

II. OUTLINE OF COVERAGE

Services and Supplies	Medicare Pays per Benefit Period (2020 information. Updated annually per CMS.)	Medicare Plus Pays (2020 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 \$1,408*</p> <p>61st to 90th day, all but \$352* a day</p> <p>91st to 150th day, all but \$704* a day (Lifetime Reserve)</p> <p>If lifetime reserve days are exhausted, \$0</p>	<p>Initial \$1,408* deductible</p> <p>\$352* a day</p> <p>\$704*</p> <p>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</p> <p>First 20 days, 100% of costs</p> <p>21st - 100th days, all but \$176 a day</p> <p>Beyond 100 days, \$0</p>	<p>Requires a 3-day period of hospital stay</p> <p>Not Applicable</p> <p>\$176* a day</p> <p>All covered services up to a maximum of 120 days per BENEFIT PERIOD.</p> <p>Custodial care is not covered.</p>
<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>

Services and Supplies	Medicare Pays per Benefit Period (2020 information. Updated annually per CMS.)	Medicare Plus Pays (2020 information. Updated annually.)
<p>Home Health Care**</p> <p>Under a doctor for part-time skilled nursing care, part-time home health aide care, physical therapy, occupational therapy, speech-language pathology services, medical social services.</p>	<p>100% of charges for visits considered medically necessary by Medicare.</p> <p>Generally fewer than 7 days a week, less than 8 hours a day and 28 or fewer hours per week for up to 21 days.</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>
<p>Hospice Facility</p>	<p>All but very limited coinsurance for inpatient respite care</p>	<p>Medicare copayment/coinsurance up to the equivalent charges of a Skilled Nursing Facility</p>
<p>Miscellaneous Services</p> <p>Physical, speech and occupational therapy; ambulance; prosthetic devices; durable medical equipment</p>	<p>After annual \$198* Medicare deductible, 80% of allowable charges</p>	<p>Initial \$198* deductible and 20% of Medicare approved expenses</p>

Services and Supplies	Medicare Pays per Benefit Period (2020 information. Updated annually per CMS.)	Medicare Plus Pays (2020 information. Updated annually.)
<p>Physician's Services</p> <p>Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.</p>	After annual \$198* Medicare deductible, 80% of allowable charges	Initial \$198* deductible and 20% of Medicare approved expenses
<p>Telemedicine, telehealth, or e-visit service</p>	Not covered	100% of costs for network providers
<p>Drugs and Biologicals (non-hospitalization)</p> <p>Immunosuppressive drugs during the first year following a covered transplant</p> <p>Self-administered drugs prescribed by a physician</p>	<p>After annual \$198* Medicare deductible, 80% of allowable charges</p> <p>Not Covered</p>	<p>Initial \$198 deductible and 20% of Medicare approved expenses</p> <p>Refer to Pharmacy Benefit Manager portion of booklet for pharmacy benefits</p>
<p>Outpatient Hospital Services</p> <p>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</p>	After the annual \$198* Medicare deductible, 80% of allowable charges	Initial \$198* deductible and 20% of Medicare approved expenses
<p>Psychiatric Treatment</p> <p>Other than hospital inpatient</p>	After the annual \$198* Medicare deductible, 80% of the allowable charges	Initial \$198* deductible and the amount, which combined with the Medicare benefit, equals 20% of the reasonable charges
<p>Private Duty Nursing</p> <p>While hospitalized and provided by an RN or LPN</p>	\$0	\$0
<p>Blood</p>	After annual \$198* Medicare deductible, 80% of costs except non-replacement fees (blood DEDUCTIBLE) 1st 3 pints in each benefit period	Initial \$198* deductible and 20% of Medicare approved expenses

* Federal Medicare deductibles are adjusted annually. Amounts shown above are for 2020. IYC MEDICARE PLUS benefits are also adjusted annually to pay these deductibles.

** Custodial care as defined is not covered.

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.

IV. 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 section III E 1.
- 10) Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in section III.
- 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.

V. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the CONTRACTOR 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 CONTRACTOR and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the CONTRACTOR, provide any relevant and reasonably available information which the CONTRACTOR 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 CONTRACTOR 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 CONTRACTOR'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 CONTRACTOR, 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 CONTRACTOR, 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 CONTRACTOR may employ a professional staff to provide case management services. As part of this case management, the CONTRACTOR 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 CONTRACTOR agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the CONTRACTOR'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 CONTRACTOR. 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 CONTRACTOR 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 CONTRACTOR and/or PBM might pay more than the CONTRACTOR and/or PBM owes under the policy. If so, the CONTRACTOR and/or PBM can recover the excess from YOU. The CONTRACTOR 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 CONTRACTOR and/or PBM.

Each PARTICIPANT agrees to reimburse the CONTRACTOR 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 CONTRACTOR and/or PBM. At the option of the CONTRACTOR and/or PBM, benefits for future CHARGES may be reduced by the CONTRACTOR 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 these UNIFORM BENEFITS, whether that is a CONTRACTOR or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the CONTRACTOR 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 CONTRACTOR'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 CONTRACTOR or DEPARTMENT to such extent.

The CONTRACTOR'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 CONTRACTOR'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the CONTRACTOR'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the CONTRACTOR or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the CONTRACTOR or DEPARTMENT such additional information as is reasonably requested by the CONTRACTOR or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the CONTRACTOR'S or DEPARTMENT'S rights against a third party. The CONTRACTOR 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 CONTRACTOR or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the CONTRACTOR 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 CONTRACTOR 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 CONTRACTOR or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the CONTRACTOR or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the CONTRACTOR 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 CONTRACTOR or DEPARTMENT for all amounts theretofore or thereafter paid by the CONTRACTOR or DEPARTMENT which would have otherwise been recoverable under such acts and the CONTRACTOR 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 CONTRACTOR 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 IYC MEDICARE PLUS BENEFIT PLAN. Failure to do so could result in a delay in the claim being paid.

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 CONTRACTOR 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 CONTRACTOR and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating CONTRACTORS and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the CONTRACTOR's and/or PBM's administration of these benefits (for example, denial of claim or referral), YOU should contact the CONTRACTOR 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 CONTRACTOR and/or PBM. Contact the CONTRACTOR and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the CONTRACTOR'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 CONTRACTOR and/or PBM. The CONTRACTOR 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 CONTRACTOR and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of UNIFORM BENEFITS, 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 HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the CONTRACTOR and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. 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 CONTRACTOR'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 HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal 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 benefits under this section, 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 HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the CONTRACTOR and/or PBM breached its contract with the Group Insurance Board.