It could also include social workers, clergymen, counselors, volunteers, clinical psychologists. Physiotherapists and occupational therapists.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Mail Order Prescription Drugs. Mail order maintenance medication prescriptions may be filled up to a ninety (90) day supply when prescribed by a physician. Prescriptions are subject to the coinsurance provisions stated in the Schedule of Benefits. Details are available from the Human Resources Office. The mail order prescription drug benefit is limited to a ninety (90) day supply.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the

convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Formulary drug means a drug that is not on a list of prescription medications compiled by the third party payer of safe, effective therapeutic drugs as a method of rational drug therapy in a cost effective manner specifically covered by this Plan.

Non-PPO Provider means any health care provider who is not a contracting member of a preferred provider organization utilized by this Plan.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Protected Health Information (PHI) means individually identifiable health information (any health information that can be tied back to an individual).

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Wyoming Lawyers Health Benefit Plan which is a multiple-employer welfare benefit plan for employees of participating employer members of the Wyoming State Bar and is described in this document and the Plan Declaration adopted by the Plan Sponsor.

Plan Administrator The person or group responsible for the day-to-day functions and management of the Plan. The Plan Administrator may retain persons or firms to process claims and perform other Plan-connected services.

The Plan Administrator is the Plan Sponsor unless otherwise designated.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor The term "Plan Sponsor" means an entity that sponsors a health plan. This can be an employer, an association of employers, a union or some other entity. The Plan Sponsor of this Plan is the Wyoming State Bar Health Foundation.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year.

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan (e.g. the six month look back period for an Enrollment Date of August 15 is February 15 through August 14). Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under any Creditable Coverage within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption is covered under any Creditable Coverage. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Residential Treatment The term "Residential Treatment" means a program provided by a facility established for the purpose of residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

Retail Prescription Drugs. Retail prescription drugs are subject to the deductible and coinsurance provisions stated in the Schedule of Benefits. Participants must present proper identification and pay the total charge to the pharmacy at the time the prescription is received. The retail prescription drug benefit is limited to a thirty (30) day supply when prescribed by a physician. FDA Standard dispensing limits may apply.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer or their designee.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- (2) **Acupuncture.**
- (3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (4) **Amniocentesis** charges when performed to determine the sex of the child.
- (5) **Biofeedback.**
- (6) **Blood.** Charges for donated or replaced blood.
- (7) **Co-Dependency Treatment.** Services related to the treatment of the family of a person receiving treatment for nicotine, chemical, or alcohol dependence.
- (8) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (9) **Court ordered treatment.** Charges resulting from court ordered or recommended alcohol, substance abuse or psychological treatment or evaluation.
- (10) **Convalescent Care.**
- (11) **Cosmetic surgery.** Charges for any treatment for cosmetic purposes or for cosmetic surgery are not a covered expense. Except that the Plan will pay for cosmetic treatment or surgery if:
 - (a) due solely to an accidental bodily injury which occurred while the individual was continuously covered under a medical Plan at the time the injury occurred: or
 - (b) due solely to a birth defect of an individual who was continuously covered under a medical Plan from the date of his or her birth: or
 - (c) due solely to surgical removal of all or part of the breast tissue as a result of an illness.

If services are in connection with a mastectomy and breast reconstruction is elected, coverage will be provided for the following:

- (i) reconstruction of the breast on which the mastectomy has been performed;

- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (iii) prostheses and physical complications for all stages of mastectomy, including lymphedemas; In a manner determined in consultation with the attending physician and the patient.
- (12) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (13) **Dental Implants.** Charges for dental implants and hospital admissions for psychiatric reasons related to Dental services are not covered.
- (14) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (15) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (16) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (17) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (18) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (19) **Eyelid and Eyebrow Surgery.** Charges for Lower Lid Blepharoplasty, Upper Lid Blepharoplasty and Blepharoptosis (upper eyelid surgery), or Brow Ptosis (eyebrow lift); unless preoperative formal visual tests indicate correctable impairment of central visual acuity or peripheral vision and a preoperative photograph demonstrate the impingement of the lid margin on the pupil.
- (20) **Failure to keep appointments.** Charges for failure to keep scheduled appointments.
- (21) **Food.** Food, nutritional supplements. Or special diets and liquids unless provided while the covered person is confined in a hospital or for the treatment of phenylketonuria (PKU).
- (22) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (23) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (24) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (25) **Genetic counseling.** Such as discussions of family history and tests to determine the sex or physical characteristics of an unborn child.

- (26) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (27) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- (28) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (29) **Hypnotism.** Charges for hypnotism for anesthesia or medical purposes.
- (30) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (31) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (32) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (33) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation, prescription drugs for treatment of infertility and charges for surgical correction of physiological abnormalities.
- (34) **Mailing Expenses.** Mailing and/or shipping charges or other taxes imposed by law that apply to benefits covered under this Plan.
- (35) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (36) **Newborn services.** not provided for the newborn children of covered dependent daughters.
- (37) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (38) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

- (39) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (40) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (41) **Non-prescription items.** Drugs or medicines that are available without a physician's prescription, even if prescribed or administered by a physician.
- (42) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (43) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (44) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.
- (45) **Orthognathic Surgery.** The following types of procedures are not covered, whether caused by birth defect, facial deformities, cleft palate, cleft palate disease or otherwise:
- (a) Upper or lower jaw augmentation or reduction procedures; or
 - (b) Reconstructive procedures which correct deformities of the jaw, or
 - (c) Procedures related to facial skeleton and associated soft tissues (surgical procedures may include but not be limited to, procedures involving repositioning and recontouring of the facial bones.
- (46) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (47) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (48) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
- (49) **Providing medical information. Charges for completion of claim forms or providing medical information necessary to determine coverage.**
- (50) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (51) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (52) **Respite Care.** Offering rest for the family or covered person is not covered.

- (53) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (54) **Sales tax.**
- (55) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (56) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (57) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (58) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (59) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (60) **Staff Consultations/Telephone.** Charges for telephone consultations, which are required by rules and regulations of a hospital or other facility, are not covered.
- (61) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (62) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (63) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (64) **Unwanted hair.** Care and treatment for unwanted facial hair.
- (65) **Visual Training or Orthoptics.** Charges for visual training or orthoptics training. Servicing of visual corrective devices or consultations related to such services.
- (66) **Workers' compensation.** Expenses for which Payment is required under applicable Workers' Compensation Statutes are not eligible for Payment under this medical Plan. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance. However, work-related claims for Plan Participants for which Workers' Compensation is not required can be considered for benefits under this Plan.
- (67) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CVS/Caremark is the administrator of the pharmacy drug plan.

PRESCRIPTION DRUGS

Plans 1-4 Retail prescription drugs: The Maximum Allowable Fee will be paid, less a co-pay per prescription, to participating pharmacies and/or drug stores. Co-pays required at the time of purchase are as listed in the Schedule of Benefits. Participants must present the proper identification and sign a receipt for each prescription received from a participating pharmacy, and pay the applicable co-pay before the prescription is received. Retail prescription drugs may be filled up to a maximum as shown in the Schedule of Benefits. FDA Standard dispensing limits may apply.

Mail Order prescription drugs: Maintenance medication prescriptions may be filled up to a maximum as shown in the Schedule of Benefits when prescribed by a physician. Co-pays required at the time of purchases are as listed in the Schedule of Benefits.

When a generic equivalent is available and the participant purchases the brand name drug he or she will have to pay the difference in price between the maximum allowable fee for the generic drug and the average wholesale cost for the brand name drug, in addition to the co-pay, if applicable.

Plans 5-6 Retail prescription drugs: Retail prescription drugs are subject to the deductible and in-network coinsurance provisions stated in the Schedule of Benefits. Participants must present the proper identification to participating pharmacies and pay the total charge to the pharmacy at the time the prescription is received.

Retail prescription drugs may be filled up to a maximum as shown in the Schedule of Benefits. FDA Standard dispensing limits may apply.

Mail Order prescription drugs: Maintenance medication prescriptions may be filled up to a maximum as shown in the Schedule of Benefits when prescribed by a physician. Prescriptions are subject to the deductible and coinsurance provisions stated in the Schedule of Benefits.

When a generic equivalent is available and the participant purchases the brand name drug he or she will have to pay the difference in price between the maximum allowable fee for the generic drug and the average wholesale cost for the brand name drug, in addition to the applicable co-pay.

When a pharmacy that is not participating in the network is used, the participant must file the claim directly with CVS Caremark. Nonparticipating pharmacies do not agree to accept payment arrangements. This means that the participant may not be reimbursed for the full amount the participant pays non-participating pharmacies. The participant is responsible for any difference between the billed charge and the maximum allowable fee. A Prescription Drug Reimbursement Form must be completed and is available from the Benefit Administrator.

Maintenance prescriptions refer to a drug treatment appropriate to control a specific ongoing condition. The drug may be required for a long time, even a lifetime. When practitioners write prescriptions, they indicate whether refills are allowed and, if so, how many. The participant may not receive benefits for a refill if:

- (1) sufficient time has not elapsed since the last prescription was filled. Sufficient time means that at least seventy-five percent (75%) of the medication has been taken according to the instructions given by the practitioner;

- (2) the refill is to replace medications that have been lost, stolen, or used inappropriately;
- (3) the refill is in excess of the number authorized by the practitioner; or
- (4) state law limits the refill.

Generic drugs should be used whenever there is a generic equivalent for the drug the participant is taking. A generic equivalent means a prescription drug available from more than one drug manufacturer, which has the same active therapeutic ingredient as a brand or trade name prescription drug.

Formulary Brand/Preferred Brand Drugs - Preferred Brand Drugs are safe and cost-effective medications. The list of Preferred Brand Drugs (provided on CVS Caremark website as listed on the *Plan Specifications* page) serves as a guide to physicians when deciding which medications to prescribe for their patients. Based upon the clinical judgment of physicians, pharmacists, and other experts, the list suggests medications the physician might prescribe when there is a choice of medications that produce the same result. The list represents the current standards of care regarding appropriate medication options. If the participant's physician prescribes a drug from the Preferred Brand Drugs list, the participant's out-of-pocket costs may be reduced.

Prior authorization may be required for some drugs. Prior authorization allows a drug that is not normally covered by the Plan, to be allowed when used to treat a covered medical condition. Certain excluded drugs may have a dual purpose or multiple indications and prior authorization will be required for these drugs.

To obtain prior authorization, the participant or his or her health care provider must request the prior authorization by calling or writing to CVS Caremark at the phone number on the participant's identification card with the following information:

- (1) Name and age of patient;
- (2) Participant's name, group number, and identification number,
- (3) Name of drug and dosage;
- (4) The reason the drug should be covered, and
- (5) The length of time the drug should be covered.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Prescription Drugs purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used are not covered.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Per-Prescription Maximum

The per-prescription maximum is the maximum amount this Plan will pay toward any one covered prescription.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Emissary Pharmacy, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.
- (4) Injectable drugs or any prescription directing administration by injection.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Impotence.** A charge for impotence medication.
- (11) **Infertility.** A charge for infertility medication.
- (12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

- (16) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (19) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

- (1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- (2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
- (4) **No prescription.** Charges for lenses ordered without a prescription.
- (5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).
- (6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.
- (7) **Training.** Charges for vision training or subnormal vision aids.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Plan Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Service: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 times per Covered Person each per plan year.
- (2) One bitewing x-ray series 2 times per plan year.
- (3) One full mouth x-ray once every 36 months.
- (4) Topical application of sodium fluoride or stannous fluoride and sealants.
- (5) Emergency palliative treatment for pain.

**Class B Services:
Basic Dental Procedures**

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Periodontics (gum treatments).
- (4) Endodontics (root canals).
- (5) Extractions. This service includes local anesthesia and routine post-operative care.
- (6) Recementing bridges, crowns or inlays.
- (7) Fillings, other than gold.
- (8) General anesthetics, upon demonstration of Medical Necessity.
- (9) Antibiotic drugs.
- (10) Space maintainers.

**Class C Services:
Major Dental Procedures**

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during 6 months following the installation.
- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Initial installation of fixed bridgework to replace one or more natural teeth.
- (7) Repair of crowns, bridgework and removable dentures.
- (8) Rebasement or relining of removable dentures.
- (9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
 - (b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 6 months from the date the temporary denture was installed.
- (10) Charges for implantology.
- (11) Appliances to reduce or prevent pain or damage from bruxism (grinding of the teeth).

**Class D Services:
Orthodontic Treatment and Appliances**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age Dependent Children only and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be \$400 or more, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Mountain Benefit Associates, LLC
809 South Railway Avenue - P.O. Box 98
Worland, Wyoming 82401
307-426-5500

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (7) **No listing.** Services which are not included in the list of covered dental services.
- (8) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (9) **Personalization.** Personalization of dentures.
- (10) **Replacement.** Replacement of lost or stolen appliances.
- (11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (12) **Temporomandibular Joint syndrome (TMJ)**

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Personnel Office or the Claims Administrator or obtain one by visiting the MBA website at www.mba-national.com.
- (2) Complete the Employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED.**
- (3) Have the Physician or Dentist complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW:**
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

Mountain Benefit Associates, LLC
809 South Railway Avenue - P.O. Box 98
Worland, Wyoming 82401
307-426-5500

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within **120 days** of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within **12 months** from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
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Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
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Response by claimant, orally or in writing	48 hours
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Benefit determination, orally or in writing	48 hours
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Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
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Determination as to extending course of treatment	24 hours
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If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
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Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

- (1) Claims shall be submitted in compliance with the requirements of the Benefit Programs adopted by the Plan Sponsor, subject to such waivers as are authorized by such Programs. Claims shall be filed within the time period provided in the Benefit Program under which the claim is to be submitted, but not later one year from the date the services providing the basis for the claim were provided to the Plan Participant.
- (2) The Plan Administrator, or its delegatee, shall approve, partially approve, or deny a claim within such reasonable time periods as are required by the Adopted Benefit Programs.
- (3) If a claim is denied (in whole or in part), the Plan Administrator, or its delegatee, shall provide the Plan Participant submitting the claim with a written notice of the denial (together with a notice of the Plan's claim review procedures), pursuant to such reasonable notice requirements set forth in the Benefit Program. The notice shall at least set forth the following:
 - (a) the specific reasons for the denial
 - (b) specific reference to pertinent Plan provisions
 - (c) a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary and
 - (d) information as to the steps to be taken if the person wishes to submit a request for review.
- (4) A Plan Participant who receives a written notice of a denied claim and who desires to appeal such denial shall submit a written request for appeal to the Plan Administrator. If the denial was by a third party administrator, the appeal shall be to the Plan Administrator. If the denial was by the Plan Administrator, the appeal shall be to the Trustees of the Trust.
- (5) If the Wyoming Department of Insurance establishes an external appeal procedure that is applicable to this Plan, the Plan Participant may appeal a denial of the Trustees of the Trust to

the office or person designated by the Wyoming Insurance Commissioner to hear such appeals.

- (6)** The appeal procedure set forth in this section is also available to a Plan Participant who is denied coverage under this Plan. In the event of an appeal of denial of coverage, the Plan Participant's coverage will continue pending the appeal as long as Plan Contributions are received for the coverage.
- (7)** A Plan Participant appealing a claim denial or coverage denial shall be allowed to review his or her files maintained by the Plan Administrator and Third Party Administrators and shall be allowed to present evidence and testimony at any hearing concerning his or her appeal.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a

laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

PERSONS ELIGIBLE FOR MEDICARE

For employers with twenty (20) or more employees, active employees age sixty-five (65) and over and their dependent spouses age sixty-five (65) and over who are covered under this Plan are entitled to benefits under this Plan on the same basis as active employees and their dependent spouses under the age sixty-five (65).

This Plan will pay as the primary plan to Medicare. If under twenty (20) employees, Medicare is the primary plan.

For employers with one-hundred (100) or more employees, this Plan will be the primary plan for totally disabled employees and totally disabled dependents that are covered under this Plan while entitled to Medicare disability benefits. If under one-hundred (100) employees, Medicare is the primary plan.

For persons eligible for Medicare by reason of End Stage Renal Disease, this Plan shall be primary during the initial thirty (30) month period (not including any waiting period established by Medicare). Thereafter, Medicare will be the primary plan.

The following applies to a non-employee individual who is covered under the Plan and also is eligible for Medicare. The payments under the Plan are determined as shown in the Schedule of Benefits.

The person will be assumed to have full Medicare coverage (that is, Part A and Part B) whether or not the individual has enrolled for the full coverage. If Medicare benefits are paid for expenses not covered under the Plan, they will not be used to determine benefits payable under the Plan. In cases of services and supplies which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the Maximum Allowable Fee for the services and supplies.

Once you are a retired employee and you or your dependents become eligible for Medicare, the benefits covered by this Plan are **automatically reduced** by the benefits available to the Medicare-eligible person under Part A or Part B of Medicare regardless of whether or not the person eligible for Medicare enrolls for Medicare coverage. To avoid having to pay for Medicare-available benefits yourself, it is important that you or your dependent enroll for Medicare Part A or Part B coverage as soon as you become eligible.

If a dependent is eligible for Medicare and the active employee is not, this Plan will continue to be primary until the employee is retired and eligible for Medicare.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Wyoming Lawyers Health Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is:

ALPS Risk & Insurance Services, Inc.,
P. O. Box 9169
Missoula, MT 59807, 406-728-3113

COBRA continuation coverage for the Plan is administered by:

Mountain Benefit Associates, LLC
809 Railway Avenue - P.O. Box 98
Worland, Wyoming 82401, 307-426-5500

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or

- (4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mountain Benefit Associates, LLC
151 S 6th Street - P.O. Box 98
Worland, Wyoming 82401

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or

Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a

Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Wyoming Lawyers Health Benefit Plan is the benefit plan of the Wyoming State Bar Health Foundation, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. The Wyoming State Bar Health Foundation has appointed ALPS Risk & Insurance Services, Inc. to be the Plan Administrator to serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. Except as provided for denial of claims appeals as provided in the section of this Plan Document and Summary Plan Description entitled "Appeals," the decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator receives compensation and expenses for plan administration will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

HOW TO FILE A COMPLAINT REGARDING THE USE AND DISCLOSURE OF YOUR PHI.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. All complaints must be in writing. Please be assured that you may not be retaliated against for filing a complaint.

HOW TO CONTACT US

You may contact our representative at:

Privacy Officer - HIPAA Compliance Department
Mountain Benefit Associates
P. O. Box 98
Worland, WY 82401
(307) 426-5500

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from participating Employer and Covered Employee contributions to the welfare benefit trust fund.

The level of any Employee contributions will be set by the Employee's Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Plan Sponsor intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement.

NEW YORK HEALTH CARE REFORM ACT

Effective September 1, 2010, Wyoming State Bar Health Foundation is represented by Mountain Benefit Associates which has elected to pay the surcharge directly to the state pool for any health services provided to Plan Participants in the state of New York as outlined in the New Health Care Reform Act.

COMMON WEALTH OF MASSACHUSETTS UNCOMPENSATED CARE POOL SURCHARGE

Wyoming State Bar Health Foundation is represented by Mountain Benefit Associates which has elected to pay the surcharge directly to the Common Wealth pool for any health services provided to Plan Participants in the Common Wealth of Massachusetts as outlined in the Common Wealth of Massachusetts Uncompensated Care Pool Surcharge.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Wyoming Lawyers Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 27-6757447

PLAN EFFECTIVE DATE: September 1st

PLAN YEAR ENDS: August 31st

PLAN SPONSOR INFORMATION

Wyoming State Bar Health Foundation
4124 Laramie Street
Cheyenne, Wyoming 82003
307-632-9061

PLAN ADMINISTRATOR

ALPS Risk & Insurance Services, Inc.
P. O. Box 9169
Missoula, MT 59807
406-728-3113

NAMED FIDUCIARY

Wyoming State Bar Health Foundation
4124 Laramie Street
Cheyenne, WY 82003.

AGENT FOR SERVICE OF LEGAL PROCESS

ALPS Risk & Insurance Services, Inc.
P. O. Box 9169
Missoula, MT 59807
406-728-3113

CLAIMS ADMINISTRATOR

Mountain Benefit Associates, LLC
151 S 6th Street - P.O. Box 98
Worland, Wyoming 82401
307-426-5500

TRUSTEE(S)

- Bill Hiser
- Tim Bepler
- Rick Lavery

BY THIS AGREEMENT, Wyoming Lawyers Health Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Wyoming State Bar Health Foundation on or as of the day and year first below written.

By William A. Hiser
Wyoming State Bar Health Foundation.

Date 9/9/10

Witness Michelle Peterson

Date 09/09/10