

**State of Wisconsin and Wisconsin Public Employers (WPE)
Group Health Insurance Program**

**Certificate of Coverage
2018 Benefit Year**

It's Your Choice Medicare Plus Plan

Revised 10/20/17

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I. OUTLINE OF COVERAGE

For PARTICIPANTS enrolled in IYC MEDICARE PLUS coverage, the following benefits apply. PARTICIPANTS covered under this section must be covered by MEDICARE as the primary insurer.

All benefits are paid according to the terms of this contract between the CONTRACTOR, the PBM, and the Group Insurance Board. IYC MEDICARE PLUS and this Outline of Coverage are wholly incorporated in the contract. The Outline of Coverage describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, additional services received from an NON-PARTICIPATING PROVIDER), benefits will be determined according to the REASONABLE CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the IYC MEDICARE PLUS for those who are COVERED under the State of Wisconsin Health Benefit Program.

IYC MEDICARE PLUS

Services and Supplies	Medicare Pays per Benefit Period (2017 information. Updated annually per CMS.)	Medicare Plus Pays (2017 information. Updated annually.)
<p>Hospital Semiprivate room and board and miscellaneous hospital services and supplies such as drugs, x-rays, lab tests and operating room</p>	<p>First 60 days, all but \$1,316* 61st to 90th day, all but \$329* a day 91st to 150th day, all but \$658* a day (Lifetime Reserve) If lifetime reserve days are exhausted, \$0</p>	<p>Initial \$1,316* deductible \$329* a day \$658* 100% from the 91st to 120th day of confinement</p>
<p>Licensed Skilled Nursing Facility** Medicare covered services in a Medicare Approved Facility**</p>	<p>Requires a 3-day period of hospital stay First 20 days, 100% of costs 21st - 100th days, all but \$164.50 a day Beyond 100 days, \$0</p>	<p>Requires a 3-day period of hospital stay Not Applicable \$164.50* a day All covered services up to a maximum of 120 days per BENEFIT PERIOD.</p>

Services and Supplies	Medicare Pays per Benefit Period (2017 information. Updated annually per CMS.)	Medicare Plus Pays (2017 information. Updated annually.)
		Custodial care is not covered.
<p>Licensed Skilled Nursing Facility**</p> <p>(Non-Medicare Approved Facility) If admitted within 24 hours following a hospital stay</p>	<p>Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility</p> <p>\$0</p>	<p>Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility</p> <p>Maximum daily rate for up to 30 days per confinement</p>
<p>Home Health Care**</p> <p>Under an approved plan of care, part-time services of an RN, LPN or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling</p>	<p>100% of charges for visits considered medically necessary by Medicare.</p> <p>Generally 5 visits per week for 2 to 3 weeks; or 4 or fewer visits per week as long as required</p>	<p>Up to 365 visits per year</p>
<p>Hospice Care</p> <p>Medicare certified program of terminal illness care for pain relief and symptom management. Includes: nursing care; physician services; physical, occupational and speech therapy; social worker services; home health aids; homemaker services; medical supplies. First 180 days and any Medicare approved extension</p>	<p>All covered services</p>	<p>Coinsurance or copayments for all MEDICARE Part A eligible expenses</p>

Services and Supplies	Medicare Pays per Benefit Period (2017 information. Updated annually per CMS.)	Medicare Plus Pays (2017 information. Updated annually.)
Hospice Facility	All but very limited coinsurance for inpatient respite care	Medicare copayment/coinsurance up to the equivalent charges of a Skilled Nursing Facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance; prosthetic devices; durable medical equipment	After annual \$183* Medicare deductible, 80% of allowable charges	Initial \$183* deductible and 20% of Medicare approved expenses
Physician's Services Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual \$183* Medicare deductible, 80% of allowable charges	Initial \$183* deductible and 20% of Medicare approved expenses
Drugs and Biologicals (non-hospitalization) Immunosuppressive drugs during the first year following a covered transplant Self-administered drugs prescribed by a physician	After annual \$183* Medicare deductible, 80% of allowable charges Not Covered	Initial \$183 deductible and 20% of Medicare approved expenses Refer to Pharmacy Benefit Manager portion of booklet for pharmacy benefits
Outpatient Hospital Services In an emergency room or outpatient clinic, diagnostic lab and x-rays; medical supplies such as casts, splints, and drugs which cannot be self-administered	After the annual \$183* Medicare deductible, 80% of allowable charges	Initial \$183* deductible and 20% of Medicare approved expenses
Psychiatric Treatment Other than hospital inpatient	After the annual \$183* Medicare deductible, 80% of the allowable charges	Initial \$183* deductible and the amount, which combined with the Medicare benefit,

Services and Supplies	Medicare Pays per Benefit Period (2017 information. Updated annually per CMS.)	Medicare Plus Pays (2017 information. Updated annually.)
		equals 20% of the reasonable charges
Private Duty Nursing While hospitalized and provided by an RN or LPN	\$0	\$0
Blood	After annual \$183* Medicare deductible, 80% of costs except non-replacement fees (blood DEDUCTIBLE) 1st 3 pints in each benefit period	Initial \$183* deductible and 20% of Medicare approved expenses
Prescription Drugs		See below.

* Federal Medicare deductibles are adjusted annually. Amounts shown above are for 2017. IYC MEDICARE PLUS benefits are also adjusted annually to pay these deductibles.

** Custodial care as defined is not covered.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following schedule of benefits:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

- a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.
- b) Preventive Prescription Drugs:
 - i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.
 - ii) Under the High Deductible Health Plan (HDHP), preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.
 - iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:

Level 1 COPAYMENT: \$5.00

The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:

Level 2 COINSURANCE: 20% (\$50 max)

The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% (\$150 max)

The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:

Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

- a) IYC Health Plan, IYC MEDICARE, IYC Access Plan, IYC MEDICARE Plus: \$600 per individual or \$1,200 per family for all PARTICIPANTS.
- b) IYC Access HDHP: all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

Level 3 Annual OOPL:

Level 3 out-of-pocket costs accumulate toward OOPLs as follows:

- a) IYC Health Plan, IYC MEDICARE, IYC Access Plan, IYC MEDICARE Plus: no annual OOPL.
- b) IYC Access HDHP: all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS

Specialty Drug Cost Share:

Level 4 COPAYMENT: \$50

The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

If YOU do not have MEDICARE as YOUR primary coverage, YOU must use a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% (\$200 max)

The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOP:

There is no OOP for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of \$6,850 individual / \$13,700 family.

The maximum annual amount YOU pay for YOUR Level 4 Preferred SPECIALTY MEDICATIONS.

Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPs as follows:

- a) IYC Health Plan, IYC MEDICARE, IYC Access Plan, IYC MEDICARE Plus: \$1,200 per individual or \$2,400 per family.
- b) IYC Access HDHP: all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOP of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOP is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

- 3) Certain medications as defined by the PBM:** Certain medications as defined by the PBM are available to YOU at a discount, but are not covered by the BENEFIT PLAN. These medications may include drugs for weight loss, infertility, and erectile dysfunction. YOU will pay 100% of the cost of these medications.
- 4) Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOP.
- 5) Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this IYC MEDICARE PLUS plan description, are defined and limited as follows:

ALLOWED AMOUNT: Means the maximum amount on which payment is based for covered health care services. Generally this is composed of the PROVIDER'S CHARGE, less any discount negotiated by the PBM.

ASSIGNMENT means that a PARTICIPANT'S physician or health care PROVIDER agrees (or is required by law) to accept the MEDICARE-approved amount as full payment for covered health care services.

BALANCE BILL means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against a PARTICIPANT or any person acting on the PARTICIPANT'S behalf for health care costs for which he/she is not liable. The prohibition on recovery does not affect the PARTICIPANT'S liability for any deductibles, coinsurance or copayments, or for premiums owed under the BENEFIT PLAN.

BENEFIT PERIOD means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the IYC MEDICARE PLUS option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BENEFITS means those items and services as listed. A PARTICIPANT'S right to BENEFITS is subject to the terms, conditions, limitations and exclusions of the HEALTH BENEFIT PROGRAM.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGES means the reasonable CHARGES for items or services set by MEDICARE. The CONTRACTOR treats CHARGES for stays in a HOSPITAL or licensed SKILLED NURSING FACILITY as incurred on the date of admission. The CONTRACTOR treats all other CHARGES as incurred on the date the PARTICIPANT gets the service or item. BENEFITS are payable only up to the reasonable charge set by MEDICARE, except as stated in section III. Benefits Available, below. No agreement between the PARTICIPANT (or someone acting for the PARTICIPANT) and any other person, group, or PROVIDER of services will cause the BENEFIT PLAN to pay more.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the PBM schedule of benefits.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the PBM schedule of benefits.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an PARTICIPATING PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the PARTICIPATING PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

- 1) Spouse.¹
- 2) Child.^{2, 3, 4}
- 3) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse prior to age 19.^{2, 3, 4}
- 4) Adopted child when placed in the custody of the parent as provided by [Wis. Stat. § 632.896](#).^{2, 3, 4}
- 5) Stepchild.^{1, 2, 3, 4}
- 6) Grandchild if the parent is a DEPENDENT child.^{2, 3, 4, 5}

¹ A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

² All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except when:

- a) An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is DEPENDENT on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The CONTRACTOR will monitor eligibility

annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR determination.

- b) After attaining age 26, as required by [Wis. Stat. § 632.885](#), a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

³ A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

⁴ A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

⁵ A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DURABLE MEDICAL EQUIPMENT: See MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT.

EMERGENCY: Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:

- 1) Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
- 2) Serious impairment to the PARTICIPANT'S bodily functions.
- 3) Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

Examples of EMERGENCIES are listed in [Section III, A, 1, d](#). EMERGENCY services from a NON-AFFILIATED PROVIDER may be subject to REASONABLE CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the REASONABLE CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the CONTRACTOR and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the CONTRACTOR and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or

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investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the CONTRACTOR and/or PBM concerning some aspect of the CONTRACTOR and/or PBM.

HEALTH BENEFIT PROGRAM means the program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

HEALTH PLAN: Means the health plan that is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

HOSPITAL: Means an institution that:

- 1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or
- 2) Qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission (formerly known as the Joint Commission on Accreditation of Hospitals).

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IYC MEDICARE PLUS is a fee-for-service MEDICARE supplement plan administered by the CONTRACTOR for retirees enrolled in MEDICARE Parts A and B and pays for benefits defined under this section.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

LIFETIME RESERVE DAYS mean additional days that MEDICARE will pay for when the PARTICIPANT is in a hospital for more than 90 days. The PARTICIPANT has a total of 60 reserve days that can be used during his/her lifetime. For each lifetime reserve day, MEDICARE pays all covered costs except for a daily coinsurance.

LIMITING CHARGE means the amount above the MEDICARE-approved amount billed by a NON-PARTICIPATING PROVIDER and allowed by MEDICARE.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the CONTRACTOR:

- 1) Used primarily to treat an ILLNESS or INJURY, and
- 2) generally not useful to a person in the absence of an ILLNESS or INJURY, and
- 3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and
- 4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or

treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the CONTRACTOR and/or PBM:

- 1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and
- 2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and
- 3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and
- 4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE means benefits available under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE ELIGIBLE EXPENSES means health care expenses that are covered by MEDICARE Parts A and B, recognized as MEDICALLY NECESSARY and reasonable by MEDICARE, and that may or may not be fully reimbursed by MEDICARE.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

NON-AFFILIATED PROVIDER means (1) a physician or health care PROVIDER that has decided not to provide services through MEDICARE and MEDICARE will not cover those services; or (2) a licensed health care PROVIDER who is not allowed to bill MEDICARE for services.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM'S directory of PARTICIPATING PHARMACIES.

NON-PARTICIPATING PROVIDER means that a physician or health care PROVIDER has not signed an agreement to accept assignment for all MEDICARE covered services, but they can still choose to accept assignment for individual services.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

MAXIMUM OUT-OF-POCKET LIMIT (MOOP): Means the most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health

care that YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit. The most YOU pay during a policy period (usually a calendar year) for benefits considered essential health benefits under federal law. This limit never includes YOUR premium, balance-billed charges, charges for health care YOUR BENEFIT PLAN does not cover, or services that are not considered essential health benefits.

PARTICIPANT means a SUBSCRIBER, or any of his/her DEPENDENTS, covered by MEDICARE for whom proper application for IYC MEDICARE PLUS coverage has been made and for whom the appropriate PREMIUM has been paid.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PARTICIPATING PROVIDER means that a physician or health care PROVIDER has signed an agreement to accept assignment for all MEDICARE covered services.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a third party administrator (TPA) that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

PREFERRED DRUG: Means a drug the PBM has determined offers more value and/or cost-effective treatment options compared to a NON-PREFERRED DRUG. This would include Preferred GENERIC DRUGS, Preferred BRAND NAME DRUGS and Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program.

PREFERRED SPECIALTY PHARMACY: Means a PARTICIPATING PHARMACY which meets criteria established by the PBM to specifically administer SPECIALTY MEDICATION services, with which the PBM has executed a written contract to provide services to PARTICIPANTS, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one PARTICIPATING PHARMACY as a PREFERRED SPECIALTY PHARMACY.

PRIMARY CARE PROVIDER (PCP): Means an IN-NETWORK PROVIDER who is named as a PARTICIPANT'S primary health care contact. He/She provides entry into the health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves

continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

YOU must name YOUR PCP on YOUR enrollment application. Each family PARTICIPANT may have a different PCP.

PRIOR AUTHORIZATION: Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any NON-PARTICIPATING and NON-AFFILIATED PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the HEALTH PLAN and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REASONABLE CHARGES means an amount for a health care service that is reasonable, as determined by the CONTRACTOR. The CONTRACTOR takes into consideration, among other factors (including national sources) determined by the CONTRACTOR: (1) amounts charged by health care PROVIDERS for similar health care services when provided in the same geographical area; (2) the CONTRACTOR' methodology guidelines; (3) pricing guidelines of any third party responsible pricing a claim; and (4) the negotiated rate determined by the CONTRACTOR in accordance with the applicable contract between the CONTRACTOR and a health care PROVIDER. As used herein, the term "area" means a county or other geographical area which the CONTRACTOR determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. Also, the amount the CONTRACTOR determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S) unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. This definition applies only to III. E. Additional Services.

SELF-ADMINISTERED INJECTABLE: Means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting

patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER means an EMPLOYEE, ANNUITANT or his/her surviving DEPENDENTS who have been specified by the DEPARTMENT to the BENEFIT PLAN for enrollment and who is entitled to BENEFITS.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an PARTICIPATING PROVIDER. Urgent services from an NON-PARTICIPATING or NON-AFFILIATED PROVIDER may be subject to REASONABLE CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the REASONABLE CHARGES for medical/HOSPITAL services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits Available

BENEFITS are payable for REASONABLE CHARGES for the following services and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of the CONTRACT, if those services and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by the CONTRACTOR.

When services are provided by a NON-PARTICIPATING PROVIDER, BENEFITS are payable for amounts in excess of the MEDICARE-approved CHARGE up to the lesser of the actual amount charged by the NON-PARTICIPATING PROVIDER and the LIMITING CHARGE.

The BENEFITS of this section of the BENEFIT PLAN will automatically change to coincide with any changes in applicable MEDICARE deductible amounts and coinsurance percentage factors.

A. HOSPITAL INPATIENT BENEFITS

- 1) BENEFITS are payable for the MEDICARE Part A deductible during the first 60 days of CONFINEMENT.
- 2) BENEFITS are payable for the MEDICARE Part A HOSPITAL daily coinsurance from the 61st to the 90th day of a PARTICIPANT'S CONFINEMENT.
- 3) After a PARTICIPANT has been in a HOSPITAL for 90 days, Medicare pays an extra 60 reserve days during the PARTICIPANT'S lifetime. BENEFITS are payable for the MEDICARE Part A HOSPITAL coinsurance for each reserve day used by the PARTICIPANT.

If the PARTICIPANT has exhausted the lifetime reserve days during a previous BENEFIT PERIOD, BENEFITS will continue to be payable for an additional 30 days of CONFINEMENT beginning on the 91st day of CONFINEMENT. The PROVIDER shall accept our payment as payment in full and may not BALANCE BILL you.

- 4) After MEDICARE pays its 190-day lifetime hospital INPATIENT psychiatric care BENEFITS, the BENEFIT PLAN will pay the MEDICARE Part A ELIGIBLE EXPENSES for INPATIENT psychiatric HOSPITAL care for each day a PARTICIPANT is confined for psychiatric care beyond the MEDICARE lifetime limit but not to exceed a lifetime limit of 175 days CONFINEMENT under the BENEFIT PLAN. BENEFITS will not exceed a total of 365 days for your lifetime.
- 5) BENEFITS are payable for the MEDICARE Part A ELIGIBLE EXPENSES for blood to the extent not covered by MEDICARE.

B. SERVICES IN A LICENSED SKILLED NURSING FACILITY

- 1) For CONFINEMENT in a licensed SKILLED NURSING FACILITY certified by and participating in MEDICARE, while the CONFINEMENT is covered by MEDICARE, BENEFITS are payable for such a CONFINEMENT, provided: (1) a PARTICIPANT receives care in a MEDICARE approved licensed SKILLED NURSING FACILITY and remains under continuous active medical supervision; and (2) the PARTICIPANT was a HOSPITAL INPATIENT for at least three days prior to CONFINEMENT in a licensed SKILLED NURSING FACILITY. BENEFITS are payable for up to a maximum of 120 days per BENEFIT PERIOD beginning on the first day of admission to the licensed SKILLED NURSING FACILITY.

- 2) For CONFINEMENT in a licensed SKILLED NURSING FACILITY not participating in MEDICARE, or when the CONFINEMENT is not covered by MEDICARE, BENEFITS are payable provided the PARTICIPANT is transferred within 24 hours of release from a HOSPITAL. BENEFITS are payable up to the maximum daily rate established for SKILLED CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to 30 days per CONFINEMENT. BENEFITS are payable only if the attending physician certifies that the SKILLED CARE is MEDICALLY NECESSARY. The physician must recertify this every seven days. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without CHARGE or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

C. HOSPICE CARE

The PLAN will pay a PARTICIPANT'S coinsurance or co-payments for all MEDICARE PART A ELIGIBLE EXPENSES for HOSPICE CARE and respite care. HOSPICE CARE is available as long as the PARTICIPANT'S physician certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of MEDICARE.

D. PROFESSIONAL and OTHER SERVICES.

The BENEFIT PLAN will pay the MEDICARE Part B deductible and all MEDICARE Part B ELIGIBLE EXPENSES, to the extent not paid by MEDICARE, or in the case of HOSPITAL outpatient department services paid under a prospective payment system, the COPAYMENT amount, for the following services:

- 1) Cataract lenses following cataract surgery and one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.
- 2) Chemotherapy in a physician's office, freestanding clinic or HOSPITAL outpatient setting.
- 3) Prescription drugs covered by Medicare such as injections that can't be self-administered that a PARTICIPANT receives in a physician's office, certain oral cancer drugs, drugs used with some types of DURABLE MEDICAL EQUIPMENT, and under very limited circumstances, certain drugs a PARTICIPANT receives in a HOSPITAL OUTPATIENT setting.
- 4) Physical therapy, speech-language pathology services and occupational therapy when recommended by a physician.
- 5) Oxygen and rental of equipment and supplies for its administration.
- 6) Professional licensed ambulance service necessary to transport a PARTICIPANT to or from a HOSPITAL or licensed SKILLED NURSING FACILITY. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a physician as being MEDICALLY NECESSARY.
- 7) MEDICAL SUPPLIES prescribed by a physician.
- 8) Rental of or purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, walkers and hospital type beds.

- 9) OUTPATIENT cardiac rehabilitation services.
- 10) Facility fees for approved surgical procedures in an ambulatory surgical center.
- 11) Blood processing and handling services for every unit of blood a PARTICIPANT receives.
- 12) Chiropractic services limited to those services to help correct a subluxation using manipulation of the spine. BENEFITS are not payable for any other services or tests ordered by a chiropractor (including x-rays or massage therapy).
- 13) X-rays, MRIs, CT scans, EKGs, and other diagnostic tests, other than laboratory tests.
- 14) Diabetes supplies and self-management training.
- 15) Physician services that are medically necessary or provided in connection with preventive services covered by MEDICARE. BENEFITS are also payable for services provided by health care PROVIDERS, such as physician assistants, nurse practitioners, social workers, and psychologists.
- 16) Foot exams and treatment if a PARTICIPANT has diabetes-related nerve damage and/or meets certain conditions determined by MEDICARE.
- 17) Kidney dialysis services and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, BENEFITS are also payable for CHARGES for kidney disease education services prescribed by a physician.
- 18) Outpatient mental health care services. Coverage includes services generally provided in an OUTPATIENT setting, including visits with a psychiatrist or other physician, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker.
- 19) Outpatient HOSPITAL services, OUTPATIENT medical and surgical services and supplies.
- 20) Prosthetic and orthotic items including arm, leg, back and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part of function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a physician or other health care PROVIDER.
- 21) Pulmonary rehabilitation programs if a PARTICIPANT has moderate to severe chronic obstructive pulmonary disease prescribed by a physician.
- 22) Services for treatment of a surgical or surgically-treated wound.
- 23) Tobacco smoking cessation counseling if a PARTICIPANT is diagnosed with an ILLNESS caused or complicated by tobacco use or takes a medicine that is affected by tobacco.
- 24) Physician services for heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a MEDICARE-certified facility. Also covered are immunosuppressive drugs if the transplant was eligible for MEDICARE payment, or an employer or union group health plan was required to pay before MEDICARE paid for the transplant.

25) Glaucoma tests once every 12 months for PARTICIPANTS at high risk for glaucoma.

E. Additional Services

- 1) **Foreign Travel.** BENEFITS are payable at 100% of the REASONABLE CHARGES for MEDICALLY NECESSARY health care services received by a PARTICIPANT in a foreign country.
- 2) **Immunizations.** BENEFITS are payable at 100% of the REASONABLE CHARGES for immunizations not covered by MEDICARE.
- 3) **Chiropractic Services.** BENEFITS are payable at 100% of the REASONABLE CHARGES for chiropractic services provided by a chiropractor within the scope of his/her license and not covered by MEDICARE per Wis. Stat. 632.875.
- 4) **HOME CARE.** BENEFITS are payable at 100% of the REASONABLE CHARGES for home care services described below:
 - a) Covered Services. This paragraph only if CHARGES for home care services are not covered elsewhere under this CONTRACT. A state licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the services. A PARTICIPANT should make sure the agency meets this requirement before services are provided. BENEFITS are payable for CHARGES for the following services when MEDICALLY NECESSARY for treatment:
 - i) Part time or intermittent home nursing care by or under supervision of a registered nurse;
 - ii) Part time or intermittent home health aide services when MEDICALLY NECESSARY as part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
 - iii) Physical, respiratory, occupational or speech therapy;
 - iv) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a physician required to be administered by a professional PROVIDER; laboratory services by or on behalf of a HOSPITAL, if needed under the home care plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;
 - v) Nutrition counseling provided or supervised by a registered dietician;
 - vi) Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending physician must request or approve this evaluation.

MEDICARE benefits will not be duplicated.

- b) Limitations. The following limits apply to home care services:

- i) Home care is not covered unless the PARTICIPANT'S attending physician certifies that: (a) hospitalization or CONFINEMENT in a licensed SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have home care; and (b) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;
 - ii) If the PARTICIPANT was hospitalized just before home care started, the PARTICIPANT'S physician during his/her HOSPITAL stay must also approve the home care plan;
 - iii) BENEFITS are payable for CHARGES for up to 365 home care visits in any 12 month period per PARTICIPANT. Each visit by a person providing services under a home care plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide service counts as one home care visit.
 - iv) If home care is covered under two or more health insurance CONTRACTS or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has home care coverage under this CONTRACT and another source;
 - v) The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED CARE in a licensed SKILLED NURSING FACILITY, as determined by the CONTRACTOR.
- 5) **Equipment and Supplies for Treatment of Diabetes.** BENEFITS are payable at 100% of the REASONABLE CHARGES incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and charges for diabetic self-management education programs. This benefit is limited to the purchase of one pump per calendar year. You must use the pump for at least 30 days before the pump is purchased. Medicare benefits won't be duplicated.
- 6) **BENEFITS for Kidney Disease.** BENEFITS are payable for REASONABLE CHARGES for inpatient, outpatient and home treatment of kidney disease, if not covered elsewhere under the BENEFIT PLAN. These services must be necessary for a PARTICIPANT'S diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There's a maximum of \$30,000 per year for these BENEFITS. The BENEFIT PLAN will not pay any BENEFITS for any CHARGES paid for, or covered by, MEDICARE.
- 7) **Breast Reconstruction.** BENEFITS are payable for REASONABLE CHARGES for breast reconstruction of the affected tissue incident to a mastectomy.
- 8) **Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care.** BENEFITS are payable for REASONABLE CHARGES for HOSPITAL or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided in a HOSPITAL or ambulatory surgery center, if any of the following applies:
- a) The PARTICIPANT is a child under the age of 5;

- b) The PARTICIPANT has a chronic disability that meets all of the conditions under s. 230.04(9r) (a) 2. a., b. and c., Wisconsin Statutes; or
 - c) The PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.
- 9) **Health Care Services Provided by a NON-AFFILIATED PROVIDER.** If a PARTICIPANT receives services from a NON-AFFILIATED PROVIDER, BENEFITS will be payable for REASONABLE CHARGES for those services provided the services are covered under this section.

F. Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

If YOU do not show YOUR PBM identification card at the pharmacy at the time YOU are obtaining benefits, YOU may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of IYC MEDICARE PLUS including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by IYC MEDICARE PLUS.

Prescription Drugs

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the PBM schedule of benefits. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the PBM schedule of benefits. When any PARTICIPANT meets the annual OOPPL, when applicable, as described on the PBM schedule of benefits, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPPL as described in the PBM schedule of benefits, even if no one PARTICIPANT has met his or her individual annual OOPPL, all family PARTICIPANTS will have satisfied the annual

OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The IYC MEDICARE PLUS plan, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under IYC MEDICARE PLUS. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of IYC MEDICARE PLUS, unless otherwise specified in IYC MEDICARE PLUS (for example, SELF-ADMINISTERED INJECTABLE).

MEDICARE eligible PARTICIPANTS will be covered by a MEDICARE Part D prescription drug plan (PDP) provided by the PBM. PARTICIPANTS who choose to be enrolled in another MEDICARE Part D PDP other than this PDP will not have benefits duplicated.

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM ALLOWED AMOUNT. The ALLOWED AMOUNT is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the IYC MEDICARE PLUS or a contracted PROVIDER administers the injection. If the IYC MEDICARE PLUS or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

- a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.
- b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).
- c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.
- e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained

at a time and is subject to the prescription drug COPAYMENT and annual OOP. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

- f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.
- g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the PARTICIPATING PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.
- h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTABLES and narcotics are among those for which a 90-day supply is not available.
- i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.
- j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.
- k) SPECIALTY MEDICATIONS and SELF-ADMINISTERED INJECTABLES when obtained by prescription and which can safely be administered by the PARTICIPANT, must be obtained from a PBM PARTICIPATING PHARMACY OR PREFERRED SPECIALTY PHARMACY. In some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by [Wis. Stat. § 632.895 \(9\)](#).

Insulin, Disposable Diabetic Supplies, Glucometers

The PBM will list approved products on the FORMULARY. PRIOR AUTHORIZATION is required for anything not listed on the FORMULARY.

- a) Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug COPAYMENT, as described on the PBM schedule of benefits.
- b) Disposable Diabetic Supplies and Glucometers will be covered after a 20% COINSURANCE as outlined in the PBM schedule of benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips.

The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL for prescription drugs.

Other Devices and Supplies

Other devices and supplies administered by the PBM that are subject to a 20% COINSURANCE and applied to the annual OOPL for prescription drugs are as follows:

- a) Diaphragms
- b) Syringes/Needles
- c) Spacers/Peak Flow Meters

IV. Exclusions

A. Exclusions

The following services are excluded from BENEFITS, except as otherwise specifically provided:

- 1) Health care services MEDICARE does not cover, unless the BENEFIT PLAN specifically provides for them.
- 2) Health care services which neither a PARTICIPANT nor a party on the PARTICIPANT'S behalf has a legal obligation to pay in the absence of insurance.
- 3) Health care services to the extent that they are paid for by MEDICARE, or would have been paid for by MEDICARE if a PARTICIPANT is enrolled in MEDICARE Parts A and B; health care services to the extent that they are paid for by another government entity or program, directly or indirectly.
- 4) Personal comfort items. Examples include: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.
- 5) CUSTODIAL CARE, including maintenance care and supportive care.
- 6) Cosmetic surgery.
- 7) Health care services received by a PARTICIPANT before his/her coverage becomes effective or after coverage ends.
- 8) Health care services that are deemed unreasonable and unnecessary by MEDICARE. This includes, but is not limited to, the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services including drugs or devices, not considered safe and effective because they are EXPERIMENTAL or investigational except for the HIV drugs as described in Section 632.895(9) Wis. Stat. as amended.
- 9) Health care services received outside the United States, except as specifically stated in paragraph 6. a. of subsection B.
- 10) Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in subsection B.
- 11) Health care services which are not medically necessary as determined by the CONTRACTOR, except for such health care services that MEDICARE covers.
- 12) Routine physical exams and any related diagnostic X-ray and laboratory tests covered by MEDICARE.
- 13) Private duty nursing.
- 14) Routine dental care.
- 15) Hearing aids; exams for fitting of hearing aids.

16) Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

B. Outpatient Prescription Drugs – Administered by the PBM

- 1) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.
- 2) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.
- 3) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.
- 4) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).
- 5) Anorexic agents.
- 6) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.
- 7) All over-the-counter drug items, except those designated as covered by the PBM.
- 8) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- 9) Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.
- 10) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.
- 11) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM'S Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- 12) Infertility and fertility medications.
- 13) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.
- 14) Charges to replace expired, spilled, stolen or lost prescription drugs.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the HEALTH PLAN and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the HEALTH PLAN and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the HEALTH PLAN, provide any relevant and reasonably available information which the HEALTH PLAN believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the HEALTH PLAN and/or PBM but also disclosures to:

- 1) Health care PROVIDERS as necessary and appropriate for treatment,
- 2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the HEALTH PLAN'S/PBM'S claims determinations for compliance with contract requirements, or other necessary health care operations,
- 3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The HEALTH PLAN, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the HEALTH PLAN, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The HEALTH PLAN may employ a professional staff to provide case management services. As part of this case management, the HEALTH PLAN or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

- 1) The recommended treatment offers at least equal medical therapeutic value, and
- 2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and
- 3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the HEALTH PLAN agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the HEALTH PLAN'S recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The HEALTH PLAN and/or PBM might pay more than the HEALTH PLAN and/or PBM owes under the policy. If so, the HEALTH PLAN and/or PBM can recover the excess from YOU. The HEALTH PLAN and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the HEALTH PLAN and/or PBM.

Each PARTICIPANT agrees to reimburse the HEALTH PLAN and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the HEALTH PLAN and/or PBM. At the option of the HEALTH PLAN and/or PBM, benefits for future CHARGES may be reduced by the HEALTH PLAN and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under IYC MEDICARE PLUS, whether that is a HEALTH PLAN or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the HEALTH PLAN provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The HEALTH PLAN'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

- 1) The third party or any liability or other insurance covering the third party.
- 2) The PARTICIPANT'S own uninsured motorist insurance coverage.
- 3) Under-insured motorist insurance coverage.
- 4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the HEALTH PLAN or DEPARTMENT to such extent.

The HEALTH PLAN'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the HEALTH PLAN'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the HEALTH PLAN'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the HEALTH PLAN or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the HEALTH PLAN or DEPARTMENT such additional information as is reasonably requested by the HEALTH PLAN or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the HEALTH PLAN'S or DEPARTMENT'S rights against a third party. The HEALTH PLAN or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the HEALTH PLAN or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the HEALTH PLAN or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the HEALTH PLAN or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the

PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the HEALTH PLAN and PBM.

Failure to notify an PARTICIPATING PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an NON-PARTICIPATING or NON-AFFILIATED PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the HEALTH PLAN, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the HEALTH PLAN and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the HEALTH PLAN and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating HEALTH PLANS and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the HEALTH PLAN and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT

complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of IYC MEDICARE PLUS, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. YOU may request an external review. In this event, YOU must notify the TPA and/or PBM of YOUR request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of IYC MEDICARE PLUS, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.

Miscellaneous Provisions

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) & (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

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://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020 (TTY: 1-800-947-3529)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم

(1-800-947-3529) (خدمة الصم والبكم: 1-877-533-5020)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-877-533-5020 (TTY: 1-800-947-3529).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).