Annuitants who are eligible for and enrolled in **Medicare** may have different **Benefit Plan** designs available to them. See Section 2. F. Medicare Enrollment for more information.

D. Individual & Family Coverage

Individual Coverage

Individual coverage covers only the **Subscriber**. If you are enrolled in individual coverage, only your health care services will be covered by your policy. You may change between individual and family coverage when you have a **Qualifying Life Event** or during the annual **Open Enrollment** period.

Family Coverage

Family coverage allows you to cover both yourself (the **Subscriber**) and your **Dependents**. All eligible **Dependents** must be listed on your application and are covered under family coverage. You cannot choose to exclude any eligible **Dependent** from family coverage unless that **Dependent** is already covered under the **GHIP** through either their own policy or another **Subscriber**.

E. No Double Coverage & Spouse-to-Spouse Transfer

A **Dependent** or **Subscriber** cannot be covered at the same time by more than one **Subscriber** of the **Group Health Insurance Program** (including **State** and **Local**). If a **Dependent** on your **Benefit Plan** is covered by another **GHIP Subscriber**, you and the other **Subscriber** will be notified. You will have thirty (30) calendar days to decide which of you will keep your **Dependent** on your plan. Whoever does not keep the **Dependent** must submit an application to remove the **Dependent**. The **Effective Date** of the change will be the first of the month following receipt of the application.

If no application is submitted within the thirty (30) calendar day period, **ETF** will select one **Subscriber** and re-enroll all other **Participants** as **Dependents**.

If you and your spouse are both employed by a **State** or **Local Employer** that offers the **GHIP**, and you are both enrolled under a family policy provided by one employer, you can opt to change which of you is the **Subscriber** for your **GHIP** coverage. This is called a spouse-to-spouse transfer. Note that you will only be able to select the **Benefit Plans** available to you under the **Subscriber's Employer**. If you change mid-year due to a qualifying life event, you may be able to transfer the amounts you have already paid towards your benefit maximums; see Section 3. D. Transfer of Benefit Maximums, Deductibles, and Out-of-Pocket Limits below for more information.

F. Medicare Enrollment for Annuitants and Continuants

If you are an **Annuitant**, you and your **Dependents** (or your surviving **Dependents** if you die) who enroll in Medicare may continue your coverage at reduced **Premium** rates.

> Employees only: You (and your eligible **Dependents**) do not need to enroll in Medicare while you are an active **Employee** of your **State Employer** or participating **Local Employer**. However, if you have End Stage Renal Disease (ESRD) as determined by **Medicare**, you may want to be enrolled in **Medicare Parts A** and **B** effective at the end of your 30-month waiting period. If you retire or otherwise leave active employment, you (and

If you are an **Annuitant** and you or your spouse are covered under another group health plan through a different employer (such as your spouse's employer) that health plan is the primary payer for **Medicare Part A** and **Part B** charges, therefore you and/or your spouse may delay **Part B** enrollment (to the extent allowed by federal law. More information is available in Section 3. C. Medicare Participant Premiums below.

H. Qualifying Life Events

If you have recently had a change in marital status, a baby, or a change of home address, you may have the opportunity to enroll or change coverage outside of the annual **Open Enrollment** period. The information below is for the most common activities following a qualifying life event. More information is available online; go to https://etf.wi.gov and search "Life Event."

Some events may cause your **Dependents** to no longer be eligible for coverage under your **Health Plan.** If you are aware that one of the following events will happen soon, contact your Human Resources department if you are an active **Employee**, or **ETF** if you are an **Annuitant** or **Continuant**. If your **Health Plan** finds that one of your **Dependents** is no longer eligible, the **Health Plan** will also notify **ETF**. If your non-eligible **Dependent** received benefits during a time they should not have been on your policy, their claims will be adjusted, and you or they may be responsible for costs.

1. Marriage

If you get married while you are enrolled in the **GHIP**, you can add your new spouse to your **Health Plan** within thirty (30) days of your marriage. If your new spouse has children, you must also add those children to your family policy.

2. Divorce

If you divorce your spouse while enrolled in the **GHIP**, your spouse and any stepchildren on your plan will no longer be eligible for coverage. Spouses and stepchildren stop being **Dependents** at the end of the month in which a marriage is terminated by either divorce or annulment. For documentation of divorce, you will need to provide the judgment of divorce that is entered or final and has been signed and dated by the clerk of courts. It is the date of this document that determines when the divorce is final.

3. New Dependent

If you gain a new **Dependent** because of a birth, adoption or adoption placement, transfer of custody, paternity order, National Medical Support Notice or legal guardianship while enrolled in the **GHIP**, you must add that new **Dependent** to your family coverage or you may change to family coverage if you are enrolled in individual coverage. You must file your application to add your new **Dependent** within sixty (60) calendar days of the life event except for a custody change, where you have thirty (30) calendar days.

a. Children Born Outside of Marriage

A child born outside of marriage becomes your **Dependent** when you provide a birth certificate that lists your name to your **Employer**.

Fathers of children born outside of marriage can also submit the following documentation:

C. Medicare Participant Premiums for Retirees

Annuitants who are eligible for **Medicare Parts A** and **Part B** pay less for their **GHIP Premiums**. The reduction in **Premium** is effective on the first day of the month on or after the date you and/or your **Medicare**-eligible **Dependents** are eligible for **Medicare Parts A** and **Part B** as your primary health benefit coverage and you, the **Subscriber**, are no longer covered as an **Active Employee.** This reduced-**Premium** coverage is also referred to as **Medicare** coordinated coverage. In addition to opting for **Medicare** coordinated coverage, you may also choose to enroll in IYC Medicare Plus or IYC Medicare Advantage. These benefit plan designs typically have lower **Premiums** than other **Health Plans**, and both have some additional benefits and services that vary from **Uniform Benefits**. Additional Information is available in Section 4. Benefits & Coverages below.

As discussed in Section 2. F. Medicare Enrollment, you must enroll in **Medicare Part A** and **Part B** if you are continuing your health insurance coverage when you retire. If you don't, it could affect your health insurance **Premiums** and your overall **Benefits**.

Except in cases of fraud, if you either do not enroll in **Medicare Part B** at the time you enroll in a **Medicare** coordinated benefit plan and when **Medicare** is first available as the primary payer, or if you cancel **Medicare** coverage, your coverage will be limited and you will be responsible for any costs that **Medicare** would have paid.

If you or your **Medicare** eligible **Dependent** are enrolled in the IYC Medicare Advantage plan and subsequently cancel **Medicare** coverage, you will be disenrolled from the IYC Medicare Advantage plan and enrolled in IYC Medicare Plus effective as of the date of loss of **Medicare** coverage. That IYC Medicare Plus coverage will only cover costs beyond what **Medicare** would have paid; you will be responsible for the costs **Medicare** would have covered.

If you are found to have either not enrolled or disenrolled in **Medicare Part B** while on a **Medicare** coordinated benefit plan, retrospective adjustments to **Premium** or claims shall be limited to the shortest retroactive enrollment limit set by **Medicare** for either medical or prescription drug claims, not to exceed six (6) months. In such a case, you (or your **Medicare** eligible **Dependent**) must enroll in **Medicare Part B** at the next available opportunity.

If you are enrolled in non-**Medicare** coordinated coverage while enrolled in **Medicare Parts A** and **Part B** and are retired, **ETF** will refund any **Premium** paid in excess of the **Medicare**-reduced **Premium** for any months for which **Benefits** were coordinated. In such cases, your **Health Plan** will make claims adjustments prospectively. However, **Premium** refunds for retroactive enrollment in a coordinated **Benefit Plan** will correspond with the retroactive enrollment limits and requirements established by **CMS** for medical and/or prescription drug coverage. This may limit the amount of **Premium** refund you are eligible to receive.

There may be additional limitations to retrospective enrollment for the IYC Medicare Advantage plan. You should review your IYC Medicare Advantage Evidence of Coverage document and/or contact the IYC Medicare Advantage **Health Plan** to verify these limitations.

D. End Stage Renal Disease & Medicare Enrollment for Employees and Annuitants

Your **GHIP Benefits** will pay as the primary payer for the first thirty (30) months after you become eligible for **Medicare** due to kidney disease, whether or not you or your **Dependent** are enrolled in **Medicare**. The **Premium** rate for non-**Medicare Advantage Health Plans** will be the non-**Medicare** rate during this period.

Medicare becomes the primary payer after the thirty (30)-month period ends, upon enrollment in **Medicare Part A** and **Part B**. If you or your **Dependent** have more than one period of **Medicare** enrollment based on kidney disease, there is a separate thirty (30)-month period during which the **GHIP** will again be the primary payer. No reduction in **Premium** is available for active **Employees**.

Annuitants are required to enroll in **Medicare Part A** and **Part B. ETF** strongly recommends that **Employees** enroll in both **Medicare Part A** and **Part B** by the end of the thirty (30)-month waiting period. If an **Employee** does not enroll by the time that the waiting period ends, **Medicare** may impose a penalty on your **Medicare Premium**.

E. Transfer of Benefit Maximums, Deductibles, and Out of Pocket Limits

As discussed in Section 2. H. Qualifying Life Events, you may have the opportunity to change **Health Plans** or **Benefit Plans** (e.g., change from or to the **HDHP**) during a **Benefit Period** in certain situations. In some cases, you may be able to transfer amounts you have already paid under your former coverage to your new coverage.

The amounts that you have already paid toward your **Deductible** and **Out of Pocket Limits (OOPLs)** are referred to as Accumulations. Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** under your **GHIP** coverage will continue to add up for the **Benefit Period** in the following situations if you do not change **Health Plans**:

- If you change the coverage level (e.g., single to family);
- If you change benefit plan designs (e.g., change from or to the **HDHP**);
- If you have a spouse-to-spouse transfer resulting in a change of **Subscriber**; or
- If you have a **Dependent** change (e.g., following a divorce) resulting in a change of **Subscriber**.

Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** will start over at zero ($0) dollars as of the **Effective Date** of the change if you change from being a **Participant** of the **State** program to the **Local** program, or vice versa.

Accumulations to the annual pharmacy and uniform dental (if applicable) benefits continue to accumulate for the **Benefit Period** regardless of a **Benefit Plan**/**Health Plan** change. See your Uniform Pharmacy Benefits document and Uniform Dental Benefits for more information. For **HDHPs**, medical and pharmacy accumulations are combined.

Your **Health Plan** will apply all **Maximum Out-of-Pocket (MOOP)** limits as required by Wisconsin and federal laws.

F. Recovery of Premium Overpayments

If you or your **Dependents** receive coverage or **Benefits** that you were not entitled to, you will need to reimburse your **Health Plan** for those services. You must reimburse your **Health Plan** immediately upon receiving notification from the **Health Plan** and/or **PBM**. At the option of the **Health Plan** and/or **PBM**, payments for future **Benefits** may be reduced by the **Health Plan** and/or **PBM** in order to offset a balance owed.

C. Cost Sharing May Apply

Your benefits may be subject to the **Copayments**, **Coinsurance, Deductible**, and other limitations shown in the **Schedule of Benefits** for your **Benefit Plan.** If you are unsure whether a service is subject to cost sharing, refer to your **Schedule of Benefits** that can be found when you visit ETF's website at http://etf.wi.gov/benefits-by-employer and search for your Employer. You may also contact your **Health Plan** to verify.

D. Medical Necessity

All services must be medically necessary, as determined by your **Health Plan.** A service, treatment, procedure, equipment, drug, device or supply that is provided by a **Hospital**, physician or other health care **Provider** and is required to identify or treat a **Participant's Illness** or **Injury** is considered medically necessary when it is:

a. consistent with the symptom(s) or diagnosis and treatment of the **Participant**'s **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.

Your **Health Plan** will determine if all the above criteria have been met to determine which services are covered. If you or your **Provider** disagree with the determination made by your **Health Plan**, you may seek external review. See Section 8. Grievances & Appeals below.

E. Disease Management, Prior Authorizations, & Utilization Review

Your **Health Plan** will collaborate with other vendors who provide your **GHIP** benefits to provide disease management services. Disease management programs support you in managing your medical conditions, and in some cases provide nursing or other health professional support to find strategies to improve your overall health.

Your health plan may require **Prior Authorization** for some services. **Prior Authorization** is intended to help ensure that the services you receive are the most appropriate for your condition. Your **Health Plan** will use evidence based medical policy development process to determine **Prior Authorization** criteria and will provide you a copy of these policies on request.

Your **Health Plan** may also require a **Referral** from your **Primary Care Provider** in order to obtain certain specialty services. In many cases, the **Referral** must be in writing and on the **Health Plan's Prior Authorization** form and approved by the **Health Plan** in advance of a **Participant**'s treatment or service. **Referral** requirements are determined by each **Health Plan**. The authorization from the **Health Plan** will state the type or extent of treatment authorized and the number of visits and the period of time during which the authorization is valid. In most cases, it is the **Participant**'s responsibility to ensure a **Referral**, when required, is approved by the **Health Plan** before services are rendered.

In some cases, your **Health Plan** may use a process called utilization management or utilization review to ensure that the services you receive are evidence-based and focus on quality, positive

health outcomes, and cost savings. The **Health Plan** must demonstrate effective and appropriate means of identifying, monitoring and directing **Participant**'s care by providers such as utilization review (UR) and chronic care/disease management, and wellness/prevention programs.

F. Covered Services

The following services and supplies are covered under your **GHIP Benefits** if they are medically necessary for the treatment of an **Injury** or **Illness.** See Section 4. D. Medical Necessity for details on how services are determined to be medically necessary.

1. Ambulance Services

Your plan covers licensed professional ambulance services (or comparable **Emergency** transportation if authorized by your **Health Plan**) when transportation to a **Hospital** is an **Emergency** or **Urgent** and medical attention is required enroute. This includes licensed professional air ambulance when another mode of ambulance service would endanger the **Participant's** health. **Emergency** air ambulance services are limited to only those services necessary for transport to the nearest medical facility equipped to handle the **Emergency**. Ambulance services include medically necessary transportation and all associated supplies and services provided therein. If the **Participant** is not in the **Health Plan's Service Area**, the **Health Plan** should be contacted, if possible, before transport.

2. Ancillary Services

Ancillary services are those services that are generally provided in conjunction with another medically necessary service. Some examples include anesthesia provided for a surgery or a lab test to diagnose an **Illness**. If you receive anesthesiology, radiology, or pathology services (including all lab tests) at an **In-Network** clinic or **Hospital**, those services will be covered at the **In-Network** level of **Benefits,** even if the service is not provided by an **In-Network Provider**.

3. Anesthesia Services

Anesthesia services are covered when provided in connection with other medical and surgical services covered under this Certificate of Coverage.

4. Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m) and the Federal Mental Health Parity and Equity Act (MHPAEA). Autism spectrum disorder means any of the following:

a. Autism disorder;
b. Asperger's syndrome; or
c. Pervasive developmental disorder not otherwise specified.

Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following **In-Network Providers** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services):

a. Psychiatrist;
b. Psychologist;
c. Social worker;
d. Behavior analyst;

visit or **Urgent Care** setting, if those drugs are covered under the **GHIP**. Injectable and infusible medications, except for **Self-Administered Injectable** medications, are included in this coverage.

Prescriptions for covered drugs written in any of the above settings that do not require an office visit to administer will be the responsibility of the **PBM** and payable as provided under the terms and conditions of Uniform Pharmacy Benefits. See Prescription Drugs and Other Benefits Administered by the PBM below for additional information.

16. Durable Diabetic Equipment and Related Supplies

Durable diabetic equipment and the supplies that are required for use with the durable diabetic equipment will be covered when prescribed by and purchased from an **In-Network Provider** for treatment of diabetes (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services). Cost sharing may apply; see your **Schedule of Benefits** for more information.

Durable diabetic equipment includes automated injection devices, continuous glucose monitoring devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year and you must use the pump for thirty (30) calendar days before purchase.

Glucometers are available through the **PBM**. Refer to the Uniform Pharmacy Benefits document for more information.

Durable diabetic equipment and supplies may require **Prior Authorization** from your **Health Plan.**

17. Durable Medical Equipment and Medical Supplies

When prescribed by an **In-Network Provider** for treatment of a diagnosed **Illness** or **Injury** and purchased from an **In-Network Provider** outside of a **Hospital** setting, **Medical Supplies** and **Durable Medical Equipment** will be covered subject to cost sharing as outlined in the **Schedule of Benefits** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services).

All **Durable Medical Equipment** purchases, or monthly rentals must have **Prior Authorization** as determined by your **Health Plan**. In addition, the following **Durable Medical Equipment** and **Medical Supplies** may require **Prior Authorization** by your **Health Plan:**

a. Initial acquisition of artificial limbs and eyes, including replacements due to significant physiological changes, such as physical maturation, when medically necessary and when refitting of any existing prosthesis is not possible.
b. Casts, splints, trusses, crutches, prostheses, orthopedic braces, and appliances.
c. Custom-made orthotics, limited to one orthotic per foot per calendar year.
d. Rental or, at the option of the **Health Plan**, purchase of equipment including, but not limited to, wheelchairs and **Hospital**-type beds.
e. IUDs and diaphragms.
f. An initial external lens per eye directly related to cataract surgery (contact lens or framed lens) or keratoconus (hard contact lens). Any subsequent lenses after the first lens will not be covered (See Section 5. Exclusions).

Stage Renal Disease & Medicare Enrollment to learn more about how this may impact your **Premium** costs.

26. Mastectomy & Breast Reconstruction (Women's Health and Cancer Act of 1998)

Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies associated with breast cancer treatment includes:

a. Reconstruction of the breast on which a mastectomy was performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses (see Durable Medical Equipment) and physical complications of all stages of mastectomy, including lymphedemas; and
d. Breast implants.

27. Mental Health & Substance Use Disorder Services

Following the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, services to diagnose and treat mental health and substance use disorder are covered by the **GHIP**. Coverage includes:

a. Outpatient Services, meaning non-residential services provided by **In-Network Providers**, as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This benefit also includes services for a full-time student attending school in Wisconsin but out of the **Service Area,** as required by Wis. Stat. § 609.655;
b. Transitional Services, meaning services provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA;
c. Inpatient Services, provided by an **In-Network Provider** as described in **Schedule of Benefits** and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This includes court-ordered services as required by Wis. Stat. § 609.65, and these services are covered if performed by an **Out-of-Network Provider** if provided as required by an **Emergency** detention or on an **Emergency** basis. The **Provider** must notify the **Health Plan** within 72 hours after the initial provision of service;
d. Detoxification Services; and
e. Methadone Treatment.
f. Family Counseling when it is part of developing or supporting you or your **Dependent's** treatment plan. (For **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be covered under the Uniform Pharmacy Benefit, subject to the benefits provided under the Uniform Pharmacy Benefit Certificate of Coverage.

28. Nutritional Counseling

Nutritional Counseling is covered when provided by a participating registered dietician or an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network**

condition that requires hospitalization or general anesthesia for dental care, or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

30. Physical, Speech and Occupation Therapy

Habilitation or **Rehabilitation** services and treatment that result from an **Illness** or **Injury** will be covered if provided by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). **Providers** must be registered and must not live in your home or be a family member.

Up to 50 visits per **Participant** for all therapies combined are covered per calendar year. Your **Health Plan** may review utilization and clinical information during the initial 50 visits to verify medical necessity (See Section 4. E. Disease Management, Prior Authorizations, & Utilization Review for additional information). Additional visits may be available with **Prior Authorization** from your **Health Plan**, up to a maximum of 50 additional visits per therapy, per **Participant,** per calendar year.

These therapies benefits are only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

31. Prescription Drugs and Other Benefits Administered by the PBM

Your coverage for most medications under the **GHIP** is provided by a **Pharmacy Benefit Manager (PBM).** You must obtain pharmacy benefits at a **PBM Participating Pharmacy**, except when not reasonably possible because of **Emergency** or **Urgent Care**. For full detail on services covered by the **PBM**, please see the Uniform Pharmacy Benefits Certificate of Coverage.

32. Preventive Care & Immunizations

The **GHIP** covers all preventive care services that have received an A or B grade by the United States Preventive Services Task Force (USPSTF) without cost sharing to you when received from an **In-Network Provider** as required by the Affordable Care Act, regardless of the **Benefit Plan** in which you are enrolled. Check with your **Provider** and your **Health Plan** to verify which services are recommended for you and your family.

Preventive services include routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

Preventive care also includes well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

33. Primary Care

You are required to select a **Primary Care Provider (PCP)** or **Primary Care Clinic (PCC)** when you enroll in the **GHIP** and when you change **Health Plans**. You must select your **PCP** or **PCC** from your **Health Plan's** list of **In-Network Providers**. Your **PCP** may be a physician, physician assistant, nurse practitioner or other **Provider** if that **Provider** is managing your primary care services. Primary care includes ongoing responsibility for preventive health care, treatment of **Illness** and **Injuries**, and the coordination of access to needed specialty **Providers** or other services. Your **PCP** or **PCC** shall either furnish or arrange for most of your health care needs,

5. Exclusions & Limitations

The following is a list of services, treatments, equipment or supplies that are excluded, meaning no benefits are payable under the **GHIP**, or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by your **Health Plan** and the **PBM**. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy benefit administered by the **PBM**. Some of the services listed exclusions may be medically necessary, but still are not covered under the **GHIP**. Others may be examples of services which are not medically necessary or not medical in nature, as determined by your **Health Plan** and/or **PBM**. As discussed in Section 4. D. Medical Necessity above, the determination of medical necessity is ultimately reached by your **Health Plan.**

A. Excluded Services

The services described in this section are specifically not covered by the **GHIP**.

1. Administrative & Clerical Charges

a. Charges for any missed appointment.
b. Expenses for medical reports, including preparation and presentation.

2. Care Needed for Employment

a. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, Smallpox vaccinations, etc.).
b. Vocational rehabilitation including work hardening programs.
c. Physical exams for employment.

3. Cosmetic Treatments & Services

a. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to **Congenital** bodily disorders or conditions or when associated with covered reconstructive surgery due to an **Illness** or accidental **Injury** (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
b. Removal of skin tags.

4. Durable Medical Equipment, Durable Diabetic Equipment, and Medical Supplies

a. **Durable Medical Equipment, Durable Diabetic Equipment,** or **Medical Supplies** that have not received **Prior Authorization** by your **Health Plan.**
b. **Durable Medical Equipment** and **Medical Supplies** that are provided solely for comfort, personal hygiene and convenience items. Examples of these items include, but are not limited to:
    i. wigs
    ii. hair prostheses
    iii. air conditioners
    iv. air cleaners
    v. humidifiers
    vi. physical fitness equipment

i. Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

15. Routine Foot Care

a. The examination, treatment or removal of all or part of corns, calluses, hypertrophy, or hyperplasia of the skin or subcutaneous tissues of the feet.
b. Cutting, trimming or other nonoperative partial removal of toenails. *Note:* This exclusion does not apply when services are intended to treat a metabolic or peripheral disease or a skin or tissue infection.
c. Treatment of flexible flat feet.

16. Services Covered by Other Payors

a. 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 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**. See Section 2. F. Medicare Enrollment.
b. Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which the **GHIP** 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.
c. Treatment, services, and supplies to which the **Participant** would be entitled to have furnished or paid for, fully or partially, under any law, regulation, or agency of any government.
d. Treatment, services, and supplies to which the **Participant** 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.
e. Services that a child's school is legally obligated to provide, whether the school actually provides the services and whether the **Participant** chooses to use those services.
f. Services to the extent a **Participant** 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 **Participant** is actually insured under Worker's Compensation.

17. Services Not Medically Necessary

a. Any service, treatment, procedure, equipment, drug, device, or supply which is not reasonably and medically necessary or is not required in accordance with accepted standards of medical, surgical or psychiatric practice.
b. Personal comfort or convenience items or services such as in-**Hospital** television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.
c. **Maintenance Care**. The determination of what constitutes "**Maintenance Care**" is made by the **Health Plan** after reviewing an individual's case history or treatment plan submitted by a **Provider**.

18. Services Outside of Enrollment

a. Expenses incurred prior to the **Effective Date** of coverage by the **Health Plan** and/or **PBM**, or services received after the **Health Plan** and/or **PBM** coverage or eligibility terminates.

19. Services Related to the Commission of a Crime

a. Treatment or service in connection with any **Illness** or **Injury** caused by a **Participant** either engaging in an illegal occupation or the commission of, or attempt to commit, a felony.
b. Services related to an **Injury** that was self-inflicted for the purpose of receiving **Health Plan** and/or **PBM Benefits**.

20. Therapies Not Covered

a. Treatment, services, or supplies used in educational or vocational training; care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL); except for services covered under the **Habilitation Services** therapy **Benefit**, and mandated therapy **Benefits** for autism spectrum disorders under Wis. Stat. § 632.895 (12m).
b. Physical fitness or exercise programs.
c. Biofeedback, except for treatment of headaches, spastic torticollis, and urinary incontinence.
d. Massage therapy.

21. Transplants & Donor-Related Services

a. Services in connection with covered transplants that have not received **Prior Authorization** from the **Health Plan**.
b. Costs related to a failed transplant that is otherwise covered under the global fee.
c. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
d. All separately billed donor-related services, except for kidney transplants.
e. Non-human organ transplants or artificial organs.
f. Transplants not performed at a facility designated by the **Health Plan**.
g. Services of a blood donor. Medically necessary autologous blood donations are not considered to be services of a blood donor.

22. Travel & Transportation

a. Charges for, or in connection with, travel, except for ambulance transportation as outlined in Section 4. F. Covered Services. This includes but is not limited to meals, lodging and transportation.

23. Weight Loss, Diet Programs, & Food or Supplements

a. Weight loss programs including dietary and nutritional treatment in connection with obesity unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan**. This does not include **Nutritional Counseling** as provided in Section 4. F. Covered Services, Nutritional Counseling.

b. Any diet control program, treatment, or supply for weight reduction unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan.**
c. Food or food supplements except when provided during a covered outpatient or inpatient **Confinement**.

24. Vision Correction

a. Eyeglasses or corrective contact lenses.
b. Fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery or keratoconus.
c. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens.
d. Keratoefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.

B. Coverage Limitations

1. Major Disaster, Epidemic, or Pandemic

If a major disaster, epidemic, or pandemic occurs, **In-Network Providers** and **Hospitals** must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the **PBM** and its **Participating Pharmacies**.

During a major disaster, epidemic, or pandemic, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** if services are unavailable from **In-Network Providers** and/or **Participating Pharmacies**. Any novel services developed that receive emergency authorization or other short-term clearance from applicable federal agencies for use to address the disaster, epidemic, or pandemic, may be covered by the **Health Plan**, subject to instruction by **ETF**.

2. Circumstances Beyond the Health Plan’s Control

If, due to circumstances not reasonably within the control of the **Health Plan**, such as a complete or partial insurrection, labor disputes not within the control of the **Health Plan**, disability of a significant part of **Hospital** or medical group personnel, or similar causes, the provision of services and other **Benefits** covered hereunder is delayed or rendered impractical, the **Health Plan**, **In-Network Providers** and/or the **PBM** will use their best efforts to provide services and other **Benefits** covered hereunder. In this case, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** so long as services remain disrupted.

6. Coordination of Benefits

A. Applicability

This Coordination of Benefits (COB) provision applies to the **GHIP** when a **Participant** has health care 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**:

1. Shall not be reduced when, under the order of benefit determination rules, the **GHIP** determines its benefits before another **Plan**, but
2. May be reduced when, under the order of benefit determination rules, another **Plan** determines its benefits first. This reduction is described in Section C. Effect on the Benefits of The GHIP.

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:

1. The other **Plan** has rules coordinating its benefits with those of the **GHIP**, and
2. 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**.

Rules

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

1. Non-**Dependent**/**Dependent**
   a. 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**.

2. **Dependent** Child/Parents Not Separated or Divorced
   Except as stated in paragraph 3. below, when the **GHIP** and another **Plan** cover the same child as a **Dependent** of different persons, called "parents":
   a. 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
   b. 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 subparagraph a. 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.

3. **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:
   a. First, the **Plan** of the parent with custody of the child;
   b. Then, the **Plan** of the spouse of the parent with the custody of the child; and

c. 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 2. 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.

4. Active/Inactive Employee
   The **Benefits** of a **Plan** which covers a person as an employee who is neither laid off nor retired or 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 4. is ignored.

5. 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:
   a. First, the benefits of a **Plan** covering the person as an employee, member, or **Subscriber** or as a **Dependent** of an employee, member, or **Subscriber**.
   b. Second, the **Benefits** under the continuation coverage.

   If the other **Plan** does not have the rule described in subparagraph a. above, and if, as a result, the **Plans** do not agree on the order of **Benefits**, this paragraph 5. is ignored.

6. 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.

C. 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**:

1. The **Benefits** that would be payable for the **Allowable Expenses** under the **GHIP** in the absence of this COB provision; and
2. 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 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 **Benefits** is reduced in proportion. It is then charged against any applicable benefit limit of the **GHIP**.

D. 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.

E. Facility of Payment

A payment made under another **Plan** may include an amount which 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.

F. 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:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

G. Subrogation

Each **Participant** agrees that the payor under the **GHIP**, whether that is a **Health Plan** or **ETF**, shall be subrogated to a **Participant's** rights to damages, to the extent of the **Benefits** the **Health Plan** provides under the policy, for **Illness** or **Injury** a third party caused or is liable for. It is only necessary that the **Illness** or **Injury** occur through the act of a third party. The **Health Plan's** or **ETF'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; and
4. Any medical payments, no-fault or school insurance coverages which are paid or payable.

A **Participant's** rights to damages shall be, and they are hereby, assigned to the **Health Plan** or **ETF** to such extent.

The **Health Plan'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 **Health Plan's** or **ETF's** prior written consent shall be deemed to prejudice the **Health Plan's** or **ETF's** rights. Each **Participant** shall promptly advise the **Health Plan** or **ETF** in writing whenever a claim against another party is made on behalf of a **Participant** and shall further provide to the **Health Plan** or **ETF** such additional information as is reasonably requested by the **Health Plan** or **ETF**. The **Participant** agrees to fully cooperate in protecting the **Health Plan's** or **ETF's** rights against a third party. The **Health Plan** 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 **Health Plan** or **ETF** and the **Participant** over the question of whether or not the **Participant** has been "made whole", the **Health Plan** or **ETF** reserves the right to a judicial determination whether the insured has been "made whole."

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

7. Member Rights & Responsibilities

Your **Health Plan** shall comply with and abide by the Patient's Rights and Responsibilities as provided in **ETF's** annual **Open Enrollment** materials. **Health Plans** that have their own Patient's Rights and Responsibilities may use them unless there is a conflict with the **ETF's** materials. In this case, the Patient's Rights and Responsibilities which are more favorable to the **Participant** will apply.

A. New Rights to Benefits Transparency (Rules Pending)

In 2021, the U.S. Congress passed the No Surprises Act. This Act adds new rights to benefits coverage transparency, such as **Advanced Explanations of Benefits (A-EOBs),** searchable **Provider** directory requirements, and access to price comparison tools through your **Health Plan**. While the law states that these rights are effective January 1, 2022, the federal government is still writing the rules that your **Health Plan** must follow to comply with the new requirements. Your **Health Plan** will notify you when each of these new services or features become available. In the meantime, you can check out https://etf.wi.gov/no-surprises-act to find more information on the provisions of the law and any updates on when changes will be implemented.

B. Disenrollment Due to Fraud

No person other than a **Participant** is eligible for health **Benefits** under this policy. 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 **Open Enrollment** period. Re-enrollment options may be limited under the **Board's** authority.

The **Board** may forfeit a **Subscriber's** rights to participate in the **GHIP** if a **Participant** fraudulently or inappropriately assigns or transfers rights to an ineligible individual, aids any other person in obtaining **Benefits** to which they are not entitled, or otherwise fraudulently attempts to obtain **Benefits**.

ETF may at any time request such documentation as it deems necessary to substantiate **Subscriber** or **Dependent** eligibility. Failure to provide such documentation upon request may result in the suspension of benefits.

The **Health Plan** shall report to **ETF** any suspected or identified **Participant** fraud. The **Health Plan** must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the **ETF**. Fraud may result in the reprocessing of claims and recovery of overpayments.

C. Enrollment Change Due to Member Behavior

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

8. Grievances & Appeals

A. Grievance Process

All participating **Health Plan**s and the **PBM** are required to make a reasonable effort to resolve **Participants'** problems and complaints. If the **Participant** has a complaint regarding the **Health Plan**'s and/or **PBM's** administration of these **Benefits** (for example, denial of claim or **Referral**), the **Participant** should contact the **Health Plan** and/or **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 **Health Plan** and/or **PBM**. Contact the **Health Plan** and/or **PBM** for specific information on its **Grievance** procedures.

If the **Participant** exhausts the **Health Plan's** and/or **PBM's Grievance** process and remain dissatisfied with the outcome, the **Participant** may appeal to the **ETF** by completing an ETF Insurance Complaint form (ET-2405). The **Participant** should also submit copies of all pertinent documentation including the written determinations issued by the **Health Plan** and/or PBM. The **Health Plan** and/or **PBM** will advise 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 **Health Plan** and/or **PBM**.

However, the **Participant** may not appeal to **ETF** issues which do not arise under the terms and conditions of this **Certificate of Coverage**, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, **Experimental** treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. The **Participant** may request an external review. In this event, the **Participant** must notify the **Health Plan** and/or **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 **Health Plan's** or **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 which do not arise under the terms and conditions of this **Certificate of Coverage**, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, **Experimental** treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the **Health Plan** and/or **PBM** breached its contract with the **Board**.