Plan Year 2025

Uniform Pharmacy Benefits

Certificate of Coverage

Uniform Pharmacy Benefits Certificate of Coverage

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

Effective January 1, 2025

25ET-2107upb (Revised 5/1/2025)

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 $1,650, the pharmacy **Benefit Plan** will not pay anything until the **Participant** has incurred $1,650 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 **Subscribe**r.

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**.

Medicare Prescription Payment Plan: A payment option for **Medicare** members that can help members manage drug costs by spreading them across monthly payments that vary thought the year (January-December). All members are eligible to participate in the plan regardless of income level. Contact **Navitus** or visit Medicare.gov to find out more information.

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 **Participan**t.

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 2025.

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 **Subscribe**r 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://etf.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.

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

This chart describes each plan's Deductibles and Out-Of-Pocket Limits (OOPLs).

	IYC Health Plan	**IYC HDHP**	**Medicare Part D**
Plan Deductibles			
All Levels	None	$1,650/$3,300 combined medical and pharmacy	None
OOPLs			
Level 1 & 2 Combined	$600/$1,200	$2,500/$5,000 combined medical and pharmacy	$600
Level 3	$9,200/$18,400		$2,000
Level 4	$9,200/18,400		$1,200

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 $1,650 for that drug, any other prescriptions they may be on, and medical costs. After the $1,650 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,** except flu and Covid-19 vaccines/booster, 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.

At no cost under **Medicare Part B**, a member can receive their flu and Covid-19 vaccines/boosters either at an in-network medical provider using their insurance card, or you can go to a pharmacy, but you must show your red, white and blue **Medicare** card.

You will continue to use your **Navitus** card when you fill your prescriptions and receive other vaccines/boosters at a **pharmacy**.

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 **Prescribe**r 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 **Copaymen**t 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 **OOPL**. To see the complete Discount Drug List visit 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 $9,450 individual/$18,900 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 ET-2180 (Rev 1/13/2022) Page 58 of 63

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**, **Experimenta**l 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**.