Medicare Plus
Certificate of Coverage
Insured by UnitedHealthcare

2026 State of Wisconsin Group Health Insurance Program

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MEDICARE PLUS Coverage

Medicare Plus BENEFITS

This is the CERTIFICATE OF COVERAGE for MEDICARE PLUS BENEFITS and applies to PARTICIPANTS enrolled in MEDICARE PLUS. PARTICIPANTS covered under this section should be enrolled in MEDICARE Parts A and B. If they are not, they will have greater out-of-pocket costs for BENEFITS as shown in Section 9. Exclusions, c. and p.

PARTICIPANTS who are employed with a State or participating Wisconsin Public Employer (Local) employer are not eligible to enroll in MEDICARE PLUS. Retired State or participating Local PARTICIPANTS who are over age 65 and/or are eligible for MEDICARE are eligible to enroll.

A PARTICIPANT insured on a State or participating Local retiree policy who is enrolled in the ACCESS PLAN or SMP, loses that coverage with MEDICARE eligibility and automatically becomes a PARTICIPANT under the MEDICARE PLUS coverage.

All BENEFITS are paid according to the terms of the contract. The Schedule of Benefits below describes certain essential dollar or visit limits of a PARTICIPANT'S coverage and certain rules, if any, a PARTICIPANT must follow to obtain covered services. In some situations (for example, additional services received from a NON-PARTICIPATING PROVIDER), BENEFITS will be paid according to the USUAL AND CUSTOMARY CHARGES.

The Group Insurance Board contracts with a PHARMACY BENEFIT MANAGER (PBM) to provide prescription drug BENEFITS. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Pharmacy Benefits for those who are covered under the HEALTH BENEFIT PROGRAM.

1. Definitions

The following additional definitions apply to the MEDICARE PLUS BENEFITS:

ACCESS PLAN: means the nationwide Preferred Provider Organization (PPO) BENEFIT PLAN offering available to all Participants. Participants may use In-Network or Out-of-Network Providers for covered services.

AMBULATORY SURGERY CENTER (ASC): means an outpatient free-standing facility where surgeries are performed that allows patients to go home the same day. In most cases, ambulatory surgical centers release patients within 24 hours. ASCs might be part of a HOSPITAL system, but they are not usually physically attached to a HOSPITAL. ASCs might also be known as Surgery Centers or Outpatient Surgery Centers.

ANNUITANT: Means a retiree of the Wisconsin Retirement System. See SUBSCRIBER for more information.

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

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

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

BENEFIT PLAN: Means the package of coverage and cost-sharing levels that you are enrolled in under the State of Wisconsin GHIP.

BENEFITS: Means the services that are paid for as a part of your coverage under the GHIP.

BOARD: Means the Group Insurance Board.

BUSINESS DAY: means each calendar day except Saturday, Sunday, and official State of Wisconsin holidays, as listed under Wis. Stat. § 230.35(4)(a).

CERTIFICATE OF COVERAGE: Means this document, which may be updated as required by the DEPARTMENT, and includes details on the services that are covered by your BENEFIT PLAN under the GHIP.

CHARGES: Means the reasonable charges for items or services set by MEDICARE. The HEALTH PLAN treats CHARGES for stays in a HOSPITAL or licensed skilled nursing facility as incurred on the date of admission. The HEALTH PLAN treats all other CHARGES as incurred on the date the PARTICIPANT gets the service or item. BENEFITS are payable only up to the reasonable charge set by MEDICARE, except as stated in Section 3. BENEFITS Available, below. No agreement between the PARTICIPANT (or someone acting for the PARTICIPANT) and any other person, group, or PROVIDER of services will cause the HEALTH BENEFIT PROGRAM to pay more.

CMS: Means Centers for Medicare & Medicaid Services in the U.S. Department of Health and Human Services.

CONTINUANT: Means any SUBSCRIBER enrolled under federal COBRA or State continuation provisions.

CONFINEMENT/CONFINED: Means (a) the period of time between admission at an INPATIENT facility, or outpatient to a HOSPITAL, covered residential center, skilled nursing facility or licensed AMBULATORY SURGICAL CENTER on the advice of the PARTICIPANT'S physician; and discharge therefrom, or (b) the time spent receiving emergency care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the

same as CONFINEMENT in a skilled nursing facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The BENEFIT levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in BENEFIT levels during the CONFINEMENT.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, home care provided by family members and non-skilled personal care, like help with activities of daily living such as bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, MEDICARE doesn't pay for custodial care.

DAY(S) means calendar day(s) unless otherwise indicated.

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

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

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

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

a. An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is DEPENDENT on the

SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The HEALTH PLAN will monitor eligibility annually, notifying the DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

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

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

[4] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE employee of the State or participating Local employer.

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

DEPARTMENT: Means the State of Wisconsin Department of Employee Trust Funds.

E-VISIT: MEDICARE covers E-visits to allow you to talk with your provider using an online patient portal without going to the provider's office. Providers who can give these services include doctors, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, occupational therapists, speech-language pathologists; and for mental health care, providers include licensed clinical social workers, clinical psychologists, marriage and family therapists, and mental health counselors. To get an E-visit, you must request one with your doctor or other provider.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CERTIFICATE OF COVERAGE.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the HEALTH PLAN and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet

recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY.

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 Drugs and Non-Preferred Drugs before coverage applies. Drugs that are not included in the FORMULARY are not covered by the BENEFITS of the GHIP.

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

GROUP HEALTH INSURANCE PROGRAM (GHIP): Means the BENEFITS program offered by the Group Insurance Board that provides medical, pharmacy, and wellness BENEFITS to enrolled current and former public workers.

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

HEALTH PLAN: means the health insurer that is under contract with the BOARD to provide BENEFITS and services to PARTICIPANTS in the GHIP.

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

b. Qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission (formerly known as the Joint Commission on Accreditation of Hospitals).

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

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

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

INPATIENT: Means semi-private hospital rooms, meals, general nursing, drugs (including methadone to treat an Opioid Use Disorder), and other hospital services and supplies as part of your inpatient treatment. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, psychiatric care in inpatient psychiatric facilities, and inpatient care for a qualifying clinical research study.

This doesn’t include private-duty nursing, a television or phone in your room (if there’s a separate charge for these items), personal care items (like razors or slipper socks), or a private room, unless medically necessary.

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

LIFETIME RESERVE DAYS: Means additional DAYS that MEDICARE will pay for when the PARTICIPANT is in a HOSPITAL for more than ninety (90) DAYS. The PARTICIPANT has a total of sixty (60) LIFETIME RESERVE DAYS that can be used during their lifetime. For each LIFETIME RESERVE DAY, MEDICARE pays all covered costs except for a daily coinsurance.

LIMITING CHARGE: The highest amount of money you can be charged for a covered service by NON-PARTICIPATING PROVIDERS (doctors and other health care suppliers who don't accept assignment). When providers accept Medicare assignment, that means the PROVIDER agrees to accept the Medicare-approved amount as full payment for covered services, limiting the amount they can charge the patient. The limiting charge is 15% over MEDICARE'S approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

MEDICAID: Medicaid is a joint federal and state program that helps cover medical costs for some people with limited income and resources. Medicaid offers benefits not normally covered by MEDICARE, like nursing home care and personal care services. The rules regarding who is eligible for Medicaid are different in each state.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT (DME): Means items which are, as determined by the HEALTH PLAN:

a. Used primarily to treat an ILLNESS or INJURY, and

b. generally, not useful to a person in the absence of an ILLNESS or INJURY, and

c. the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

d. prescribed by a PROVIDER.

Note: DME is defined as equipment that meets these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Typically only useful to someone who is sick or injured
- Used in your home
- Expected to last at least 3 years

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 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.

MEDICARE: Refers to 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. MEDICARE Part B refers to coverage for outpatient services. Medicare Part D refers to prescription drug coverage. The PBM provides Part D benefits.

MEDICARE PART A: In general, Medicare Part A helps pay for INPATIENT care you get in hospitals and skilled nursing facilities. It also helps cover hospice care and some home health care.

MEDICARE PART B helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)

MEDICARE PART A ELIGIBLE EXPENSES AND MEDICARE PART B ELIGIBLE EXPENSES: Means health care expenses that are covered by MEDICARE Part A or Part B, recognized as MEDICALLY NECESSARY and reasonable by MEDICARE, and that may or may not be fully reimbursed by MEDICARE.

MEDICARE PLUS: Is a fee-for-service MEDICARE supplement plan administered by the HEALTH PLAN for retirees enrolled in MEDICARE Parts A and B and pays for BENEFITS defined under this section.

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

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

OPEN ENROLLMENT: Means the yearly period when all members in the GHIP may make changes to their BENEFITS. The dates for this time period are set each year by the DEPARTMENT and the BOARD.

PARTICIPANT: Means a SUBSCRIBER, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for MEDICARE PLUS coverage has been made and for whom the appropriate PREMIUM has been paid.

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

PHARMACY BENEFIT MANAGER (PBM): Means a third-party administrator that is contracted with the BOARD to administer the Part D prescription drug BENEFITS under the GHIP. The PBM is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

PREMIUM: Means the amount to be paid for health insurance every month.

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.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

State Maintenance Plan (SMP): means a Plan offered as a qualified tier 1 Plan, as determined by the BOARD. SMP is a Preferred Provider Organization (PPO) BENEFIT PLAN. PARTICIPANTS are encouraged to use In-Network Providers for covered services as the Out-of-Pocket costs for Out-of-Network Providers can be high, as described on the SMPdescription page. The SMP offers Uniform Benefits and the High Deductible Health Plan Uniform Benefits.

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

TELEHEALTH: Medicare covers certain telehealth services you get from a doctor or other health care provider who's located elsewhere using technology to communicate with you in real time. Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and certain other medical or health services.

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

2. Schedule of BENEFITS

Services and Supplies	**Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)**	**Medicare Plus Pays (2025 information. Updated annually.)**
HOSPITAL Semiprivate room and board and miscellaneous HOSPITAL services and supplies such as drugs, x-rays, lab tests and operating room	First 60 DAYS, all but $1,676* 61st to 90th DAY, all but $419* per DAY 91st to 150th DAY, all but $838* per DAY (LIFETIME RESERVE) If LIFETIME RESERVE DAYS are exhausted, $0	Initial $1,676* deductible $419* per DAY $838* 100% from the 91st to 120th DAY of CONFINEMENT
Licensed Skilled Nursing Facility** MEDICARE covered services in a MEDICARE Approved Facility**	Requires a 3-DAY period of HOSPITAL stay	Requires a 3-DAY period of HOSPITAL stay

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
	First 20 DAYS, 100% of costs 21st - 100th DAYS, all but $209.50 per DAY Beyond 100 DAYS, $0	Not Applicable $209.50* per DAY All covered services up to a maximum of 120 DAYS per BENEFIT PERIOD CUSTODIAL CARE is not covered
Licensed Skilled Nursing Facility** **(Non-MEDICARE Approved Facility)** If admitted within 24 hours following a HOSPITAL stay	Covers only the same type of expenses normally covered by MEDICARE in a MEDICARE Approved Facility $0	Covers only the same type of expenses normally covered by MEDICARE in a MEDICARE Approved Facility Maximum daily rate for up to 30 DAYS per CONFINEMENT
Home Health Care** Under a doctor for part-time skilled nursing care, part-time home health aide care, physical therapy, occupational therapy, speech-language pathology services, medical social services.	100% of CHARGES for visits considered MEDICALLY NECESSARY by MEDICARE. Generally fewer than 7 DAYS a week, less than 8 hours a DAY and 28 or fewer hours per week for up to 21 DAYS.	Up to 365 visits per year

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
Hospice Care MEDICARE certified program of terminal ILLNESS care for pain relief and symptom management. Includes: nursing care; physician services; physical, occupational and speech therapy; social worker services; home health aids; homeworker services; medical supplies. First 180 DAYS and any MEDICARE approved extension	All covered services	Coinsurance or copayments for all MEDICARE Part A Eligible Expenses
Hospice Facility	All but very limited coinsurance for INPATIENT respite care	MEDICARE copayment/coinsurance up to the equivalent USUAL AND CUSTOMARY CHARGES of a skilled nursing facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance; prosthetic devices; DURABLE MEDICAL EQUIPMENT	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Physician's Services Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Telemedicine, TELEHEALTH, or E-VISIT service	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
Drugs and Biologicals (non-hospitalization) Immunosuppressive drugs during the first year following a covered transplant Self-administered drugs prescribed by a physician	 After annual $257* MEDICARE deductible, 80% of allowable CHARGES Not covered	 Initial $257 deductible and 20% of MEDICARE approved expenses Refer to Pharmacy Benefit Manager portion of booklet for pharmacy BENEFITS
Outpatient Hospital Services In an emergency room or outpatient clinic, diagnostic lab and x-rays; medical supplies such as casts, splints, and drugs which cannot be self-administered	After the annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Psychiatric Treatment Other than HOSPITAL INPATIENT	After the annual $257* MEDICARE deductible, 80% of the allowable CHARGES	Initial $257* deductible and the amount, which combined with the MEDICARE BENEFIT, equals 20% of the USUAL AND CUSTOMARY CHARGES
Private Duty Nursing While hospitalized and provided by an RN or LPN	$0	$0
Blood	After annual $257* MEDICARE deductible, 80% of costs except non-replacement fees (blood deductible) 1st 3 pints in each BENEFIT PERIOD	Initial $257* deductible and 20% of MEDICARE approved expenses

* Federal MEDICARE deductibles are adjusted annually. Amounts shown above are for 2025. MEDICARE PLUS BENEFITS are also adjusted annually to pay these deductibles**.**

** CUSTODIAL CARE as defined is not covered.

3. BENEFITS Available

BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for the services and supplies described in Sections 4. through 8. below on or after the EFFECTIVE DATE according to the

terms, conditions and provisions of the CONTRACT, if those services and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by the HEALTH PLAN.

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

The BENEFITS listed below will automatically change to coincide with any changes in applicable MEDICARE deductible amounts and coinsurance percentage factors.

4. Hospital INPATIENT BENEFITS

BENEFITS are payable for the MEDICARE Part A deductible during the first sixty (60) DAYS of CONFINEMENT.

a. BENEFITS are payable for the MEDICARE Part A HOSPITAL daily coinsurance from the 61st to the 90th DAY of a PARTICIPANT'S CONFINEMENT.

b. After a PARTICIPANT has been in a HOSPITAL for ninety (90) DAYS**,** MEDICARE pays an extra sixty (60) LIFETIME RESERVE DAYS during the PARTICIPANTS lifetime. BENEFITS are payable for the MEDICARE Part A HOSPITAL coinsurance for each reserve DAY used by the PARTICIPANT. If the PARTICIPANT has exhausted the LIFETIME RESERVE DAYS during a previous BENEFIT PERIOD, BENEFITS will continue to be payable for an additional thirty (30) DAYS of CONFINEMENT beginning on the 91st DAY of CONFINEMENT. The PROVIDER shall accept the HEALTH PLAN'S payment as payment in full and may not BALANCE BILL the PARTICIPANT.

c. After MEDICARE pays its one hundred ninety (190) DAY lifetime HOSPITAL INPATIENT psychiatric care BENEFITS, the BENEFIT PLAN will pay the MEDICARE PART A ELIGIBLE EXPENSES for INPATIENT psychiatric HOSPITAL care for each DAY a PARTICIPANT is confined for psychiatric care beyond the MEDICARE lifetime limit but not to exceed a lifetime limit of one hundred seventy-five (175) DAYS CONFINEMENT under the BENEFIT PLAN. BENEFITS will not exceed a total of three hundred sixty-five (365) DAYS for the PARTICIPANT'S lifetime.

d. BENEFITS are payable for the MEDICARE Part A ELIGIBLE EXPENSES for blood to the extent not covered by MEDICARE.

5. Services in a Licensed Skilled Nursing Facility

For CONFINEMENT in a licensed skilled nursing facility certified by and participating in MEDICARE, while the CONFINEMENT is covered by MEDICARE, BENEFITS are payable for such a CONFINEMENT, provided:

a. a PARTICIPANT receives care in a MEDICARE approved licensed skilled nursing facility and remains under continuous active medical supervision; and

b. the PARTICIPANT was a HOSPITAL INPATIENT for at least three (3) DAYS prior to CONFINEMENT in a licensed skilled nursing facility.

BENEFITS are payable for up to a maximum of one hundred twenty (120) DAYS per BENEFIT PERIOD beginning on the first day of admission to the licensed skilled nursing facility.

For CONFINEMENT in a licensed skilled nursing facility not participating in MEDICARE, or when the CONFINEMENT is not covered by MEDICARE, BENEFITS are payable provided the PARTICIPANT is transferred within 24 hours of release from a HOSPITAL. BENEFITS are payable up to the maximum daily rate established for SKILLED CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to thirty (30) DAYS per CONFINEMENT. BENEFITS are payable only if the attending physician certifies that the SKILLED CARE MEDICALLY NECESSARY. The physician must recertify this every seven (7) DAYS. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without charge or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

6. Hospice Care

The HEALTH PLAN shall pay a PARTICIPANT'S coinsurance or copayments for all MEDICARE Part A ELIGIBLE EXPENSES for Hospice Care and respite care. Hospice Care is available as long as the PARTICIPANT'S physician certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of MEDICARE.

7. Professional and Other Services

MEDICARE PLUS shall pay the MEDICARE Part B deductible and all MEDICARE Part B Eligible Expenses, to the extent not paid by MEDICARE, or in the case of HOSPITAL outpatient department services paid under a prospective payment system, the copayment amount, for the following services:

a. Cataract lenses following cataract surgery and one pair of eyeglasses with standard frames (or one set of contract lenses) after cataract surgery that implants an intraocular lens.

b. Chemotherapy in a physician's office, freestanding clinic or HOSPITAL outpatient setting.

c. Prescription drugs covered by MEDICARE such as injections that can't be self-administered that a PARTICIPANT receives in a physician's office, certain oral cancer drugs, drugs used with some types of DURABLE MEDICAL EQUIPMENT, and under very

limited circumstances, certain drugs a PARTICIPANT receives in a HOSPITAL outpatient setting.

d. Physical therapy, speech-language pathology services and occupational therapy when recommended by a physician.

e. Oxygen and rental of equipment and supplies for its administration.

f. Professional licensed ambulance service necessary to transport a PARTICIPANT to or from a HOSPITAL or licensed skilled nursing facility. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a physician as being MEDICALLY NECESSARY.

g. Medical Supplies prescribed by a physician.

h. Rental of or purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, walkers and hospital-type beds.

i. Outpatient cardiac rehabilitation services.

j. Facility fees for approved surgical procedures in an AMBULATORY SURGICAL CENTER.

k. Blood processing and handling services for every unit of blood a PARTICIPANT receives.

l. Chiropractic services limited to those services to help correct a subluxation using manipulation of the spine. BENEFITS are not payable for any other services or tests ordered by a chiropractor (including x-rays or massage therapy).

m. X-rays, MRIs, CT scans, EKGs, and other diagnostic tests, other than laboratory tests.

n. Diabetes supplies and self-management training.

o. Physician services that are MEDICALLY NECESSARY or provided in connection with preventive services covered by MEDICARE. BENEFITS are also payable for services provided by health care PROVIDERS, such as physician assistants, nurse practitioners, social workers, and psychologists.

p. Foot exams and treatment if a PARTICIPANT has diabetes-related nerve damage and/or meets certain conditions determined by MEDICARE.

q. Kidney dialysis services and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, BENEFITS are

also payable for CHARGES for kidney disease education services prescribed by a physician.

r. Outpatient mental health care services. Coverage includes services generally provided in an outpatient setting, including visits with a psychiatrist or other physician, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker.

s. Outpatient HOSPITAL services, outpatient medical and surgical services and supplies.

t. Prosthetic and orthotic items including arm, leg, back and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part of function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a physician or other health care PROVIDER.

u. Pulmonary rehabilitation programs if a PARTICIPANT has moderate to severe chronic obstructive pulmonary disease prescribed by a physician.

v. Services for treatment of a surgical or surgically treated wound.

w. Tobacco smoking cessation counseling if a PARTICIPANT is diagnosed with an ILLNESS caused or complicated by tobacco use or takes a medicine that is affected by tobacco.

x. Physician services for heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a MEDICARE-certified facility. Also covered are immunosuppressive drugs if the transplant was eligible for MEDICARE payment, or an employer or union group health plan was required to pay before MEDICARE paid for the transplant.

y. Glaucoma tests once every twelve (12) months for PARTICIPANTS at high risk for glaucoma.

z. Telehealth services.

8. Additional Services

Foreign Travel. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for MEDICALLY NECESSARY health care services received by a PARTICIPANT in a foreign country.

Immunizations. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for immunizations not covered by MEDICARE.

Chiropractic Services. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for chiropractic services provided by a chiropractor within the scope of his/her license and not covered by MEDICARE per Wis. Stat. 632.875.

Home Care. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for home care services described below:

a. **Covered Services**. Home Care Sections 8.a. and 8.b. apply only if charges for home care services are not covered elsewhere under the CERTIFICATE OF COVERAGE. A state licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the home care services. A PARTICIPANT should make sure the agency meets this requirement before services are provided. BENEFITS are payable for CHARGES for the following services when MEDICALLY NECESSARY for treatment:

   i. Part time or intermittent home nursing care by or under supervision of a registered nurse;
   ii. Part time or intermittent home health aide services when MEDICALLY NECESSARY as part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
   iii. Physical, respiratory, occupational or speech therapy;
   iv. Medical Supplies, prescription drugs and Biologicals prescribed by a physician required to be administered by a professional PROVIDER; laboratory services by or on behalf of a HOSPITAL, if needed under the home care plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;
   v. Nutrition counseling provided or supervised by a registered dietician;
   vi. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending physician must request or approve this evaluation.

   Note: MEDICARE BENEFITS will not be duplicated.

b. **Limitations**. The following limitations apply to Home Care services:

   i. Home care is not covered unless the PARTICIPANT'S attending physician certifies that: (a) hospitalization or CONFINEMENT in a licensed skilled nursing facility would be needed if the PARTICIPANT didn't have home care; and (b) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;
   ii. If the PARTICIPANT was hospitalized just before home care started, the PARTICIPANT'S physician during the PARTICIPANT'S HOSPITAL stay must also approve the home care plan;
   iii. BENEFITS are payable for CHARGES for up to three hundred sixty-five (365) home care visits in any 12-month period per PARTICIPANT. Each visit by a person providing

services under a home care plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide service counts as one home care visit.

iv. If home care is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has home care coverage under the BENEFITS and another source;

v. The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED CARE in a licensed skilled nursing facility, as determined by the HEALTH PLAN.

Wellness. SUBSCRIBERS and their insured spouses may use Renew Active, a fitness program that includes access to a free gym membership at in-network gyms.

Equipment and Supplies for Treatment of Diabetes. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and USUAL AND CUSTOMARY CHARGES for diabetic self-management education programs. This BENEFIT is limited to the purchase of one pump per calendar year. The PARTICIPANT must use the pump for at least thirty (30) DAYS before the pump is purchased. MEDICARE BENEFITS won't be duplicated.

Benefits for Kidney Disease. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for INPATIENT, outpatient, and home treatment of kidney disease, if not covered elsewhere under the HEALTH BENEFIT PROGRAM. These services must be necessary for a PARTICIPANT'S diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There is a maximum of $30,000 per year for these BENEFITS. The HEALTH PLAN will not pay for any CHARGES paid for, or covered by, MEDICARE.

Breast Reconstruction. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for breast reconstruction of the affected tissue incident to a mastectomy.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for HOSPITAL or AMBULATORY SURGERY CENTER CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided in a HOSPITAL or AMBULATORY SURGERY CENTER, if any of the following applies:

a. The PARTICIPANT is a child under the age of 5;

b. The PARTICIPANT has a chronic disability that meets all of the conditions under s. 230.04(9r) (a) 2. a., b. and c., Wisconsin Statutes; or

c. The PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

Health Care Services Provided by a Non-Affiliated Provider. If a PARTICIPANT receives services from a NON-AFFILIATED PROVIDER, BENEFITS will be payable for USUAL AND CUSTOMARY CHARGES for those services provided the services are covered under this Section.

9. Exclusions

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

a. Health care services MEDICARE does not cover, unless the HEALTH BENEFIT PROGRAM specifically provides for them.

b. Health care services which neither a PARTICIPANT nor a party on the PARTICIPANT'S behalf has a legal obligation to pay in the absence of insurance.

c. Health care services to the extent that they are paid for by MEDICARE or would have been paid for by MEDICARE if a PARTICIPANT is enrolled in MEDICARE Parts A and B; health care services to the extent that they are paid for by another government entity or program, directly or indirectly. This means that except in cases of fraud, if the PARTICIPANT either does not enroll in MEDICARE Parts A and B at the time the PARTICIPANT enrolls in a MEDICARE coordinated BENEFIT PLAN and when MEDICARE is first available as the primary payer, or if the PARTICIPANT cancels MEDICARE coverage, the PARTICIPANT'S coverage will be limited, and the PARTICIPANT will be responsible for any costs that MEDICARE would have paid.

d. Personal comfort items. Examples include: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

e. CUSTODIAL CARE, including maintenance care and supportive care.

f. Cosmetic surgery.

g. Health care services received by a PARTICIPANT before his/her coverage becomes effective or after coverage ends.

h. Health care services that are deemed unreasonable and unnecessary by MEDICARE. This includes, but is not limited to, the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services including drugs or devices, not considered safe and effective because they are EXPERIMENTAL or investigational except for the HIV drugs as described in Section 632.895(9) Wis. Stat. as amended.

i. Health care services received outside the United States, except as specifically stated in Section 8. Additional Services.

j. Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in this MEDICARE PLUS BENEFITS - CERTIFICATE OF COVERAGE.

k. Health care services that are not MEDICALLY NECESSARY as determined by the HEALTH PLAN, except for such health care services that MEDICARE covers.

l. Routine physical exams and any related diagnostic X-ray and laboratory tests not covered by MEDICARE.

m. Private duty nursing.

n. Routine dental care.

o. Hearing aids; exams for fitting of hearing aids.

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

10. Miscellaneous Provisions

a. Right to Obtain and Provide Information

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

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

i. Health care PROVIDERS as necessary and appropriate for treatment,

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

b. Physical Examination

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

c. Case Management/Alternate

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

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

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

d. Disenrollment

No person other than a PARTICIPANT is eligible for BENEFITS. The SUBSCRIBER'S rights to 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 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 DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

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

e. Recovery of Excess Payments

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

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

f. Limit on Assignability of BENEFITS

A PARTICIPANT cannot assign any benefit to another person other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for the PARTICIPANT.

g. Severability

If any part of the policy is ever prohibited by law, it will no longer apply. The rest of the policy will continue in full force.

h. Subrogation

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

i. The third party or any liability or other insurance covering the third party.
ii. The PARTICIPANT'S own uninsured motorist insurance coverage.
iii. Under-insured motorist insurance coverage.
iv. Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

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

In the event the PARTICIPANT can recover any amounts, for an ILLNESS or INJURY for which the HEALTH PLAN or DEPARTMENT provides BENEFITS, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of the policy, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT

shall not be required to provide any future BENEFITS for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of the. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for BENEFITS under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

i. Proof of Claim

It is the PARTICIPANT'S responsibility to notify their PROVIDER of the PARTICIPANT'S participation in the MEDICARE PLUS plan. Failure to do so could result in a delay in the PARTICIPANT'S claim being paid.

If the services were received outside the United States, the PARTICIPANT must indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of the PARTICIPANT'S claim.

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

j. GRIEVANCE Process

The HEALTH PLAN 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 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 remains dissatisfied with the outcome, the **Participant** may appeal to the DEPARTMENT by completing a DEPARTMENT 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 the right to appeal to the DEPARTMENT within sixty (60) DAYS of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM. Ombudsperson Services can provide additional information and assistance with this process.

However, the PARTICIPANT may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions, for example, determination of MEDICALLY

NECESSARY care, appropriate care, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External or Independent Review Process. The PARTICIPANT may request an external review pursuant to federal law. In this event, the PARTICIPANT must notify the HEALTH PLAN and/or PBM of their request. In accordance with federal law, any decision by an HHS-administered federal external review is final and binding. The PARTICIPANT shall have no further right to administrative review once the external review decision is rendered.

k. Appeals to the BOARD

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the BOARD, unless an HHS-administered federal 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 BENEFITS under this CERTIFICATE OF COVERAGE, for example, determination of MEDICALLY NECESSARY care, appropriate care, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the BOARD.