



Wyoming Chambers Welfare Benefit Association

AN INVESTMENT IN
YOUR COMPANY
YOUR EMPLOYEES
YOUR COMMUNITY
YOUR CHAMBER OF COMMERCE

Plan Description

A SUMMARY OF THE WYOMING CHAMBERS HEALTH BENEFIT PLAN

The Wyoming Chambers Health Benefit Plan is a non-grandfathered benefit Plan under the Patient Protection and Affordable Care Act of 2010. This means the Plan includes the mandated coverage(s) as required in the law for the benefit of Plan participants.

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

PARTICIPATING CHAMBERS

Campbell County Chamber of Commerce
Sheridan County Chamber of Commerce
Douglas Chamber of Commerce
Powell Chamber of Commerce
Thermopolis Chamber of Commerce
Lander Area Chamber of Commerce
Casper Area Chamber of Commerce
Newcastle Chamber of Commerce
Star Valley Area Chamber of Commerce
Torrington Area Chamber
Albany County Chamber

The Wyoming Chambers Health Benefit Plan is:

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



WYOMING CHAMBERS WELFARE BENEFIT ASSOCIATION

Julie Simon, President

Gail Lofing, Plan Administrator

Campbell County Chamber of Commerce

314 South Gillette Ave.

Gillette, WY 82716

(307) 682-3673

Program Objectives

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

Defined Contribution Healthcare

IN A DEFINED CONTRIBUTION STYLE PLAN

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

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

EMPLOYEES CHOOSE the plan that best fits their need...

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

DEFINED CONTRIBUTION HEALTHCARE

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

One benefit plan
DOES NOT fit all
employees' healthcare needs!

ENROLLMENT REQUIREMENTS/CONTINGENCIES

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

Group Medical Plans

	Plan - 1	Plan - 2	Plan - 3	Plan - 4	Plan - 5	Plan - 6	Plan - 7
Deductible Amount							
Single	\$500	\$1,000	\$1,500	\$250 per Month	\$2,500	\$5,000	\$2,500
Family	\$1,000	\$2,000	\$3,000		\$5,000	\$10,000	\$5,000
Co-Insurance							
Non-Network	50% to \$6,000	80% to \$8,000	50% to \$7,000	50% to \$7,000	90% to \$8,000	90% to \$8,000	50% to \$12,000
PPO	60% to \$6,000	90% to \$8,000	60% to \$7,000	60% to \$7,000	90% to \$3,000	100%	60% to \$12,000
Out-of-Pocket Maximum							
Non-Network							
Single	\$3,500	\$2,600	\$5,000	\$3,500	\$3,300	\$5,800	\$8,500
Family	\$7,000	\$5,200	\$10,000	\$7,000	\$6,600	\$11,600	\$17,000
PPO							
Single	\$2,900	\$1,800	\$4,300	\$2,800	\$2,800	\$5,320	\$6,300
Family	\$5,800	\$3,600	\$8,600	\$5,600	\$5,600	\$10,640	\$12,600
Out of Pocket Amounts are cross accumulating							
Accident Benefit	100% to \$1,000/person/year	100% to \$1,000/person/year	100% to \$1,000/person/year	100% to \$1,000/person/year	100% to \$1,000/person/year	100% to \$1,000/person/year	100% to \$1,000/person/year
Dr. Office Co-Pay							
Primary Care	Ded & Coins	\$30	\$30	Ded & Coins	Ded & Coins	Ded & Coins	\$30
Specialist							
Non-PPO	Ded & Coins	\$125	\$125	Ded & Coins	Ded & Coins	Ded & Coins	\$125
PPO		\$70	\$70				\$70
Rx Card Co-Pay							
Generic					Deductible & Co-insurance	Deductible & Co-insurance	
Preferred	\$7	\$7	\$7	\$7			\$7
Non-Preferred	\$15	\$15	\$15	\$15			\$15
Brand Name							
Preferred	\$35	\$35	\$35	\$35			\$35
Non-Preferred	\$75	\$75	\$75	\$75			\$75

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

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

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

ALL PLANS INCLUDE

- ➡ Mail Order Pharmacy (Wyoming Company)
- ➡ Medically Necessary Ambulance Coverage
- ➡ Credit for Pre-Existing Conditions (with Proof of Credible Coverage)
- ➡ \$2,000,000 Annual Maximum per insured / Unlimited Lifetime
- ➡ \$150 Co-pay for Non-Emergency use of Emergency Room
- ➡ Out-of-Pocket Maximum = Deductible amount + Co-insurance amount
- ➡ Maternity Coverage Options
 - ➡ As "normal" coverage; or
 - ➡ Coverage following a \$7,500 Deductible Amount (Groups of 14 covered employees or less)
- ➡ Limited Chiropractic Benefits
- ➡ Credit for Prior Group Deductible Amount Met
- ➡ Dr. Office Co-Pay Limits (per visit)
 - ➡ \$200 - Primary Care Provider
 - ➡ \$500 - Specialist
- ➡ Amounts over limit apply to deductible & co-insurance
- ➡ Routine Wellness (Annual Limits)
 - ➡ 100%
 - ➡ Includes Annual Exams
 - ➡ Wellness Mammograms, Pap Tests and PSA Tests at 100%
- ➡ PPO Benefits provided
- ➡ Group Life Insurance with Matching AD&D (\$15,000 per employee)



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

Dental Schedule of Benefits

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

Self-Audit Billing Credit

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

In the event a participant's self-audit results in elimination or reduction of charges, twenty-five percent (25%) of the amount eliminated or reduced will be paid directly to the participant (subject to a twenty dollar (\$20) minimum savings, provided the

savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Benefit Services Administrator (e.g., A copy of the incorrect bill and a copy of the corrected billing.)

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the plan as well as the plan participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the plan member's liability) on an incorrect billing.

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

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

- A Health Risk Assessment
- Biometric Full Blood Panel Screening

Wellness Initiative

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

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

Benefits available...but NOT limited to:

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

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

Benefits Exclusion:

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

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

Section 125 - Section 125 of the Internal Revenue Code allows for the premiums paid by employees for employer provided group benefits to be withheld from employee pay on a pre-tax basis. **The Wyoming Chamber Health Benefit Plan qualifies as an employer sponsored group benefit plan that could be offered under an employer's Section 125 plan. However, before an employer can offer pre-tax premium payments for his or her employees, the employer must adopt a separate "Section 125 Plan" and allow employees the right to choose whether they wish to participate.** The claims administrator for the Wyoming Chamber Health Benefit Plan has sample documents and/or administration options an employer may need, in order to adopt a pre-tax Section in consultation with the employer's tax counsel. For clarification, please consult with your Agent or the Trust's consultant.

**NOT ALL
HOSPITALS and
PHYSICIANS
perform at the same
level.**

**If a participant is
going to seek care
with a Specialist,
the Centers of
Excellence Program
is an option for that
care.**

**High Quality
providers at a VERY
competitive cost.**

**When claims costs
are lower,
premiums are lower
... when outcomes of
surgeries are high,
costs are lower ...
win-win.**

Centers of Excellence

*I*n Health Care, as with all other issues of life, there are Doctors and Hospitals that do what they do better than others in their same profession. Many times, because they do their service so very well, it saves the patient recovery time, complication risks and cost of care.



The locations where these services are available, the quality of their care is exceptional along with a competitiveness of price is offered, are called Centers of Excellence.

In typical benefit programs, Centers of Excellence are used particularly for transplant

FOR JOINT REPLACEMENT AND
University of Utah Medical Center
“One of America's Best”

Over the years, our reputation of excellence has



FOR NEUROSURGICAL NECK AND BACK
Poudre Valley Health Systems

“Poudre Valley Health System, based in Fort Collins, Colorado since 1925. With two hospitals, Poudre Valley Hospital in Fort Collins and Medical Center of the Rockies in Loveland, plus a network of clinics and care facilities, our mission is to



FOR CARDIOVASCULAR / HEART
Mayo Clinic in Rochester, MN

“Thousands of patients come to Mayo Clinic in Rochester, Minnesota every day for diagnosis or treatment of a medical problem. Patients can make their own appointments or be referred by a physician.



There are hospitals and physicians who, through training and quality control measures perform their services to the very best levels. Many of these providers also contract with benefit plans for very aggressive pricing. When care is sought at these facilities, for certain diagnosed conditions the Plan will alter the structure of how benefits are paid and include a travel allowance for the participant and companion.

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

Submission Checklist 1

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

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

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

Submission Checklist 2

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

ACCEPTANCE FORM	This form shows that the group has been accepted along with the names of the employees who applied, the benefit plan chosen, the billed rates for that plan, and the group's total premium per month. This form must be signed and returned by the employer <u>within 1 week</u> .
FIRST MONTH'S PREMIUM	The first month's premium must be submitted (check made out to the Trust). Available bill payment options are included (invoicing with either check payment, ACH payment or EFT payment).
ADOPTION AGREEMENT	This contract outlines the obligations of the Plan and the Employer, for the duration of the benefit plan. Two copies must be signed and returned. Both will be countersigned and one returned to the employer.

