Uniform Pharmacy Benefits Certificate of Coverage

For all State of Wisconsin and Wisconsin Public Employers Group Health Insurance Programs

Effective January 1, 2023
Certificate of Coverage

This Certificate of Coverage is your Summary Plan Description and contains the Uniform Pharmacy Benefits (UPB) offered under the Group Health Insurance Program (GHIP).

Keep this document with your insurance papers. The purpose of this document is to help you (the Member) and your Dependents understand the Benefits covered under this policy.

Navitus Health Solutions, LLC. (Navitus) the Pharmacy Benefit Manager (PBM) contracted with Wisconsin Group Health Insurance Board (Board) to provide pharmacy coverage for Members and their Dependents must offer the coverage described in this document.

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

These Benefits comply with state and federal minimum Benefits requirements, and any additional coverage requirements made by the Group Insurance Board (Board).
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The **Pharmacy Benefit Manager** offering coverage in the State of Wisconsin and the Wisconsin Public Employers Group Health Insurance Program must include the Uniform Pharmacy Benefits. The **Pharmacy Benefit Manager** may not alter the language, **Benefits**, or exclusions and limitations of the Uniform Pharmacy Benefit.
I. Definitions

The following terms, when used and capitalized in this Pharmacy Benefit description, are defined and limited to that meaning only:

**Allowed Amount**: Means the maximum dollar amount the PBM will pay a pharmacy for your prescription and is based upon the contract agreement between the PBM and the Pharmacy.

**Benefit Plan**: Means pharmacy benefit coverage including drug Tiers, copays, and co-insurance that you are enrolled in under the State of Wisconsin Group Health Insurance Program.

**Brand Name Drugs**: Means a drug sold by a drug company under a specific name or trademark, protected by a patent, and available by prescription or over the counter.

**Clear Bagging**: Means the process in which a Provider's internal specialty pharmacy dispenses a Participants Level 4 specialty drug and transports the drug to where the drug is going to be administered to the Participant by a medical professional. Drugs administered in ETF’s Clear Bagging program are paid for through the pharmacy benefit.

**Confinement/Confined**: Means the period of time between admission as an inpatient or outpatient to a Hospital, Covered residential center, skilled nursing, or licensed ambulatory surgical center on the advice of the Participant's physician; and discharge therefrom, or 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.

**Coinsurance**: Means a specified percentage of the Drug costs that the Participant or family must pay each time those Covered services are provided, subject to any limits specified in the Schedule of Benefits.

**Copayment**: Means 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 Uniform Pharmacy Benefits. In maximum quantities, Copayments do not exceed a 30 consecutive day supply.

**Cover/Covers/Benefits**: Means the pharmacy or medical services that are paid for as a part of your coverage under the State of Wisconsin Group Health Insurance Program.

**Dispense as Written-1/DAW-1**: Is a term used on a prescription by a Prescriber to fill the prescription as written, with no Generic Drug substitution.

**Deductible**: Means the amount the Participant owes for pharmacy drug coverage the Participants pharmacy Benefit Plan Covers before the pharmacy Benefit Plan begins to pay. For example, if the Participants Deductible is $1,500, the pharmacy Benefit Plan will not pay anything until the Participant has incurred $1,500 in Out-Of-Pocket
expenses for covered pharmacy services subject to the Deductible. The Deductible may not apply to all services.

**Department/ETF:** Means the State of Wisconsin Department of Employee Trust Funds.

**Dependent:** Means any Member or beneficiary of the GHIP who is not the Subscriber.

**Direct Member Reimbursement (DMR):** Is when a Member pays full price for a drug at the pharmacy and then submits a DMR form to the PBM for reimbursement. If approved, the Member is reimbursed from the PBM the negotiated rate with the pharmacy minus the drug’s copay.

**Effective Date:** Means the date, as certified by ETF (or as shown on the Health Plan and/or PBM records for Participants who pay their pharmacy premium directly a GHIP Health Plan) on which the Participant becomes enrolled and entitled to the Benefits specified in the contract.

**Eligible Employee:** Is as defined under Wis. Stat. § 40.02 (25), §40.02 (46), or § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to their employees.

**Embedded:** Means when a Participant within a family plan meets the individual portion of Participant financial responsibility (Deductible, Out-Of-Pocket-Limit, Maximum-Out-Of-Pocket) within the family’s total financial responsibility, that Participant is no longer responsible for any further out of pocket costs. The remaining family Deductible will still apply to other family Participants.

**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:

- a) Serious jeopardy to the Participant’s health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

- b) Serious impairment to the Participant’s bodily functions

- c) Serious dysfunction of one or more of the Participant’s body organs or parts.

**Experimental:** Means 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 PBM requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used, or isn’t yet recognized as an acceptable medical practice to treat that Illness or Injury for a Participant’s Illness or Injury.
Food and Drug Administration (FDA): Means the United States Food and Drug Administration is a federal agency of the Department of Health and Human Services responsible for, among other things, protecting public health by ensuring the safety, efficacy, and security of drugs, biological products, and medical devices.

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 in the Formulary are not Covered by the Benefits of this program.

Generic Drugs: Means a prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The FDA rates these drugs to be as safe and effective as brand-name drugs.

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 Health Plan and/or PBM concerning some aspect of the PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.

Group Health Insurance Program (GHIP): Means the Benefit Program offered by the Group Insurance Board that provides medical, pharmacy, and dental Benefits to enrolled public workers and their Dependents.

Group Insurance Board (Board): Means the governing body that oversees the Group Health Insurance Program.

Health Plan: Means the Health Plan entity that is under contract with the Group Insurance Board to provide Benefits and services to Participants of the Group Health Insurance Program.

High Deductible Health Plan (HDHP): Means a Benefit Plan that, under federal law, has a minimum annual Deductible and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual Deductible has been met (except for preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

Hospital: Means an institution that:

   a) 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 qualifies as a psychiatric or tuberculosis Hospital;

f) is a Medicare Provider; and

g) is accredited as a Hospital by the Joint Commission of 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 that exist at the same time, or which occur one after the other but are due to the same or related causes.

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

Internal Revenue Service (IRS): Means the federal agency that is responsible for collecting taxes and administering the Internal Revenue Code

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 Health Plan and/or PBM:

a) Consistent with the symptom(s) or diagnosis and treatment of the Participants Illness or Injury, and

b) appropriate under the standards of acceptable medical practice to treat that Illness or Injury, and

c) not solely for the convenience of the Participant, physician, Hospital, or other health care Provider, and

d) 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: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended. Medicare Part A refers to coverage for Hospital services, and Medicare Part B refers to coverage for outpatient services.

Medicare Prescription Drug Program/Medicare Part D: 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 GHIP.

Non-Participating Pharmacy: Means a pharmacy that 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-Preferred Drug (Non-Preferred): 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 Drugs 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 a Participant pays during a policy period (usually a calendar year) before the Pharmacy Benefit or Health Plan begins to pay 100% of the Allowed Amount. This limit never includes premium, balance-billed charges, or charges for health care that the Pharmacy Benefit or Health Plan does not Cover. Note: payments for prescription drugs obtained at a Non-Participating Pharmacy, out-of-network services, or other expenses do not accumulate toward this limit.

Out-Of-Pocket Limit (OOPL): The most the Participant pays during a policy period (usually a calendar year) for essential health Benefits as defined by the Affordable Care Act before the Pharmacy Benefit or Health Plan begins to pay 100% of the Allowed Amount. This limit never includes premium, balance-billed Charges, or Charges for health care the Benefit Plan does not Cover. Payments for out-of-network services or other expenses do not accumulate toward this limit.

Participant: Means the Subscriber or any of their Dependents who have been specified for enrollment and are entitled to Benefits.

Participating Pharmacy: Means a pharmacy that 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.

Payer/Payor: Means the person or company making the payment, satisfying the claim, or settling a financial obligation.
Pharmacy Benefit Manager (PBM)/Navitus Health Solutions, LLC. (Navitus): The PBM is a third-party administrator that is contracted with the Group Insurance Board to administer the prescription drug Benefits under this health insurance program. Its 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. Navitus is the Board’s PBM for 2023.

Preferred Drug (Preferred): 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 in the Formulary, which is covered by the Benefits of this program.

Preferred Specialty Pharmacy: Means a Participating Pharmacy that meets criteria established by the PBM to specifically administer Specialty Medications 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.

Prescriber: Means the medical professional who writes a prescription for a Participant.

Preventive Drug: The Affordable Care Act (ACA) requires that eligible people receive certain drugs and services at no cost. Preventive Drugs fall are used for breast cancer prevention, cardiovascular disease primary prevention, colorectal cancer screening, heart attack prevention, human immunodeficiency virus (HIV) pre-exposure prophylaxis, smoking cessation, and vitamins and minerals for children and women planning or capable of pregnancy.

Prior Authorization: Means obtaining approval from the PBM before obtaining the drug. Prior Authorizations are at the discretion of the PBM and are indicated on the Formulary.

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.

Quantity Limits: The highest amount of a prescription drug that can be given by a pharmacy in a period of time.

Schedule of Benefits: The document that is issued to accompany this document which details specific Benefits for covered services provided to Participants by the PBM.
**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.

**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:** An **Eligible Employee** or retiree who is enrolled for (a) single coverage; or (b) family coverage and whose **Dependents** are eligible for **Benefits**.

**Tier/Level:** The ETF’s pharmacy benefit has four **Tiers**. Each **Tier Covers** a different type of drug and has its own **Coinsurance/copay rate**.

**Urgent Care:** Means care for an accident or **Illness** which is needed sooner than a routine doctor's visit. This does not include follow-up care unless such care is necessary to prevent a **Participant’s** health from getting seriously worse before they can reach their primary care **Provider**. It also does not include care that can be safely postponed until the **Participant** can obtain a prescription from a **Participating Pharmacy**.

**Usual and Customary Charge:** An amount for a treatment, service, or supply provided by **Non-Participating Pharmacy** that is reasonable, as determined by the **PBM**, when taking into consideration, among other factors determined by the **PBM**, amounts charged by **Non-Participating Pharmacies** for similar prescription drugs when provided in the same general area under similar or comparable circumstances and amounts accepted by the **PBM** as full payment for similar Prescription Drugs. In some cases, the amount the **PBM** determines as reasonable may be less than the amount billed. In situations where the prescription drug is provided by a **Participating Pharmacy** or a **Non-Participating Pharmacy**, the Participant is held harmless for the difference between the billed and paid Charge(s), other than the **Copayments**, **Coinsurance**. **Participants** may be responsible for costs beyond **Usual and Customary Charges** for prescription drugs obtained from **Non-Participating Pharmacy** for prescription drugs that are non-**Emergency** or non-Urgent and which are not on the **Formulary**. **Emergency** or **Urgent Care** prescription drugs from a **Non-Participating Pharmacy** may be subject to **Usual and Customary Charges**, however, the **PBM** must hold the **Participant** harmless from any effort(s) by third parties to collect from the **Participant** the amount above the **Usual and Customary Charges** for the Pharmacy Benefit.
II. How the Pharmacy Benefit Works

A. Benefits and Services

Pharmacy Benefits are provided under a contract between Navitus Health Solutions, LLC. (Navitus) and The Group Insurance Board. Navitus is responsible for the prescription drug Benefits under the terms and conditions as laid out in the contract with the Group Insurance Board.

The Group Insurance Board contracts with Navitus to provide prescription drug Benefits. Navitus is responsible for the prescription drug benefit as provided for under the terms and conditions of the Pharmacy Benefits for those who are Covered under the State of Wisconsin Health Benefit Program.

All Pharmacy Benefits are paid per the terms of this contract between Navitus and the Group Insurance Board. Pharmacy Benefits are entirely incorporated in the contract.

This section describes the Benefits and services provided under the Uniform Pharmacy Benefit. All Benefits are available to you and your enrolled Dependents if they are received after the date your health insurance policy becomes effective and your Premium is paid.

B. Pharmacy Premium Payment

The Pharmacy Premium is combined with the Health Insurance premium for one payment each month. For most Subscribers, your Pharmacy Premium payments will be arranged through deductions from salary, your accumulated sick leave accounts (State Employees only), your annuity, or by converting your life insurance under certain circumstances. If a Subscriber is longer working and does not have an annuity, sick leave, or converted life insurance plan, they must pay their Premium directly to their Health Plan. If you are paying your Premium directly to your Health Plan and you either stop paying or tell your Health Plan you no longer want coverage, your Health Plan will notify ETF and ETF will notify the PBM.

C. Drug Formulary

Drugs that are not included on the Formulary are not Covered by this pharmacy benefit unless approved through an exceptions process. The IYC plans, HDHP plans, and Medicare Part D all have drug formularies. These formularies can be found at the public facing Navitus/ETF website at https://etf.benefits.navitus.com. To find the formularies just click on the name of the plan’s Formulary you are looking for and then on the word Formulary on the left side of the screen. The option to view the most current Formulary should then appear on your screen.

A Member can also view a Formulary through Navitus’s website at https://www.navitus.com/members through the Member portal. To view the
Formularies, you will need to have a portal login and password established with Navitus. A Member can create a portal login and password through the Navitus website.

D. Participating Pharmacies vs. Non-Participating Pharmacies
This Summary Plan Description applies to services received from Participating Pharmacies. Services received from Non-Participating Pharmacies are not Covered except for Emergency or Urgent situations.

Members may submit paper claims and a completed Direct Member Reimbursement form for prescriptions filled at Non-Participating Pharmacies in Urgent or Emergency situations. Members may receive reimbursement for these drugs at the pharmacy contracted rate minus the drug copay/Coinsurance.

For example, a Member fills a prescription in an Emergency or Urgent situation and pays $100 for the drug. The PBM’s contracted rate for the Level 1 drug is $50. The contracted rate ($50) minus the copay for the Level 1 drug ($5) is $45. The Member would be reimbursed $45 for the drug they obtained.

If a Member fills a prescription at a Non-Participating Pharmacy and they are not experiencing an Emergency or urgent situation they will need to pay the full price of the drug out of their pocket and not expect to be reimbursed anything.

A searchable list of in-network participating pharmacies can be found at https://ett.benefits.navitus.com/, https://www.navitus.com/members, or by contacting Navitus Customer Care at 866-333-2757 (non-Medicare)/ 866-270-2877 (Medicare).

E. How to Fill a Prescription
When filling a prescription at a Participating Pharmacy you must show your Navitus identification card at the pharmacy.

1. What if I lost my Navitus card and I need my prescription now?
If you cannot show your identification card, you may have your pharmacy call Navitus Customer Care to obtain the necessary processing information to submit your claim. Otherwise, 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, the drugs national drug classification (NDC) code, prescription name, and retail price (in U.S. currency). The Member may be responsible for more than the Copayment amount in these situations. The PBM will determine the benefit amount based on the network price. To request replacement ID cards, Member may contact Navitus Customer Care.
F. Participant Cost Share for Prescription Drugs

Prescription Drug **Copayments** or **Coinsurance** are required for all **Members** for all services unless otherwise required under federal and state law. Here is a chart to help describe each **Level** of drug coverage under the pharmacy benefit.

<table>
<thead>
<tr>
<th>Level</th>
<th>Copay/Coinsurance</th>
<th>Drug Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$5 copay</td>
<td>Preferred <strong>Generic Drugs</strong> and certain lower-cost preferred <strong>Brand Name Drugs</strong></td>
</tr>
<tr>
<td>Level 2</td>
<td>20% <strong>Coinsurance</strong> ($50 max)</td>
<td>Preferred <strong>Brand Name Drugs</strong> and certain higher cost preferred <strong>Generic Drugs</strong></td>
</tr>
<tr>
<td>Level 3</td>
<td>40% <strong>Coinsurance</strong> ($150 max)</td>
<td>Non-preferred <strong>Brand Name Drugs</strong> and certain high-cost <strong>Generic Drugs</strong> which alternative/equivalent preferred generic and <strong>Brand Name Drugs</strong> are Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Dispense as Written</strong> drugs are 40% <strong>Coinsurance</strong> plus the cost difference between the brand and <strong>Generic Drugs</strong> applied unless the <strong>Member</strong> has a medical need, and their doctor has submitted a one-time FDA MedWatch form.</td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$50 copayment</td>
<td>Includes only specialty drugs filled at a <strong>Preferred Specialty Pharmacy</strong>. This is mandatory for non-Medicare Participants.</td>
</tr>
<tr>
<td></td>
<td>40% <strong>Coinsurance</strong> ($200 max)</td>
<td>Only applies to those with <strong>Medicare</strong>. These specialty drugs are filled at a pharmacy other than a <strong>Preferred Specialty Pharmacy</strong>.</td>
</tr>
</tbody>
</table>
This chart describes each plan’s Deductibles and Out-Of-Pocket Limits (OOPLs).

<table>
<thead>
<tr>
<th>Plan Deductibles</th>
<th>IYC Health Plan</th>
<th>IYC HDHP</th>
<th>Medicare Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Levels</td>
<td>None</td>
<td>$1,500/$3,000 combined medical and pharmacy</td>
<td>None</td>
</tr>
<tr>
<td>OOPLs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 1 &amp; 2 Combined</td>
<td>$600/$1,200</td>
<td>$2,500/$5,000 combined medical and pharmacy</td>
<td>$600/$1,200</td>
</tr>
<tr>
<td>Level 3</td>
<td>$9,100/$18,200</td>
<td>$9,100/$18,200</td>
<td>$1,200/$2,400</td>
</tr>
<tr>
<td>Level 4</td>
<td>$9,100/$18,200</td>
<td>$9,100/$18,200</td>
<td>$1,200/$2,400</td>
</tr>
</tbody>
</table>

G. **Special Note for High Deductible Health Plan Members**

Unless noted otherwise all Members with HDHP will need to meet their combined medical and pharmacy Deductible before any copay or Coinsurance rates begin. For example, if an individual with HDHP is prescribed a Level 3 drug that costs $400 the Member will need to pay $1,500 for that drug, any other prescriptions they may be on, and medical costs. After the $1,500 threshold is met the Member would then pay no more than $150 for that Level 3 drug.

H. **PBM Drug Coverage vs. Medical Plan Drug Coverage**

A Member’s prescription drug will be Covered under their medical insurance, rather than their pharmacy insurance, if the prescription drug is administered during home care, in a medical professional’s office, during Confinement, during an Emergency room visit, or in an Urgent Care setting.

However, if a prescription is written for a Covered drug during home care, in a medical professional’s office, during Confinement, during an Emergency room visit, or in an Urgent Care setting that prescription will be Covered by a Member’s pharmacy benefit. An example of this would be a Self-Administered Injectable drug.

The one exception to PBM drug coverage and Medical Plan Drug Coverage is the Clear Bagging Program. Those who have some Level 4 drugs administered in a medical professional’s office, clinic, or Hospital could have their drug paid for through the pharmacy benefit. If this is the case a Member will receive two Explanations of Benefits (EOBs) and two bills, one from the PBM for the drug and one from the Medical Insurance Provider for the administration of the drug.
I. Vaccinations at Pharmacies

1. Non-Medicare Members
Non-Medicare Members can receive vaccines for Influenza, Pneumonia, Tetanus, Hepatitis, Shingles, Measles, Mumps, Human Papillomavirus (HPV) Pertussis, Varicella, Meningitis, Covid-19 at any in-network pharmacy at no cost. If Non-Medicare Members receive these vaccinations at their doctor’s office the vaccine will be Covered under their Medical Insurance.

2. Medicare Members
Vaccinations for Medicare Members are Covered under Medicare Part D. Medicare Members can receive vaccines at the pharmacy at no cost. If a Medicare Part D Member receives a vaccination at the medical Provider’s office, they will need to pay the full price of the vaccine to their medical Provider and then submit a Direct Member Reimbursement form to Navitus. Navitus will reimburse Members the negotiated price they pay pharmacies to administer the vaccine. For example, a Medicare Part D Member pays $300 to their medical Provider’s office for a Shingles vaccination. Navitus’s negotiated rate with pharmacies for the Shingles vaccine is $200. The Member will be reimbursed $200 and the remaining $100 the Member paid will be the Member's Out-Of-Pocket expense.

All Non-Medicare and Medicare Members should call ahead to a pharmacy ahead getting vaccinated to make sure the pharmacy:
   a. Has the vaccine/immunization in stock

   b. Find out if the pharmacy requires an appointment for vaccines/immunization

   c. If vaccinating/immunizing a child, make sure the pharmacy does vaccinate children

J. Medicare Part D Dual Enrollment
Medicare-eligible Members will be Covered by the PBM’s Medicare Part D prescription drug plan (PDP). If a Member chooses to be enrolled in another Medicare Part D PDP other than the PBM’s they will not have duplicate Benefits.

K. PBM Restrictions on Medications
The PBM may apply Quantity Limits to medications in certain situations. The PBM may also require the Prescriber to file a Prior Authorization form and the PBM approves the form before allowing any prescription to be Covered under the pharmacy benefit.
L. **Drug Packaging**

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**.

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.

M. **Brand Name Vs. Generic**

Cost-effective **Generic Equivalent** will be dispensed unless the **Prescriber** specifies on the prescription the Brand Name Drug and indicates that no substitutions may be made. In those cases, the Brand Name Drug will be **Covered** at whatever **Tier** the drug is at on the **Formulary**.

N. **Tablet Splitting**

This is a voluntary program where the **PBM** designates certain medications that **Members** can split the tablet of a higher strength dosage at home. In this program, the **Member** gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. **Members** who use table splitting will pay half the normal **Copayment** amount. Medications eligible for tablet splitting are designated on the **Formulary**.

O. **Over-The-Counter Drugs**

The **PBM** reserves the right to cover certain over-the-counter drugs on the **Formulary**. Over-the-counter drugs are shown on the **Formulary** with the Special Code of OTC.

P. **Preventive Prescription Drugs**

The Affordable Care Act (ACA) requires that all non-HDHP and HDHP **Members** receive certain drugs on the drug **Formulary** and services at no cost. **Preventive Drugs** fall that are used for breast cancer prevention, cardiovascular disease primary prevention, colorectal cancer screening, heart attack prevention, human immunodeficiency virus (HIV) pre-exposure prophylaxis, smoking cessation, and vitamins and minerals for children and women planning or capable of pregnancy.

Q. **Discount Eligible Medications**

There are some drugs used to treat weight loss, infertility, hair loss, and erectile dysfunction that are not **Covered** by a **Member**’s pharmacy benefit, but a **Member** can still buy them at a discount. A **Member** will pay 100% of the discounted rate and the amounts will not count towards any **OOPPL**. To see the complete Discount Drug List visit [https://etf.benefits.navitus.com/](https://etf.benefits.navitus.com/) and click on the name of the plan’s **Formulary** and then on the word **Formulary** on the left side of the screen. The option to view the **ETF Discount Drug List** will appear on the list in the middle of your screen.
R. Insulin, Disposable Diabetic Supplies, Glucometers and Continuous Glucose Monitors

The Formulary will list all approved diabetic related products. Prior Authorization is required for any product or drug not listed on the Formulary. Diabetic supplies are not Covered under Medicare Part D

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

b. Disposable Diabetic Supplies and Glucometers will be Covered on Level 2 with a 20% Coinsurance ($50 max). Members with HDHP coverage must meet their Deductible before the Level 2 coverage begins. All Members Coinsurances will be applied to the annual OOPL for prescription Drugs.

c. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood, or urine test strips.

d. Continuous Glucose Monitors for non-Medicare Members certain brands of Continuous Glucose Monitors (CGMs) are Covered under your pharmacy benefit. CGMs are Covered on Level 3 with a 40% Coinsurance ($150 max). Certain brands for CGMs are also Covered under your medical benefit. The brand of CGM coverage varies from insurer to insurer. CGMs are not Covered under Medicare Part D.

S. 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:

a. Diaphragms

b. Syringes/Needles

c. Spacers/Peak Flow Meters

**NOTE: If a Member is in the HDHP program they must satisfy the Deductible before the pharmacy benefit begins coverage, except for preventive prescription drugs. **

T. Smoking Cessation

Two ninety (90)-day courses of pharmacotherapy products that by law require a written prescription and filled at a Participating Pharmacy are Covered per calendar. This coverage includes all FDA-approved prescription and over-the-counter smoking cessation products that are on the Formulary. Only one 30-day supply of medication may be obtained at a time. A Member’s treating physician must file a Prior Authorization form to the PBM if they extend the first quit attempt.
U. No Lifetime Maximum on Pharmacy Benefits
There is no lifetime maximum benefit on all Pharmacy Benefits.

V. Specialty Medications
Specialty Medications are also known as Level 4 drugs are medications that traditionally treat complex, chronic, or rare conditions including investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

Specialty medications are usually the most expensive drugs on the pharmaceutical market.

In some cases, the PBM may limit availability to specific pharmacies.

W. Preferred Specialty Pharmacies
1. Non-Medicare Members:
   For a specialty drug to be Covered under your pharmacy benefit, which means you a Member would pay a $50 copay for the drug, with HDHP Members paying $50 for the drug after meeting their Deductible, the prescription must be filled at either Lumicera Health Services specialty pharmacy or UW Specialty Pharmacies. Outside of an Emergency or urgent situation if a specialty drug prescription is filled at another specialty pharmacy the drug won’t be Covered by the Pharmacy Benefit.

2. Medicare Members:
   If you are on Medicare Part D you will pay a $50 copy for a specialty drug filled at Lumicera Health Services specialty pharmacy or UW Specialty Pharmacies. If you do not fill your Level 4 prescription at one of these pharmacies, you will pay 40% of the total cost of the prescription with a $200 maximum payment. The amount you pay for the drug to out-of-network pharmacy will not apply to the Level 4 OOPL but, will go towards the federal limit of $9,100 individual/$18,200 family.

III. Exclusions and Limitations
The following is a list of services, treatments, equipment, or supplies that are excluded or have some limitations on the benefit provided under the pharmacy benefit. All exclusions listed below apply to Benefits offered by the PBM. Some of the listed exclusions may be Medically Necessary, but still are not Covered under the Pharmacy Benefit, while others may be examples of services that are not Medically Necessary or not medical in nature, as determined by the PBM.
A. Outpatient Prescriptions 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 that require a Prior Authorization unless approved by the PBM.

3) Charges for cosmetic drug treatments such as Retin-A and Rogaine.

4) Any diet control program, treatment, or supplies for weight reduction including any FDA medications approved for weight loss such as Wegovy, Saxenda, and Xenical.

5) Anorexic agents.

6) Non-FDA approved prescriptions, including compounded estrogen, progesterone, or testosterone products, excepted 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 medications purchased from a Non-Participating Pharmacy, except when there is an Emergency or Urgent Care is required.

11) Drugs approved by the FDA may be excluded until reviewed and approved by the Navitus’s Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

12) Charges for infertility and fertility treatment.

13) Charges for drugs prescribed for erectile dysfunction.

14) Charges for medications obtained through a discount program or over the internet, unless Prior Authorized by the PBM.

15) Charges to replace expired, spilled, stolen, or lost prescription drugs.
B. General

1) Any additional exclusion as described in this document

2) Services to the extent the Member is eligible for all Medicare benefits, regardless of whether the Member is enrolled in Medicare. This exclusion only applies if the Member is enrolled in a Medicare coordinated coverage and 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.

3) Treatment, services, and supplies for which the Member: (a) has no obligation to pay or which would be furnished to the Member without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulations, or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

4) Treatment, services, and supplies for any Injury or Illness as the result of war declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

5) Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which under the policy the PBM is the primary Payor, and the VA is the secondary Payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

6) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

7) Treatment, services or supplies used in educational or vocational training.

8) Treatment or service in connection with an Illness or Injury caused by engaging in an illegal occupation or in the commission of or attempt to commit a felony.

9) Charges for injectable medications administered in nursing when the nursing home stay is not Covered by the Medical Insurance Plan.

10) Expenses incurred prior to the Effective Date of coverage by the Pharmacy Benefit or services received after the Pharmacy Benefit coverage or eligibility terminates. Except when a Member's coverage is terminated because of Member cancellation or nonpayment of premium, Benefits shall continue to the Member if they are Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer
**Medically Necessary**; the contract maximum is reached; the end of 12 months after the date of termination; or **Confinement** ceases, whichever occurs first.

11) Any service, treatment, procedure, equipment, drug, device, or supply which is not reasonable and **Medically Necessary** or not required in accordance with accepted standards of medical, surgical, or psychiatric practice.

12) **Experimental** services, treatments, procedures, equipment, drugs, devices, or supplies Any service considered to be **Experimental**, except drugs for the treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

13) Services or medications provided by non-participating pharmacies. Exceptions to this exclusion:

14) Prescriptions related to **Emergency** or **Urgent Care** services outside the Service Area

15) Food or food supplements except when provided during a **Covered** outpatient or inpatient **Confinement**.

16) Services to the extent a **Member** receives or is entitled to receive, any **Benefits**, settlement, award, or damages for any reason of, or following any claim under, any Worker’s Compensation Act, employer’s liability insurance plan, or similar law or act. Entitled means the **Member** is actually insured under Worker’s Compensation.

17) Services related to an **Injury** that was self-inflicted for the purpose of receiving Medical Insurance and/or **Pharmacy Benefits**.

18) Treatment, services, and supplies for cosmetic or beautifying purposes, except when associated with a **Covered** service to correct a functional impairment related to congenital bodily disorders or conditions or when associated with reconstructive surgery due to an **Illness** or accidental **Injury**.

19) Any charges for, or in connections with travel. However, most travel vaccines are **Covered** under the pharmacy benefit.

20) Services that a child’s school is legally obligated to provide, whether or not the school actually provides the services and whether or not a **Member** chooses to use those services.
IV. Limitations

1. Major Disaster or Epidemic: If a major disaster or epidemic occurs, the PBM must allow Members to receive drugs and supplies on the Formulary from out-of-network Providers and/or non-participating pharmacies.

2. Circumstances Beyond the PBM’s Control: If due to circumstances not reasonable with the contract of the PBM, such as a complete or partial insurrection, labor disputes not under the control of the PBM, the rendition or provision of drugs and supplies Covered are delayed or rendered impractical, the PBM will use their best efforts to provide Covered benefits. In this case, Members may receive drugs and supplies from non-participating pharmacies.

V. Coordination of Benefits

A. Applicability

This Coordination of Benefits (COB) provision applies to the State Pharmacy Benefits which is part of the Wisconsin Group Health Insurance Plan (GHIP) when a Participant has health care and/or pharmacy coverage under more than one Plan at the same time.

If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the Benefits of the GHIP are determined before or after those of another plan. The Benefits of the GHIP: a) Shall not be reduced when, under the order of benefit determination rules, the GHIP determines its Benefits before another Plan, but b) May be reduced when, under the order of benefit determination rules, another Plan determines its Benefits first.

B. Order of Benefit Determination Rules

When there is a basis for a claim under the GHIP and another Plan, the GHIP is a Secondary Plan that has its Benefits determined after those of the other Plan, unless:

a) The other Plan has rules coordinating its Benefits with those of the GHIP, and

b) Both those rules and the GHIP’s rules described in the Rules subsection below require that the GHIP’s Benefits be determined before those of the other Plan.

C. Rules

The GHIP determines its order of Benefits using the first of the following rules:

a) Non-Dependent/Dependent

The Benefits of the Plan which Covers the person as an employee or Participant are determined before those of the Plan which Covers the person as a Dependent of an Employee or Participant.
b) **Dependent Child/Parents Not Separated or Divorced**

Except as stated in paragraph c) below, when the GHIP and another Plan Cover the same child as a Dependent of different persons, called "parents":

i) The Benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year, but

ii) If both parents have the same birthday, the Benefits of the Plan which Covered the parent longer are determined before those of the Plan which Covered the other parent for a shorter period of time.

If the other Plan does not have the rule described in i) above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of Benefits, the rule in the other Plan shall determine the order of Benefits.

c) **Dependent Child/Separated or Divorced Parents**

If two or more Plans Cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

i) First, the Plan of the parent with custody of the child,

ii) Then, the Plan of the spouse of the parent with the custody of the child, and

iii) Finally, the Plan of the parent not having custody of the child. Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the Benefits of the respective parents' Plans have actual knowledge of those terms, Benefits for the Dependent child shall be determined according to paragraph b) above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the Plan of that parent has actual knowledge of those terms, the Benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any Benefits are actually paid or provided before the entity has that actual knowledge.

d) **Active/Inactive Employee**

The Benefits of a Plan which Covers a person as an employee who is neither laid off nor retired nor as that employee's Dependent are determined before those of a Plan which Covers that person as a laid off or retired employee or as
that employee’s **Dependent**. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of **Benefits**, this paragraph d) is ignored.

e) **Continuation Coverage**

If a person has continuation coverage under federal or state law and is also **Covered** under another Plan, the following shall determine the order of **Benefits**:

i) First, the **Benefits** of a Plan **Cover** the person as an employee, **Member**, or **Subscriber** or as a **Dependent** of an employee, **Member**, or **Subscriber**.

ii) Second, the **Benefits** under the continuation coverage.

If the other Plan does not have the rule described in subparagraph i), and if, as a result, the Plans do not agree on the order of **Benefits**, this paragraph e) is ignored.

f) **Longer/Shorter Length of Coverage**

If none of the above rules determines the order of **Benefits**, the **Benefits** of the Plan which **Covered** an employee, **Member**, or **Subscriber** longer are determined before those of the Plan which **Covered** that person for the shorter time.

D. **Effect on the Benefits of the GHIP**

This section applies when, in accordance with Section B. Order of Benefit Determination Rules, the **GHIP** is a Secondary Plan as to one or more other Plans. In that event, the **Benefits** of the **GHIP** may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

The **Benefits** of the **GHIP** will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

a) The **Benefits** that would be payable for the Allowable Expenses under the **GHIP** in the absence of this COB provision, and

b) The **Benefits** that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether a claim is made. Under this provision, the **Benefits** of the **GHIP** will be reduced so that they and the **Benefits** payable under the other Plans do not total more than those Allowable Expenses.

When the **Benefits** of the **GHIP** are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the **GHIP**.
E. Right to Receive and Release Needed Information

The Health Plan has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming Benefits under the GHIP must give the Health Plan any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under the GHIP. If it does, the Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under the GHIP. The Health Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the Benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a) The persons it has paid or for whom it has paid,

b) Insurance companies, or

c) Other organizations.

The "amount of payments made" includes the reasonable cash value of any Benefits provided in the form of services.

H. Right to Obtain and Provide Information

Each Participant agrees that the PBM may obtain from the Participant’s health care Provider information, including medical records, that are reasonably necessary, relevant, and appropriate from the PBM to evaluate in connection with treatment(s), payment, or health care operations.

Each Participant must, upon request by the PBM, provide any relevant and reasonably available information which the PBM believes is necessary to determine payable Benefits. Failure to provide this information may result in denial of the claim at issue.

Participants agree that information, including medical records, may be as reasonably necessary, relevant, and appropriate to be disclosed as part of treatment, payment, or health care operations maybe disclosure not only within the PBM but also to:

1). Health Care Providers as necessary and appropriate for treatment
2). Appropriate ETF employees as part of conducting quality assessment and improvement activities, or reviewing the PBM's claims determination for compliance with contract requirements, or other necessary health care operations

3). External review of organization and parties to any appeal concerning a claim denial.

I. Case Management/Alternate Treatment

The PBM may employ professional staff to provide case management services. As part of this case management, the PBM 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 pharmacy charges incurred for drugs or supplies provided under the recommended treatment will probably be less.

If the PBM agrees to the attending physician’s recommendation or if the Participant or his/her authorized representative and the attending physician agree to the PBM'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 payment of Benefits will be as determined by the PBM.

J. Disenrollment

No person other than a Participant is eligible for health Benefits. The Subscriber's rights to group health benefits coverage are 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 at the beginning of the month following the 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.
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.

K. Recovery of Excess Payments
The PBM might pay more than the PBM owes under the policy. If so, the PBM can recover the excess from the Subscriber. The 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 PBM.

Each Participant agrees to reimburse the 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 PBM. At the option of the PBM, Benefits for future claims may be reduced by the PBM as a set-off toward reimbursement.

L. Subrogation
Each Participant agrees that the Payor under the Pharmacy Benefit, whether that is a PBM or ETF, shall be subrogated to a Participant’s rights to damages, to the extent of the Benefits the PBM 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 occurs through the act of a third party. The PBM’s or ETF’s rights of full recovery may be from any source, including but not limited to:

a) The third party or any liability or other insurance covering the third party.

b) The Participant’s own uninsured motorist insurance coverage.

c) Under-insured motorist insurance coverage.

d) Any pharmacy-related payments, no-fault, or school insurance coverages that are paid or payable.

A Participant’s rights to damages shall be, and they are hereby, assigned to the PBM or ETF to such extent.

The PBM’s or ETF’s subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the PBM’s or ETF’s prior written consent shall be deemed to prejudice the PBM’s or ETF’s rights. Each Participant shall promptly advise the PBM or ETF in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the PBM or ETF such additional information as is reasonably requested by the PBM or ETF. The Participant agrees to fully cooperate in protecting the PBM’s or ETF’s rights against a third party. The PBM or ETF 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 PBM or ETF and the Participant over the question of whether or not the Participant has been "made whole", the PBM or ETF reserves the right to a judicial determination of whether the insured has been "made whole."

In the event, the Participant can recover any amounts, for an Injury or Illness for which the PBM or ETF provides Benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefits act, or other employee Benefit act, the Participant shall either assert and process such claim and immediately turn over to the PBM or ETF the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the PBM or ETF in writing to prosecute such claim on behalf of and in the name of the Participant, in which case the PBM or ETF 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 Agreement, 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 benefits act, or other employee Benefit act, as part of the settlement or otherwise, the Participant shall reimburse the PBM or ETF for all amounts theretofore or thereafter paid by the PBM or ETF which would have otherwise been recoverable under such acts and the PBM or ETF 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 Agreement. The Participant shall advise the PBM or ETF 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 benefits act, or other employee Benefit act.

VI. Grievances and Appeals

A. Grievance Process
The PBM is required to make a reasonable effort to resolve Participants’ problems and complaints. If the Participant has a complaint regarding the PBM’s administration of these Benefits (for example, denial of claim), the Participant should contact the PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, the Participant may file a written Grievance with the PBM. Contact the PBM for specific information on its Grievance procedures.

If the Participant exhausts the PBM’s Grievance process and remains dissatisfied with the outcome, the Participant may appeal to the ETF by completing an ETF complaint form. The Participant should also submit copies of all pertinent documentation including the written determinations issued by the PBM. The PBM will advise the Participant of their right to appeal to the ETF within sixty (60) calendar days of the date of the final Grievance decision letter from the PBM.
However, the Participant may not appeal to ETF issues that do not arise under the terms and conditions of this Certificate of Coverage, for example, coverage of a drug, not the Formulary, 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. The Participant may request an external review. In this event, the Participant must notify the PBM of their request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. The Participant has no further right to administrative review once the external review decision is rendered.

B. Appeals to the Group Insurance Board

After exhausting the PBM’s Grievance process and review by ETF, the Participant may appeal ETF’s determination to the Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Board does not have the authority to hear appeals relating to issues that do not arise under the terms and conditions of this Certificate of Coverage, for example, determination of medical necessity, appropriateness, the effectiveness of a Covered drug/supply, 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 PBM breached its contract with the Board.