Health Insurance Policy

Medicare Disabled
Gold Plan

WYOMING HEALTH INSURANCE POOL

Medicare Disabled Gold Plan
February 14, 2019

This Notice is Being Provided as Required by the Affordable Care Act

Translation Services

If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-2376.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-442-2376 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.

Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.

Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.

ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Wyoming
についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。

यदि तपाईं आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ,Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा नि:शुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Wyoming ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید.800-442-2376 تماس حاصل نمایید.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે,આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.

Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídílkidgo éí doodago háída biká anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnil 800-442-2376.

NOTICE OF NON-DISCRIMINATION PRACTICE

Blue Cross Blue Shield of Wyoming (BCBSWY) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. BCBSWY does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

BCBSWY provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-442-2376 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe BCBSWY has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Compliance Officer in our Legal Department

- by email at: Legal@bcbswy.com
- by mail at: BCBSWY Compliance Officer
  Legal Department PO Box
  2266
  Cheyenne, WY 82003-2266
- or by phone at: 1-800-442-2376

Grievance forms are available by contacting us at the contacts listed above or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://www.hhs.gov/ocr/complaints/index.html
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  Centralized Case Management Operations
  U.S. Department of Health and Human Services 200
  Independence Avenue SW
  Room 509F HHH Bldg Washington,
  DC 20201

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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WYOMING HEALTH INSURANCE POOL
(Herein called We or Us or Our)

Agrees that the Person named as the subscriber on the Identification (ID) Card, herein called You or Your, is entitled to health services as herein defined subject to the terms of Your Agreement.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

PART I -- GENERAL INFORMATION

This document is an Agreement to provide benefits described as long as Your premiums are paid for the period in which the expenses are incurred.

The Schedule of Benefits provided with this Agreement gives the following information: Your name; the group number; Your Agreement or identification number; the effective date of Your coverage; and the monthly charge for this Agreement.

PART II - HOW TO ESTABLISH, CHANGE OR END COVERAGE

There are a number of ways to change or end coverage. This section explains how changes may be made.

A. THE EFFECTIVE DATE

Except as otherwise indicated, the effective date of coverage will be assigned by the Administrator after receipt and approval of the application.

B. COVERAGE OF NEWBORNS

Providing the mother is covered under the Pool, coverage for a newborn child may be established under the child's own Agreement effective on the date of birth. The newborn child will remain covered for thirty-one (31) days with no change in premiums charged to the mother. Coverage will continue beyond the initial thirty-one (31) days providing the mother completes an application for the child that is received and approved by the Wyoming Health Insurance Pool within thirty (30) days of the date of the child's birth. Premiums will be billed accordingly. Proof of the child's eligibility must be included with the application.

C. CHANGES

The subscriber must notify the Pool within thirty (30) days of all changes in the subscriber's status, such as those resulting from birth or change of address, and within ninety (90) days of entrance into, or return from, the armed services.

D. WHEN COVERAGE UNDER THIS AGREEMENT ENDS

1. Upon the death of the subscriber.

2. When the subscriber enters the armed forces on full-time duty.

3. By the subscriber's request. Coverage ends on the next billing service date after the ending date requested in writing.

4. When there is improper use of this Agreement or the identification card or deceptive filing of claims. The subscriber is liable for any benefits payments made through such improper actions.

5. When premiums are not paid within the specified time.

6. When the subscriber either becomes eligible for or obtains other coverage under health insurance or an insurance arrangement.

7. When the subscriber no longer occupies a dwelling in the state of Wyoming.

8. When the Pool has paid one million dollars ($1,000,000) on the subscriber's behalf in the subscriber's lifetime.

9. When the subscriber becomes an inmate of a public institution.

10. June 30, 2030 if the Wyoming State Legislature does not extend the enabling legislation.

11. For newborn children, at the end of the 31-day coverage period, unless a completed application for coverage of the child is received and approved by the Pool no later than thirty (30) days after the date of birth.

E. CERTIFICATE OF CREDITABLE COVERAGE

When coverage under this Agreement is terminated, the Wyoming Health Insurance Pool will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the affected subscriber. Certificates of Creditable Coverage may also be obtained from the Wyoming Health Insurance Pool upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through the Wyoming Health Insurance Pool.

PART III - TERM

The term of this Agreement shall be one (1) month from its effective date. This Agreement and coverage of the subscriber will be renewed by the Pool from month to month, so long as premiums are regularly prepaid as scheduled. Coverage will end June 30, 2030 if the Wyoming State Legislature does not extend the enabling legislation.

PART IV – PREMIUMS

A. HOW PREMIUMS ARE ESTABLISHED AND CHANGED

The required premiums are determined and established by the Wyoming Insurance Commissioner with the recommendation of the Wyoming Health Insurance Pool Board of Directors. The Board may change premiums according to any of the following:

1. Subject to Federal and State law.
2. When Medicare benefit changes occur. We may change the premiums as long as We notify You no later than 30 days prior to the annual effective date of the changes.
3. At other times of the year with 15 days written notice.
4. Payment of premiums will be conclusive proof of agreement to any change.
5. Premiums under the Agreement will be as specified on the Schedule of Benefits.

B. HOW AND WHEN TO PAY PREMIUMS

1. Initial premiums will be billed to You on the next billing cycle along with the premiums for the following month.
2. Subsequent billings will be mailed to You at the current address as indicated in Our records.
3. Electronic Fund Transfer is a service that is available between the Administrator and Your bank to automatically withdraw the premiums each month if You elect this option.

PART V -- ELIGIBILITY

Subscribers will be eligible for coverage under this Agreement according to the following guidelines, or as may be determined by Wyoming Health Insurance Pool policies and procedures.

A. WHO IS ELIGIBLE

1. Residents of the State of Wyoming who meet one of the following criteria:

   a. Have been refused coverage by one health insurance carrier for a health reason or,
   b. Have individual health insurance coverage at a rate exceeding the Pool rate or,
   c. Have health insurance coverage except with a reduction or exclusion of coverage for a preexisting health condition which reduction or exclusion is more restrictive than the reduction or exclusion provided by Pool coverage or,
   d. Are eligible for group health insurance or a group health insurance arrangement offered at a rate to the individual or his employed family member that exceeds the Pool rate by at least twelve and one-half percent (12.5%) for the coverage applied for under the Pool or,
   e. Are individuals on Medicare Disability under the age of 65 or,
   f. Are newborn children whose mothers are covered under the Pool.

2. Continued eligibility under this individual health plan is permitted past the age of 65 provided coverage is established prior to the date the subscriber attains the age of 65.

NOTE: Except in the case of newborns born to mothers covered under the Pool, or individuals who have met the lifetime maximum benefit of their prior policy, if the subscriber is in the hospital on the day this coverage would become effective, the coverage will become effective on the day following discharge.

B. WHO IS NOT ELIGIBLE

1. Persons who have coverage under health insurance or an insurance arrangement on the issue date of Pool coverage,

2. Persons who are eligible for group health insurance or a group health insurance arrangement provided in connection with a policy, plan, or program sponsored by an employer and subject to regulation as a group health plan under federal or state law, even though the employer coverage is declined, unless the cost to insure the

individual is offered at a rate to the individual or his employed family member exceeding the applicable pool rate by at least twelve and one-half percent (12.5%) for the coverage applied for under the Pool,

3. Any person who is, at the time of Pool application, eligible for Medicaid health care benefits or Medicare by reason of age (individuals on Medicare Disability under the age of 65 are eligible),

4. Any person who terminated coverage in the Pool unless twelve (12) months have elapsed from the termination date,

5 Any person on whose behalf the Pool has paid one million dollars ($1,000,000.00) in benefits,

6. Inmates of public institutions.

PART VI -- ADJUSTMENT OF DEDUCTIBLE & COINSURANCE CHARGES

This Agreement provides benefits designed to cover cost sharing amounts under Medicare. Benefits will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and coinsurance factors.

PART VII – COORDINATION OF BENEFITS

Benefits otherwise payable under Pool coverage will be reduced by any amounts paid or payable through Medicare.

PART VIII -- ASSIGNMENTS

The Benefits provided in this Agreement are non-assignable.

PART IX-- STATEMENTS AND REPRESENTATIONS

All statements contained in a written Application, Evidence of Insurability form, or other written document or instrument made by the Subscriber to obtain this Agreement, shall be deemed representations and not warranties and no such statement shall be used in defense of a claim under this Agreement, unless such statement is a misrepresentation, omission, concealment of facts, or otherwise incorrect statement which is either (a) fraudulent or, (b) material to the acceptance or issuance of this Agreement hereunder by Us or, (c) such a statement that, if the true facts had been known by Us as required by any written Applications, Evidence of Insurability or other written document or instrument or otherwise, We, in good faith, would either not have entered into the Agreement or issued the coverage, or would not have provided coverage with respect to the hazard resulting in the loss which is the basis for a claim under this Agreement.

PART X -- DEFINITIONS

These are words and terms defined to help You to understand Your Agreement.

ACCIDENT - Accidental bodily injury sustained by You which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

ADMINISTRATOR – An entity selected by the Wyoming Health Insurance Pool Board of Directors to handle claims processing, enrollment, advertising, etc.

APPLICATION - Is the form You complete when You apply for coverage.

APPROVED BED - Means any bed located in a facility which has been approved by Medicare.

ASSIGNMENT ACCEPTED BY PHYSICIAN - Means the Physician has agreed to accept the Medicare approved charge as payment in full. You will still have to pay any deductible and coinsurance amount that may apply.

BENEFIT PERIOD – The way that Medicare measures Your use of hospital and skilled nursing facility services. A benefit period starts the day You go to a hospital or skilled nursing facility. The benefit period ends when You haven't received hospital or skilled nursing care for 60 days in a row. If You go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods You can have.

BENEFITS - Payments made for covered services.

BILLING - Statement of premium owed by You and needed to keep Your Agreement prepaid.

CALENDAR YEAR – The period from January 1 through December 31.

COINSURANCE - Your balance after Medicare has paid for covered services.

COSMETIC SURGERY - Is surgery performed that is not medically necessary; a procedure performed primarily to improve appearance.

COVERED SERVICES - Are services performed which have been considered to be medically necessary by Medicare or by Us and are listed as benefits in Your Agreement.

CREDITABLE COVERAGE – Means creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 as amended, 42 U.S.C. Section 300 gg et seq.

CUSTODIAL CARE - Means care which is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

DEDUCTIBLE - A specified amount of expense for covered services that You must pay within each Benefit Period for services covered under Medicare Part A, or calendar year for services and supplies covered under Medicare Part B. Benefits will not begin until Your deductible has been met. Out of pocket expenses for Your deductible are expenses that would ordinarily be paid under this Agreement.

DIAGNOSTIC ADMISSION - Is when a Physician admits You to a hospital as a bed patient to have tests run which could be done just as safely on an outpatient basis.

FIDUCIARY - As used herein, the Wyoming Health Insurance Pool as a fiduciary of this health insurance Agreement exercises any authority or control regarding the management or disposition of the Plan's assets in accordance with this Agreement, the operation, and administration of this Agreement.

HOSPITAL - A provider that is a short-term, acute, general hospital which:

A. Is a duly licensed institution.
B. For compensation from its patients, is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians.
C. Has organized departments of medicine and surgery.
D. Provides 24-hour nursing services by or under the supervision of registered graduate nurses, which are both physically present and on duty.
E. Is not other than incidentally a:

    1. skilled nursing facility,
    2. nursing home,
    3. custodial care home,
    4. health resort,
    5. spa or sanitarium,
    6. place for rest,
    7. place for the aged,
    8. place for the treatment of mental illness,
    9. place for the treatment of alcoholism or drug abuse,
    10, place for the provision of hospice care,
    11. place for the provision of rehabilitation care,
    12. place for the treatment of pulmonary tuberculosis.

ILLNESS - Means a Sickness or Injury.

INJURY - Means bodily injury or injuries caused by an accident. Injury includes all related conditions and recurrent symptoms. The term injury shall not include injuries for which benefits are provided or available under any Worker's Compensation, employer's liability, or similar law, or motor vehicle no-fault plan unless prohibited by law.

MSN - Is the Medicare Summary Notice sent to You explaining what Medicare has paid.

MEDICALLY NECESSARY – Means services or supplies provided by a hospital, physician or other provider that are:

A. Appropriate for the symptoms and diagnosis or treatment of the subscriber's condition, illness, disease or injury; and
B. Provided for the diagnosis, or the direct care and treatment of the subscriber's condition, illness, disease or injury; and
C. In accordance with standards of good medical practice; and
D. Not primarily for the convenience of the subscriber, or the subscriber's provider; and
E. The most appropriate supply or level of service that can safely be provided to the subscriber. When applied to hospitalization, this further means that the subscriber requires acute care as a bed patient due to the nature of the services rendered or the subscriber's condition, and the subscriber cannot receive safe or adequate care as an outpatient.
F. If the subscriber's request for coverage for a health care service or treatment is denied by the Administrator as not being medically necessary or on another similar basis, the subscriber has the right to have its decision reviewed by following the procedure outlined below. The subscriber also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her:

    1. Internal Appeals: All internal appeals for claim denials may be made by sending a letter requesting an internal review to the Administrator at 4000 House Avenue, Cheyenne, WY 82003-2266 within thirty (30) days of the date the Subscriber received the denial. The subscriber may provide the Administrator with additional information that relates to his or her claim and may request copies of information that the Administrator has that pertains to his or her claim. The subscriber may request that at least one (1) accredited medical consultant who is not an Employee of the Administrator review his or her appeal if the claim was denied as not being medically necessary or on a similar basis.

    The Administrator will notify the subscriber of its decision in writing within forty-five (45) days of receiving the appeal. If the subscriber does not receive the decision within the forty-five (45) days allowed, the Subscriber may be entitled to file a request for external review. The subscriber also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her. After having completed an internal review, the subscriber may

have a right to an external review.

2. External Review: If the Administrator denies the subscriber's request for the provision of or payment for a health care service or course of treatment on the basis that it is not medically necessary or on another similar basis, the subscriber may have a right to have the decision reviewed by health care professionals who have no association with the Administrator and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice. The subscriber also may have the right to an expedited review under circumstances where a delayed review would adversely affect him or her. The subscriber must submit a request for external review within sixty (60) days after receipt of this notice to the Administrator's appeals office. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.

3. Expedited Review: The Subscriber may be entitled to an expedited review when his or her medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

   a. The timeframe for the completion of a normal review would seriously jeopardize the Subscriber's life or health or would jeopardize his or her ability to regain maximum function; or

   b. The Subscriber's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

To request an external review or an expedited review, the subscriber must complete the REQUEST FORM and RELEASE OF RECORDS that accompanied his or her claims denial, together with the documents requested, including a health care professional's statement of medical necessity. The required fee must accompany the request. The subscriber's request must be received at the Administrator's office at 4000 House Avenue, Cheyenne, WY 82003-2266 within sixty (60) days of the date on the Notice of Appeal Rights. The cost of the external review shall be the responsibility of the Administrator.

MEDICARE – The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES - Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

MEMBER HOSPITAL - Means any Hospital that is certified by Medicare and is under contract with a Blue Cross Plan.

MENTAL OR NERVOUS DISORDERS - Those conditions listed in the International Classification of Diseases as psychoses, neuroses, personality disorders and other non-psychotic mental disorders.

NON-CONTRACTING HOSPITAL - Means any Hospital that is not a Member Hospital. We will make payment for covered services in this type of facility only to You.

NOTIFICATION OF BENEFITS - This is the Notification of Benefits which We will mail to You explaining what We have paid or refused to pay.

NURSE - Is a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

PHYSICIAN – Means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.

The issuance by a state of a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards determine whether a particular physician has legal authorization. If state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered. NOTE: The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

PROVIDER - Means any person who is recognized by the law and the state in which treatment is received as being qualified to treat the type of Illness for which benefits are provided.

PRE-EXISTING CONDITION - Any condition in the subscriber (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately preceding the enrollment date. A subscriber's pregnancy existing on the subscriber's effective date of coverage is considered a pre-existing condition.

PRESCRIPTION DRUGS AND MEDICINES - Are those which require a written prescription for purchase and which, under the Federal Food, Drug and Cosmetic Act, are required to state "Caution: Federal law forbids dispensing without a prescription." All drugs and medicines must be approved by the Food and Drug Administration, and not identified as "experimental." Insulin is not considered to be a covered prescription medicine.

PRESCRIPTION ORDER - Means the order for Prescription Medication issued by a Physician licensed to make such an order.

SICKNESS - Means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

SKILLED NURSING FACILITY - Provides skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g. a nursing home) or a part of an institution (e.g. a convalescent wing of a hospital). It must be licensed or approved under state or local law, meet the health and safety conditions prescribed by the Secretary of Health and Human Services (HHS), and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified Skilled Nursing Facility has attempted in good faith, but without success to enter into a transfer Agreement, this requirement may be waived by the appropriate state agency.

The term Skilled Nursing Facility does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis for Medicare purposes.

SKILLED NURSING SERVICE - Means a service which is furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result as defined by Medicare Guidelines.

SUBSCRIBER - The person whose name appears on the identification card.

THE POOL – The Wyoming Health Insurance Pool, a not-for-profit entity created by statute.

PART XI -- COVERAGE

When, due to illness or accident, You receive Covered Services while this Agreement is in force, We will make payment as follows:

A. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

B. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

C. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnosis Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

D. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

E. Coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

F. Medicare Part A Deductible: Coverage for all the Medicare Part A inpatient hospital deductible amount per benefit period.

G. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

H. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

I. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverages for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

J. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness or sudden and unexpected onset.

K. Hospice Care: Coverage for the Medicare eligible expenses for inpatient respite care.

L. Transplants: All transplants and transplant services that are covered by Medicare A and B, which includes the following organs:

1. Heart
2. Lung
3. Kidney
4. Pancreas
5. Intestine
~~1.~~6. Liver

Organ Transplant coverage shall also include:

1. Necessary tests, labs, and exams before surgery
2. Transplant drugs also called immunosuppressive drugs (under certain conditions if these drugs are covered under Medicare Part B)
3. Follow-up care
4. Procurement of organs

Follow-up care or complications from transplants received prior to February 14, 2019 shall be a covered benefit.

PART XII -- PRE-EXISTING CONDITIONS LIMITATION

Any condition in the subscriber (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately preceding the enrollment date, will NOT be covered as a benefit under this Agreement for a period of twelve (12) months following the subscriber's enrollment date. A subscriber's pregnancy existing on the subscriber's effective date of coverage is considered a pre-existing condition.

In determining whether this pre-existing condition exclusion period applies to an eligible subscriber, the Wyoming Health Insurance Pool will credit the time an eligible subscriber was previously covered by creditable coverage, provided there was not a significant break (90 days) in coverage from the previous creditable coverage. Waiting periods applicable under this individual health plan shall not be considered in determining if a significant break in coverage has occurred and will be credited toward any pre-existing condition exclusion period under this Agreement.

PART XIII -- EXCLUSIONS

In accordance with the provisions of this Agreement, the Wyoming Health Insurance Pool will not pay for any of the following services, supplies, situations, hospitalizations, or related expenses:

A. Care, charges, and supplies which are not covered by Medicare, except those described in PART X. above. Examples of care and supplies not covered by either Medicare or this Agreement include, but are not limited to:

1. Private duty nursing.

2. Skilled nursing home care costs beyond 100 days per benefit period.

3. Custodial nursing home care.

4. Dental care or dentures.

5. Checkups and most routine immunizations.

6. Cosmetic surgery.

7. Routine foot care.

8. Examinations for and the cost of eyeglasses or hearing aids.

9. Other care and supplies not listed above.

10. Prescription drugs.

11. Some o~~O~~rgan and tissue transplant services, with the exception of high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support. Necessary drugs related to transplants that are covered by Medicare Part D plan will not be a benefit of WHIP.

B. Care that is not medically necessary under Medicare program standards. For example, We would not pay if Your doctor admits You to a hospital or skilled nursing facility when the kind of care You need could be provided at home or in an outpatient facility.

PART XIV –NON-DUPLICATION PROVISIONS

A. Non-Duplication with Medicare. Your contract does not cover that part of any services and supplies for which Medicare has paid or will pay You.

B. Exclusion due to Eligibility for Duplicate Coverage. If You are eligible for group health insurance or a group health insurance arrangement provided in connection with a policy, plan, or program sponsored by an employer and subject to regulation as a group health plan under federal or state law, even though the employer coverage is declined, You are not eligible for coverage under this Agreement.

C. Subrogation. For all benefits provided or paid under this Agreement, the Pool shall be subrogated and succeed to any rights of recovery of a subscriber for expenses incurred against any person or organization. The subscriber shall take action, furnish such information and assistance, and execute such papers as the Administrator may require to facilitate enforcement of the Pool's rights, and shall take no action prejudicing the rights and interests of the Pool under this Agreement. The subscriber shall pay the Pool all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of benefits provided or paid under this Agreement.

PART XV -- GENERAL PROVISIONS

The following general provisions apply to all benefits in this Agreement.

Reinstatement: If any renewal premiums are not paid within the time granted for the subscriber for payment, a subsequent acceptance of premiums and the application for reinstatement by the subscriber and acceptance by the Pool without the refund of premiums by the Pool, shall reinstate the policy. The Agreement will be reinstated upon approval of such application by the Pool or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Pool has previously notified the subscriber in writing of its disapproval of such application by deposit in the U.S. mail. The reinstated Agreement shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the subscriber and the Pool shall have the same rights thereunder as they had under the Agreement immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premiums accepted and without refund by the Pool, in connection with a reinstatement shall be applied to a period for which premiums may not have been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Proofs of Loss: Written proof of loss must be furnished to the Administrator at its office at 4000 House Avenue; P.O. Box 2266; Cheyenne, Wyoming 82003, in case of claim for loss for which this Agreement provides any periodic payment, contingent upon continuing loss within ninety (90) days after the termination of the period for which the Pool is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish proof within the time required does not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, not later than one year from time the proof is otherwise required.

Physical Examination and Autopsy: The Pool, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Genetic Information Nondiscrimination Act (GINA): The Pool complies with the health insurance provisions of the Genetic Information Nondiscrimination Act (GINA) of 2008.

Indemnification: This policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

Entire Contract and Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Wyoming Health Insurance Pool and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Grace Period: If the monthly charges shall not be paid when due, the Agreement shall terminate forthwith as of the date of non-payment without any notice whatsoever. Unless not less than five days prior to a due date, the Pool has delivered to the subscriber or has mailed to the subscriber's last known address as shown on the records of the Pool, written notice of its intention not to renew this Agreement, a grace period of thirty-one (31) days will be granted for the payment of the monthly premium falling due after the first due date, during which grace period this Agreement shall remain in force.

Notice of Claim: Written notice of claim must be given to the Administrator within sixty (60) days after the occurrence or commencement of any loss covered by the Agreement, or as soon thereafter as is reasonably possible. Such written notice given to the Administrator at its office at 4000 House Avenue, PO Box 2266, Cheyenne, Wyoming 82003 by, or on behalf of, the subscriber or the beneficiary, with information sufficient to identify the subscriber and the precise nature of the claim, shall be deemed notice to the Administrator.

Claim Forms: The Administrator, upon receipt of a notice of claim, shall furnish to the claimant such forms as are usually furnished by it for filing evidence of loss. If such forms are not furnished within fifteen (15) days of the filing of such notice, the claimant shall be deemed to have complied with the requirements of this Agreement as to notice of loss upon submitting, within the time fixed in the Agreement for filing notice of claim, written proof covering the occurrence, the character, and extent of the loss for which claim is made.

Time of Payment of Claim: Benefit payable under this Agreement for any loss, other than loss for which this Agreement provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss.

IN WITNESS WHEREOF, this Agreement is executed by the Pool through its duly authorized officer, undersigned, to take effect 12:01 a.m. Mountain Time on the date of issue set forth on the face of this Agreement.

Rick Schum, Wyoming Health Insurance Pool Board President