

Health Care Coverage Plan

THE STATE OF WYOMING

DAVE FREUDENTHAL
GOVERNOR

01/2003

Purpose

The Wyoming Health Insurance Pool was created by the 1990 Wyoming Legislature to provide health insurance coverage to residents of Wyoming who are denied adequate health insurance. This plan is specially designed to meet the needs of those individuals who are unable to purchase health insurance for themselves because of existing health problems.

Benefits

Two options are available from the Wyoming Health Insurance Pool: The Brown Plan and The Gold Plan. Coverage under both plans includes Type A, Type B and Type C benefits and are differentiated by certain benefits and how they are paid.

Type A Benefits: These benefits include high cost expenses such as inpatient hospitalization, outpatient and office surgery, and ambulance services.

Type B Benefits: These benefits include the smaller, less costly items and services such as outpatient prescriptions, outpatient medical care, office calls and physical therapy.

Type C Benefits: These benefits include maternity care including prenatal care, delivery and postnatal care.

Out-of-Pocket Cost: The out-of-pocket cost includes the deductibles and coinsurance paid by a member. Once the out-of-pocket maximum has been met, the plan will pay 100% of Reasonable and Customary charges for covered services.

Lifetime Maximum: The Wyoming Health Insurance Pool will pay benefits up to the specified amount during a member's lifetime.

Membership & Eligibility

1. Applicant must be a resident of the state of Wyoming and certify occupation of a dwelling in the state of Wyoming.

2. Applicant will be required to complete an application for coverage. Upon administrative approval, coverage will begin on the 1st or the 16th of the month.

3. Applicant must meet one of the following eligibility requirements and provide proof of eligibility:

a) Applicant has been refused coverage for health reasons by one insurer;

b) Applicant has health insurance coverage more restrictive than the Pool;

c) Applicant has health insurance coverage at a rate exceeding the Pool; or

d) Applicant is a Federally eligible individual

4. The following persons ARE NOT eligible for coverage:

a) Any person who has coverage under health insurance or an insurance arrangement on the issue date of Pool coverage, except those who provide evidence of termination of the coverage to the administrator within seven (7) months of the effective date of the Pool coverage.

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

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

d) Any person on whose behalf the Pool has paid the lifetime maximum benefit under any Pool plan.

e) Any person who is an inmate of a public institution.

	Brown Plan Out-of-Pocket Maximum	Gold Plan Out-of-Pocket Maximum
Individual	$4,000 Annually	$2,000 Annually
Adult & Dependent	$8,000 Annually	$4,000 Annually
Two Adult	$8,000 Annually	$4,000 Annually
Family	$8,000 Annually	$4,000 Annually
	Brown Plan Lifetime Maximum	**Gold Plan Lifetime Maximum**
Per Individual	$350,000	$600,000

Summary of Benefits

Benefits	Brown Plan* You Pay	Gold Plan* You Pay	We Pay	Features
Type A Benefits				
Hospital Services Inpatient and Outpatient	One $500 deductible per admission	One $250 deductible per admission	80% of R&C after the deductible	• Semi-private room and board • Intensive Care • Ancillary Services • Outpatient Surgical Services
Physician Services Inpatient and Outpatient Surgery	No deductible	No deductible	80% of R&C	• Surgical Services • Surgeon • Assistant Surgeon • Anesthesiologist
Office Surgery	$100 deductible per day	$75 deductible per day	80% of R&C after the deductible	• Surgery • Preoperative visits • Local administration of anesthesia • Follow-up care • Recasting
Inpatient Medical	Subject to the $500 per admission deductible	Subject to the $250 per admission deductible	80% of R&C after the deductible	• In-hospital visits • Consultations
Ambulance Services	No deductible	No deductible	Reimbursed at 80% of R&C (subject to contract maximums)	Ambulance services are covered up to $150/ground trip and $2,000/air trip.
Type B Benefits				
Nervous/Mental Substance Abuse				• Outpatient Psychotherapeutic (limited to 30 visits/calendar year and up to $30 per visit) • Inpatient treatment for nervous and mental or psychotherapeutic services is limited to $5,000 per 12 month period. • Alcohol or drug abuse payable to a lifetime maximum of $5,000
Other Covered Services	$2,000 deductible per individual per calendar year	$1,000 deductible per individual per calendar year	70% of R&C	• Rehabilitation Therapy (limited to a lifetime maximum of $20,000 for Brown Plan and $25,000 for Gold Plan) • Physician Office Calls • Supplies and Appliances • Durable Medical Equipment • Outpatient Prescription Drugs • Outpatient Diagnostic, x-ray and lab • Outpatient medical services including x-ray and laboratory • Physical Therapy (limited to 20 visits/calendar year) • Chemotherapy and Radiation Therapy • Diabetes services • Spinal Manipulations (limited to $500/per calendar year)
Wellness	Not a benefit	No deductible	$150 per individual per calendar year	• Preventive and screening services •
Type C Benefits				
Maternity	$4,000 deductible	$2,000 deductible	100% of R&C	• Prenatal Care Delivery Postnatal Care

*NOTE: As shown above, there are two Plan options available: The Brown Plan and The Gold Plan. Upon enrollment in the Wyoming Health Insurance Pool and receipt of premium payment, switching between Plan options is not permitted.

Managed Care Program

The Managed Care Features of the Pool's health care coverage plan are designed to help control the cost of your health care without reducing your benefits. By using the features listed here, you can be assured of receiving quality health care in the most cost effective setting.

• Pre-admission Authorization. This is required on all non-emergency, non-maternity hospital admissions. It ensures that your hospitalization care is medically necessary and performed in the appropriate setting. It also allows you to confirm coverage prior to treatment.

If pre-admission authorization is not obtained, benefits will be reduced by $500 under The Brown Plan or $250 under The Gold Plan after the deductible.

• ***Pre-admission Testing.*** Laboratory and radiology tests can generally be performed prior to the time you enter the hospital.

• ***Office Surgery.*** Surgery performed in a physician's office not only reduces out-of-pocket costs but may also be more convenient for you.

• ***Generic Drugs.*** A generic drug is a generally accepted substitute for a name-brand drug which may be more costly. You can generally recognize significant savings without sacrificing quality.

• ***Second Surgical Opinion.*** It is suggested that a second surgical opinion be sought to determine whether a recommended surgery is the best course of treatment.

Pre-existing Conditions

This program conforms to all Federal and State requirements regarding pre-existing condition exclusion periods including the definition of pre-existing conditions and the portability of pre-existing condition exclusion periods. Benefits will not be provided for pre-existing conditions for a period of twelve (12) months following the member's date of enrollment. Pre-existing conditions are those conditions for which medical advice, diagnosis, care or treatment was recommended or received in the six (6) months immediately preceding the enrollment date of coverage. Pregnancy existing on the enrollment date of coverage is considered a pre-existing condition.

In determining whether this pre-existing condition exclusion period applies to an eligible member, the Wyoming Health Insurance Pool will credit the time a member was previously covered by creditable coverage, provided there was not a significant break in coverage (90 days) from the previous creditable coverage. Waiting periods applicable under this individual health benefit 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.

General Limitations and Exclusions

We will not pay for: Acupuncture, artificial conception, autopsies, biofeedback services, birth control pills and devices, complications of non-benefit services, convalescent care, cosmetic surgery, custodial care, diagnostic admissions, domiciliary care, experimental or investigative procedures, eye care, genetic counseling, obesity and weight loss, hair loss, hypnosis, tobacco dependency, orthognathic surgery, eye examinations, foot care services, hearing examinations, organ and tissue transplants including pre-and post-operative care and immunosuppressant drugs, routine physicals and examinations (Brown Plan only), sex change operations, subluxation, temporomandibular joint dysfunction, non-medical therapies, travel expenses and services or supplies covered under Worker's Compensation or provided by a government facility or institution.

This application is for:

❑ Single coverage ❑ Family coverage
❑ Two-adult coverage ❑ Adult & dependent(s) coverage

I would like to enroll in the: ❑ Brown Plan ❑ Gold Plan

WYOMING HEALTH INSURANCE POOL

4000 House Avenue
PO Box 2419
Cheyenne, Wyoming 82003
1-888-557-2519 or (307) 432-2828

Enrollment may be delayed if application is not complete and accompanied by required documentation.

For Office Use Only
Completed App. Rec'd
Approval Date
Effective Date
Class
Group #
P.E.

Name _____ ❑ Male ❑ Female
Please Print

Address _____

City _____ Zip _____

Home Phone _____ Work Phone _____

Your Social Security Number _____ Date of Birth _____

Current Employer _____

Print the names and dates of birth of spouse and unmarried children 19 and under to be covered below .

PRINT FIRST NAME AND INITIAL (LAST NAME IF DIFFERENT)	MONTH	DAY	YEAR	RELATIONSHIP	SOCIAL SECURITY #

Proof of eligibility must be attached for each individual to be covered.

I am eligible for coverage under the Wyoming Health Insurance Pool because (you need only to mark one to be eligible for coverage):

❑ I have been refused health insurance for health reasons by one health insurance company; **OR**
❑ I have health insurance coverage that is more restrictive than Pool coverage; **OR**
❑ I have health insurance coverage at a higher premium than the Pool rate; **OR**
❑ I am a Federally eligible individual. (See the attached brochure for the definition of a Federally eligible individual.)

What medical condition prompted you to apply for coverage with the Wyoming Health Insurance Pool? _____

When were you last treated for this condition? _____

RESIDENCY REQUIREMENTS

I certify that I currently occupy a dwelling in the State of Wyoming, intend to make Wyoming my home and meet a **MINIMUM OF TWO** of the following four requirements. (In the case of a minor child, this criteria must be met by the custodial parent.)

❑ I am registered to vote in the state of Wyoming.
❑ I have applied for or have received a Wyoming drivers license.
❑ My minor children attend school in the state of Wyoming. (If the applicant attends school, then he/she must attend school in the state of Wyoming.)
❑ I have applied for or currently receive service in my name from a public utility at a dwelling within the state of Wyoming.

Please bill me: ❑ Monthly ❑ Quarterly ❑ Semi-annually ❑ Pre-authorized bank draft (Authorization Form below must be completed)
SEND NO MONEY NOW

Sign Here X _____ Date _____ X _____
DO NOT PRINT Applicant's Signature (or Custodial Parent's) Spouse's Signature (if applying for coverage)

AUTHORIZATION FORM FOR BANK DRAFT

Account Number _____ Date _____

I hereby authorize the _____ of _____
(Name of Bank) (Town)

Wyoming, to deduct monthly from my account, by draft of Electronic Funds Transfer, the current membership charges for the Wyoming Health Insurance Pool by Blue Cross Blue Shield of Wyoming. This authorization shall continue in effect until revoked by me in writing.

X _____
Bank Account Holder's Signature

PLEASE NOTE: In order to process this request, we require that you enclose a voided check or deposit slip in order to ensure correct account handling.

Please attach Creditable Coverage Certificates for all individuals applying for coverage on this application.

List any health insurance plans that you have had or that have accepted you for coverage in the past 18 months:

1. Company name_____ Policy #_____

Effective date _____MO _____DAY YEAR Cancellation date _____MO _____DAY _YEAR

Was this coverage ❑ Group ❑ Individual Was this coverage provided through your employer? ❑ YES ❑ NO

2. Company name_____ Policy #_____

Effective date _____MO _____DAY _____ YEAR Cancellation date _____MO _____DAY _YEAR

Was this coverage ❑ Group ❑ Individual Was this coverage provided through your employer? ❑ YES ❑ NO

If you are currently employed, does your employer offer group health coverage? ❑ YES ❑ NO If yes, why are you not enrolled in this employer-based plan? _____

Are you currently receiving Medicaid health care benefits ? ❑ YES ❑ NO

Are you currently receiving both Medicare Part A and Part B benefits due to disability? ❑ YES ❑ NO

If so, list date of eligibility for Part A* _____ Part B* _____ *Please refer to your Medicare card

CERTIFICATIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS—This program conforms to all Federal and State requirements regarding pre-existing condition exclusion periods including the definition of pre-existing conditions and the portability of pre-existing condition exclusion periods. Benefits will not be provided for pre-existing conditions for a period of twelve (12) months following the member's date of enrollment. Pre-existing conditions are those conditions for which medical advice, diagnosis, care or treatment was recommended or received in the six (6) months immediately preceding the enrollment date of coverage. Pregnancy existing on the enrollment date of coverage is considered a pre-existing condition.

In determining whether this pre-existing condition exclusion period applies to an eligible member, the Wyoming Health Insurance Pool will credit the time a member was previously covered by creditable coverage, provided there was not a significant break in coverage (90 days) from the previous creditable coverage. Waiting periods applicable under this individual health benefit 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.

A. I understand upon acceptance of my application my coverage will become effective on the date established by the Wyoming Health Insurance Pool and that the Master Agreement, together with this application and attachments, if any, shall constitute my entire agreement with the Wyoming Health Insurance Pool.

B. I certify that my spouse and all children listed on this application are residents of the state of Wyoming as defined on the front of the application.

C. I CERTIFY THAT THE STATEMENTS MADE ON THE APPLICATION ARE TRUE.

D. I REALIZE THAT ANY MISREPRESENTATION, FAILURE TO REVEAL MATERIAL INFORMATION ASKED FOR ON THIS APPLICATION, OR INCORRECT INFORMATION WILL RENDER THE CONTRACT NULL AND VOID, OR SUBJECT TO CANCELLATION, OR TO THE DISALLOWANCE OF COVERAGE FOR THE CONDITION OR THE PERSON ABOUT WHICH THE MISREPRESENTATION, OMISSION, OR INCORRECT INFORMATION OCCURRED AT THE SOLE DISCRETION OF THE WYOMING HEALTH INSURANCE POOL.

E. I hereby apply for coverage with the Wyoming Health Insurance Pool under the terms and conditions stated in the Master Agreement, including the coordination of benefits provision.

THE FOREGOING HAS BEEN EXPLAINED AND I UNDERSTAND THE BENEFITS, LIMITATIONS AND EXCLUSIONS OF THE WYOMING HEALTH INSURANCE POOL, INCLUDING THE PRE-ADMISSION AUTHORIZATION REQUIREMENTS.

Sign Here X _____ Date _____ X _____

DO NOT PRINT Applicant's Signature (or Custodial Parent's) Spouse's Signature (if applying for coverage)

FOR AGENT'S USE ONLY

You must attach a copy of your license to receive referral fee.

Agent Name _____ Agent Signature _____

Tax ID#_____ Agent Phone Number _____

Agent Address_____

DATE _____

A State of Wyoming program administered by Blue Cross Blue Shield of Wyoming W100 01/2003

INDEMNIFICATION AGREEMENT

To: The Bank named on the reverse side.

In consideration of your participation in a plan which Blue Cross Blue Shield of Wyoming has put into effect by which amounts due on Wyoming Health Insurance Pool agreements are collected by checks drawn by Blue Cross Blue Shield of Wyoming on the accounts of persons who are responsible for these payments. BLUE CROSS BLUE SHIELD OF WYOMING DOES HEREBY AGREE THAT:

(1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by Blue Cross Blue Shield of Wyoming on the account of such person, or arising out of the dishonor by you, whether with or without cause of intentionally or inadvertently, of any such check drawn by Blue Cross Blue Shield of Wyoming, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a Wyoming Health Insurance Pool contract the dues on which is sought to be collected by Blue Cross Blue Shield of Wyoming by any such check; and

(2) It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payments is made by you within twelve months from the date of the check on which such erroneous payment was made.

BLUE CROSS BLUE SHIELD OF WYOMING

By: Tom Grilly, President and Chief Executive Officer

WYOMING HEALTH INSURANCE POOL
4000 House Avenue
P.O. Box 2419
Cheyenne, Wyoming 82003

Monthly Rates Effective July 1, 2004

The Brown Plan

Age	Single Male	Single Female	Two Adult	Each Child
under 30	$262.00	$390.00	$652.00	$169.00
30 - 39	$323.00	$452.00	$775.00	
40 - 44	$390.00	$519.00	$909.00	
45 - 49	$468.00	$585.00	$1053.00	
50 - 54	$571.00	$650.00	$1221.00	
55 - 59	$673.00	$716.00	$1389.00	
60 - 64	$780.00	$780.00	$1560.00	
65 & over	$908.00	$908.00	$1816.00	

The Gold Plan

Age	Single Male	Single Female	Two Adult	Each Child
under 30	$355.00	$535.00	$890.00	$229.00
30 - 39	$446.00	$622.00	$1067.00	
40 - 44	$535.00	$712.00	$1246.00	
45 - 49	$639.00	$796.00	$1436.00	
50 - 54	$782.00	$893.00	$1675.00	
55 - 59	$924.00	$982.00	$1906.00	
60 – 64	$1067.00	$1067.00	$2134.00	
65 & over	$1245.00	$1245.00	$2490.00	

The **Each Child** rate is the rate per eligible child that is included on an adult's contract. Regardless of the number of eligible children on an adult's contract, the Pool will only charge a maximum of four times the **Each Child** rate. A child who is on a contract alone will be subject to the rate listed under **Single Male** or **Single Female.**

Billing Options (you may choose between 1 or 2):

1. We will send you a bill in the mail on the schedule you choose:
   Monthly: the rate is listed above
   Quarterly: the rate is three times the monthly rate listed above
   Semi-annually: the rate is six times the monthly rate listed above
2. We will automatically withdraw the monthly premium from your checking account each month. A voided check or deposit slip is required for proper account handling.

WYOMING HEALTH INSURANCE POOL

4000 House Avenue
P.O. Box 2419
Cheyenne, Wyoming 82003

Medicare Disabled Member Rates

Monthly Rates Effective July 1, 2004

The Brown Plan

Age	Single Male	Single Female
under 30	$50.00	$76.00
30 – 39	$62.00	$85.00
40 – 44	$76.00	$98.00
45 – 49	$87.00	$112.00
50 – 54	$112.00	$122.00
55 – 59	$130.00	$135.00
60 – 64	$149.00	$149.00
65 & over	$173.00	$173.00

The Gold Plan

Age	Single Male	Single Female
under 30	$68.00	$101.00
30 - 39	$84.00	$117.00
40 – 44	$101.00	$132.00
45 – 49	$123.00	$153.00
50 – 54	$153.00	$169.00
55 – 59	$177.00	$185.00
60 – 64	$205.00	$205.00
65 & over	$237.00	$237.00

Billing Options (you may choose between 1 or 2):

1. We will send you a bill in the mail on the schedule you choose:
   Monthly: the rate is listed above
   Quarterly: the rate is three times the monthly rate listed above
   Semi-annually: the rate is six times the monthly rate listed above
2. We will automatically withdraw the monthly premium from your checking account each month. A voided check or deposit slip is required for proper account handling.