State of Wisconsin and Wisconsin Public Employers Group Health Insurance Program

Certificate of Coverage

2019 Benefit Year

It's Your Choice Pharmacy Benefits
All Program Options

Revised 9/4/2018

UNIFORM PHARMACY BENEFITS

As of the 1994 coverage year, all HEALTH PLANS offering coverage in the State of Wisconsin and Wisconsin Public Employers Group Health Insurance Program must provide the Uniform Medical Benefits. The PHARMACY BENEFIT MANAGER must provide the Uniform Pharmacy Benefits in coordination with the HEALTH PLANS for all members. The PHARMACY BENEFIT MANAGER may not alter the language, benefits or exclusions and limitations of the Uniform Pharmacy Benefits plan.

TABLE OF CONTENTS

I. Definitions

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

ALLOWED AMOUNT: Means the maximum amount on which payment is based for covered pharmacy services. Generally this is composed of the pharmacy cost, less any discount negotiated by the PHARMACY BENEFIT MANAGER.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient 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.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: 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: 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 SCHEDULE OF BENEFITS.

DAW-1: A drug noted by a PRESCRIBER to be dispensed as written, with no GENERIC DRUG substitution.

DEDUCTIBLE: The amount the PARTICIPANT owes for health care services the BENEFIT PLAN covers before the BENEFIT PLAN begins to pay. For example, if the DEDUCTIBLE is $1,500, the BENEFIT PLAN will not pay anything until the PARTICIPANT has incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

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

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 or 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]

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[1].

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

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 CONTRACTOR will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR 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.

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 days of the birth[3].

A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE[4].

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

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 the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 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 its employees.

EMBEDDED: Means the individual portion of PARTICIPANT financial responsibility (DEDUCTIBLE, OOPL, MOOP) within the family's total financial responsibility. For example, when a PARTICIPANT within a family plan meets the individual DEDUCTIBLE, that PARTICIPANT is no longer responsible for any further DEDUCTIBLE. 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:

1) Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

2) Serious impairment to the PARTICIPANT'S bodily functions.

3) Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

Examples of EMERGENCIES are listed in Section III, A, 1, d. EMERGENCY services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN 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 medical/HOSPITAL services.

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. The criteria that the HEALTH PLAN and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment,

procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

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 on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

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 HEALTH PLAN and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HEALTH PLAN: Means the health plan that is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): 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 (with the exception of 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.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES 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.

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

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the HEALTH PLAN after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

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:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) 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 PRESCRIPTION DRUG PLAN: 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 State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

NON-EMBEDDED: Means that families must meet the full family amount before benefits are paid.

NON-PARTICIPATING PHARMACY: Means a pharmacy who 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: 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 MEDICATIONS 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 the PARTICIPANT pays during a policy period (usually a calendar year) before the BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes premium, balance-billed charges or charges for health care that the BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit. The most YOU pay during a policy period (usually a calendar year) for benefits considered essential health benefits under federal law. This limit never includes YOUR premium, balance-billed charges, charges for health care YOUR BENEFIT PLAN does not cover, or services that are not considered essential health benefits.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): 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. It 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.

PREFERRED DRUG: 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 on the FORMULARY, which are covered by the benefits of this program.

PREFERRED SPECIALTY PHARMACY: Means a PARTICIPATING PHARMACY which meets criteria established by the PBM to specifically administer SPECIALTY MEDICATION 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.

PRIOR AUTHORIZATION: Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the HEALTH PLAN and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

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.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

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 annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN 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 medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the HEALTH PLAN, when taking into consideration, among other factors determined by the HEALTH PLAN, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases 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), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she 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. HEALTH PLAN approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the HEALTH PLAN 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 medical/HOSPITAL/dental services.

II. Schedule of Benefits

All benefits are paid per the terms of this contract between the PBM and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. This SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of the PHARMACY BENEFIT. Information on medical coverage can be found in the Uniform Benefits included in the Health Program Agreement.

The Group Insurance Board contracts with a 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 Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

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 for prescriptions filled at NON-PARTICIPATING PHARMACIES in URGENT or EMERGENCY situations. Members may receive reimbursement based on the PBM contracted rate, minus their appropriate COPAY.

Except as specifically stated for EMERGENCY and URGENT CARE (see Sections III, A, 1 and III, A, 2), YOU do not have coverage for services from NON-PARTICIPATING PHARMACIES.

The covered benefits are subject to the following:

State of Wisconsin PARTICIPANTS without MEDICARE:

DEDUCTIBLES, COINSURANCE, COPAYMENTS and OUT-OF-POCKET LIMITS as described in this schedule:

State of Wisconsin Amounts paid by PARTICIPANTS who do not have MEDICARE as the primary payor		
	IYC Health Plan[1]	**IYC High-DEDUCTIBLE Health Plan (HDHP)[2]**
Annual Pharmacy DEDUCTIBLE	None	$1,500 individual / $3,000 family[3]
Preventive Drugs[4]	No cost	No cost
Level 1 COPAYMENT	$5	$5[5]

[1] IYC Health Plan Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS PLAN. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.
[2] IYC HDHP Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS HDHP PLAN. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.
[3] HDHP DEDUCTIBLE is combined with the medical benefit DEDUCTIBLE. See the HEALTH PLAN Uniform Benefits for additional information.
[4] Federally-required preventive drugs are covered at 100%.
[5] COPAYMENTS and COINSURANCE apply after DEDUCTIBLE has been met for HDHPs.

State of Wisconsin Amounts paid by PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor		
	IYC Health Plan[1]	**IYC High-DEDUCTIBLE Health Plan (HDHP)[2]**
Level 2 COINSURANCE	20% ($50 max)	20% ($50 max)
Level 3 COINSURANCE	40% ($150 max)	40% ($150 max)
Level 3 COINSURANCE + DAW-1[6] Cost Difference	40% ($150 max) **PLUS** Cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.	40% ($150 max) **PLUS** Cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.
Level 4 COPAYMENT	$50	$50
Level 1 & Level 2 OUT-OF-POCKET LIMIT	$600 individual / $1,200 family	$2,500 individual / $5,000 family
Level 3 OUT-OF-POCKET LIMIT	$6,850 individual / $13,700 family[7]	
Level 4 OUT-OF-POCKET LIMIT	$1,200 individual / $2,400 family	

[6] DAW-1 drugs will have the 40% coinsurance PLUS the cost difference between the BRAND DRUG and GENERIC DRUG applied, unless a member receives a waiver from the PBM.
[7] The Level 3 OOPL is based on the federally-defined maximum out of pocket limit. Level 1 & Level 2 OOPL and Level 4 OOPL accumulate toward the Level 3 OOPL.

State of Wisconsin PARTICIPANTS with MEDICARE:

State of Wisconsin Amounts paid by PARTICIPANTS who have MEDICARE as the primary payor		
	IYC Health Plan[8]	**IYC High-DEDUCTIBLE Health Plan (HDHP)[9][10]**
Annual Pharmacy DEDUCTIBLE	None	$1,500 individual / $3,000 family[11]
Preventive Drugs[12]	No cost	No cost
Level 1 COPAYMENT	$5	$5[13]
Level 2 COINSURANCE	20% ($50 max)	20% ($50 max)
Level 3 COINSURANCE	40% ($150 max)	40% ($150 max)
Level 4 Preferred COPAYMENT	$50	$50
Level 4 Non-Preferred COINSURANCE	40% ($200 max)	40% ($200 max)
Level 1 & Level 2 OUT-OF-POCKET LIMIT	$600 individual / $1,200 family	$2,500 individual / $5,000 family
Level 3 OUT-OF-POCKET LIMIT	$6,850 individual / $13,700 family[14]	
Level 4 OUT-OF-POCKET LIMIT	$1,200 individual / $2,400 family	

[8] IYC Health Plan Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS PLAN. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.
[9] IYC HDHP Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS HDHP. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.
[10] SUBSCRIBERS with MEDICARE as primary payor cannot elect the IYC HDHP or IYC ACCESS HDHP; subscribers with DEPENDENTS who have MEDICARE as primary payor may still elect the IYC HDHP or IYC ACCESS HDHP.
[11] HDHP DEDUCTIBLE is combined with the medical benefit DEDUCTIBLE. See the HEALTH PLAN Uniform Benefits for additional information.
[12] Federally-required preventive drugs are covered at 100%.
[13] COINSURANCE and COPAYMENTS apply after the deductible has been met for HDHP plans.
[14] The Level 3 OOPL is based on the federally-defined maximum out of pocket limit. Level 1 & Level 2 OOPL and Level 4 OOPL accumulate toward the Level 3 OOPL.

Local/Wisconsin Public Employers (WPE) without MEDICARE:

DEDUCTIBLES, COINSURANCE, COPAYMENTS and OUT-OF-POCKET LIMITS as described in this schedule:

Local / Wisconsin Public Employer (WPE) Amounts paid by PARTICIPANTS who do not have MEDICARE as the primary payor		
	IYC Local Traditional (Program Option 2/12) or Local Deductible (Program Option 4/14) or Local Health Plan (Program Option 6/16)[15]	**IYC Local High Deductible Health Plan (Program Option 7/17)[16][17]**
Annual Pharmacy DEDUCTIBLE	None	$1,500 individual / $3,000 family
Preventive Drugs[18]	No cost	No cost
Level 1 COPAYMENT	$5	$5[19]
Level 2 COINSURANCE	20% ($50 max)	20% ($50 max)
Level 3 COINSURANCE	40% ($150 max)	40% ($150 max)
Level 3 COINSURANCE + DAW-1[20] Cost Difference	40% ($150 max) **PLUS** Cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.	40% ($150 max) **PLUS** Cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.
Level 4 COPAYMENT	$50	$50
Level 1 & Level 2 OUT-OF-POCKET LIMIT	$600 individual / $1,200 family	$2,500 individual / $5,000 family
Level 3 OUT-OF-POCKET LIMIT[21]	$6,850 individual / $13,700 family	
Level 4 OUT-OF-POCKET LIMIT	$1,200 individual / $2,400 family	

[15] IYC Program Option (PO) 2/12 / PO 4/14 / PO 6/16 Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS PLAN. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.

[16] IYC PO 7/17 Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS HDHP. There are no out-of-network pharmacy benefits for non-emergency or urgent care services.

[17] HDHP DEDUCTIBLE is combined with the medical benefit DEDUCTIBLE. See the HEALTH PLAN Uniform Benefits for additional information.

[18] Federally-required preventive drugs are covered at 100%.

[19] COPAYMENTS and COINSURANCE apply after DEDUCTIBLE has been met for HDHPs.

[20] DAW-1 drugs will have the 40% coinsurance PLUS the cost difference between the BRAND DRUG and GENERIC DRUG applied, unless a member receives a waiver from the PBM.

[21] The Level 3 OOPL is based on the federally-defined maximum out of pocket limit. Level 1 & Level 2 OOPL and Level 4 OOPL accumulate toward the Level 3 OOPL.

Local/Wisconsin Public Employers with MEDICARE:

Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2/12 Uniform Benefits SCHEDULE OF BENEFITS.

State of Wisconsin **Amounts paid by PARTICIPANTS who have MEDICARE as the primary payor**	
	Local Traditional (Program Option 2/12)[22][23]
Annual Pharmacy DEDUCTIBLE	None
Preventive Drugs[24]	No cost
Level 1 COPAYMENT	$5
Level 2 COINSURANCE	20% ($50 max)
Level 3 COINSURANCE	40% ($150 max)
Level 4 Preferred COPAYMENT	$50
Level 4 Non-Preferred COINSURANCE	40% ($200 max)
Level 1 & Level 2 OUT-OF-POCKET LIMIT	$600 individual / $1,200 family
Level 3 OUT-OF-POCKET LIMIT	$6,850 individual / $13,700 family[25]
Level 4 OUT-OF-POCKET LIMIT	$1,200 individual / $2,400 family

[22] Local Traditional PARTICIPANTS with MEDICARE as primary payor are limited to participating in Program Option 2/12.
[23] IYC Health Plan Pharmacy Benefits are also the IN-NETWORK benefits for the IYC ACCESS PLAN.
[24] Federally-required preventive drugs are covered at 100%.
[25] Level 1 & Level 2 OOPL and Level 4 OOPL accumulate toward the Level 3 OOPL. The Level 3 OOPL is based on the federally-defined maximum out of pocket limit.

Additional Coverage Provisions

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are not covered by the benefits of this program unless approved through an exceptions process.

b) Preventive Prescription Drugs:

i) **Non-HDHP (State IYC Health Plan and PO2/12, PO4/14, and PO 6/16)**: Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) **HDHP (State IYC HDHP and PO7/17):** Certain preventive prescription drugs as defined by federal law are not subject to the DEDUCTIBLE and are covered at 100%.

iii) The PBM will publish a list of prescriptions drugs that are considered preventive drugs.

c) Cost Sharing Levels for Non-Preventive Prescription Drugs:
Level 1:
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Level 2:
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3:
The Level 3 COINSURANCE applies to NON-PREFERRED DRUGS, as well as drugs that have been approved for coverage through the exceptions process or independent medical review.

Non-HDHP (State IYC Health Plan and PO2/12, PO4/14, and PO 6/16): The above levels apply to all prescription drugs until plan OOPLs are met. YOU do not need to meet the DEDUCTIBLE before coverage begins.

HDHP (State IYC HDHP and PO7/17): The DEDUCTIBLE must be met before coverage begins. Once the DEDUCTIBLE has been met, the above cost sharing levels apply until the HDHP OOPL is met.

Level 1/Level 2 Annual OOPL (State IYC Health Plan and PO2/12, PO 4/14, and PO 6/16):
a) Cost sharing for Level 1 and Level 2 drugs accumulate to the Level 1/Level 2 Annual OOPL.

When this OOPL is met, YOU pay no more out-of-pocket expenses for covered Level 1 and Level 2 prescription drugs.

Level 3/Level 4 Non-Preferred Annual OOPL (State IYC Health Plan and PO2/12, PO 4/14, and PO 6/16):

Cost sharing for all drugs accumulates to the Level 3 Annual OOPL. The Level 3 Annual OOPL is based on the federally-defined maximum out of pocket limit.

When this OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS

Specialty Drug Cost Share:

Level 4:

The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

If YOU do not have MEDICARE as YOUR primary coverage, YOU must use a PREFERRED SPECIALITY PHARMACY or your medication will not be covered.

Level 4 COINSURANCE: 40% ($200 max)

Medicare Members Only: The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Preferred Annual OOPL:

The maximum annual amount YOU pay for YOUR Level 4 Preferred SPECIALTY MEDICATIONS.

Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When this OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) Discount eligible medications as defined by the PBM: Certain medications as defined by the PBM are available to YOU at a discount, but are not covered by the benefit plan. These medications may include drugs for weight loss, infertility, and erectile dysfunction. YOU will pay

100% of the cost of these medications, and amounts you pay will not accumulate toward OOPL or the federal maximum allowable out-of-pocket.

4) Disposable Diabetic Supplies and Glucometers:

a) **Non-HDHP:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.
b) **HDHP:** DEDUCTIBLE, then 20% COINSURANCE. Applies to the combined OOPL of $2,500 for single coverage or $5,000 for family coverage.

5) Smoking Cessation: Two ninety (90)-day courses of pharmacotherapy are covered per calendar year. This includes all FDA approved prescription and OTC smoking cessation products. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

6) Lifetime Maximum Benefit on All Pharmacy Benefits: NONE

III. Benefits and Services

The benefits and services provided under the Pharmacy Benefit Program are those set forth below. These services and benefits are available if received after your EFFECTIVE DATE and when the EMPLOYER premium has been paid.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the HEALTH PLAN and/or PBM.

Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

When obtaining benefits at a PBM PARTICIPATING PHARMACY, YOU must show YOUR PBM identification card at the pharmacy. If YOU do not show YOUR identification card, 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, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of medical Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.
Any benefits that are not listed in this section and are covered under this program are administered by the HEALTH PLAN.

1) Prescription Drugs
   Coverage includes legend drugs and biologics that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

   An annual OOPL and MOOP applies to pharmacy benefits. See the SCHEDULE OF BENEFITS for details.

   The HEALTH PLAN, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY

room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTABLE).

MEDICARE eligible PARTICIPANTS will be covered by a MEDICARE Part D prescription drug plan (PDP) provided by the PBM. PARTICIPANTS who choose to be enrolled in another MEDICARE Part D PDP other than this PDP will not have benefits duplicated.

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM ALLOWED AMOUNT. The ALLOWED AMOUNT is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted PROVIDER administers the injection. If the HEALTH PLAN or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.
Prescription drugs will be dispensed as follows:

a) In maximum quantities, not to exceed a 30-consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) 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.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTABLES and narcotics are among those for which a 90-day supply is not available.

i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.

j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.

k) SPECIALTY MEDICATIONS and SELF-ADMINISTERED INJECTABLES when obtained by prescription and which can safely be administered by the PARTICIPANT, must be obtained from a PBM PARTICIPATING PHARMACY OR PREFERRED SPECIALTY PHARMACY. In some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

2) Insulin, Disposable Diabetic Supplies, Glucometers
The PBM will list approved products on the FORMULARY. PRIOR AUTHORIZATION is required for anything not listed on the FORMULARY.

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, as described on the SCHEDULE OF BENEFITS.

b) Disposable Diabetic Supplies and Glucometers will be covered after a 20% COINSURANCE as outlined in the SCHEDULE OF BENEFITS when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL for prescription drugs.

3) 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 as follows:

a) Diaphragms

b) Syringes/Needles

c) Spacers/Peak Flow Meters

Note that if YOU participate in a HDHP (State IYC HDHP or Local PO 7/17), YOU must satisfy YOUR DEDUCTIBLE before YOUR PLAN begins coverage, except for preventive prescription drugs.

IV. Exclusions and Limitations

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under Uniform Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by HEALTH PLANs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be MEDICALLY NECESSARY, but still are not covered under this program, while others may be examples of services which are not MEDICALLY NECESSARY or not medical in nature, as determined by the HEALTH PLAN and/or PBM.

1) Outpatient Prescription Drugs – Administered by the PBM

   a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

   b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

   c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

   d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

   e) Anorexic agents.

   f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

   g) All over-the-counter drug items, except those designated as covered by the PBM.

   h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

   i) Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.

   j) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

   k) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM'S Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

   l) Charges for infertility and fertility medications.

m) Charges for drugs prescribed for erectile dysfunction.

n) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.

o) Charges to replace expired, spilled, stolen or lost prescription drugs.

2) General

a) Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b) 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.

c) Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation 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.

d) INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e) 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.

f) 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 HEALTH PLAN and/or 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.

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

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

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the BENEFIT PLAN.

k) Expenses incurred prior to the EFFECTIVE DATE of coverage by the HEALTH PLAN and/or PBM, or services received after the HEALTH PLAN and/or PBM coverage or eligibility terminates. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is 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. If the termination is a result of a SUBSCRIBER changing coverage under HEALTH PLANS during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding HEALTH PLAN will be the responsibility of the succeeding HEALTH PLAN unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding HEALTH PLAN'S network. In this instance, the liability will remain with the previous HEALTH PLAN.

l) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

m) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for 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).

n) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

o) Services or medications provided by NON-PARTICIPATING PHARMACIES. Exceptions to this exclusion:

    i. Prescriptions related to EMERGENCY or URGENT CARE services outside the SERVICE AREA.

p) Any diet control program, treatment, or supply for weight reduction.

q) Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.

r) Services to the extent a PARTICIPANT receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means YOU are actually insured under Worker's Compensation.

s) Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.

t) Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by an IN-NETWORK PROVIDER or PRIOR AUTHORIZED by the HEALTH PLAN. The treatment of the complication must be a covered benefit of the HEALTH PLAN and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any HEALTH PLAN as part of this program.

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

v) Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services Section.

w) Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. Travel vaccines are covered by the HEALTH BENEFIT PLAN.

x) Medications or services related to infertility.

y) Services that a child's school is legally obligated to provide, whether or not the school actually provides the services and whether or not YOU choose to use those services.

B. Limitations

1) COPAYMENTS or COINSURANCE are required for:

a) State of Wisconsin program PARTICIPANTS, except for retirees for whom MEDICARE is the primary payor, for all services unless otherwise required under federal and state law.

b) State of Wisconsin PARTICIPANTS for whom MEDICARE is the primary payor, and for all PARTICIPANTS of the Wisconsin Public Employers program, and/or limitations apply to, the following services: durable medical equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

2) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

3) Circumstances Beyond the HEALTH PLAN'S and/or PBM'S Control: If, due to circumstances not reasonably within the control of the HEALTH PLAN and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the HEALTH PLAN and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the HEALTH PLAN, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are
2) defined below.

3) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN 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. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section V, the following words are defined as follows:

ALLOWABLE EXPENSE: means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more PLANS covering the person for whom the claim is made. The difference between the cost of a private HOSPITAL room and the cost of a semi-private HOSPITAL room is not considered an ALLOWABLE EXPENSE unless the patient's stay in a private HOSPITAL room is MEDICALLY NECESSARY either in terms of generally accepted medical practice or as specifically defined by the PLAN. When a PLAN provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an ALLOWABLE EXPENSE and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the SECONDARY PLAN will also be responsible for paying up to the maximum benefit allowed for its PLAN. This will not duplicate benefits paid by the PRIMARY PLAN.

CLAIM DETERMINATION PERIOD: means a calendar year. However, it does not include any part of a year during which a person has no coverage under THIS PLAN or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN: means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical

Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any PLAN whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate PLAN. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate PLAN.

PRIMARY PLAN / SECONDARY PLAN: The order of benefit determination rules state whether THIS PLAN is a PRIMARY PLAN or SECONDARY PLAN as to another PLAN covering the person.

When THIS PLAN is a SECONDARY PLAN, its benefits are determined after those of the other PLAN and may be reduced because of the other PLAN'S benefits.

When THIS PLAN is a PRIMARY PLAN, its benefits are determined before those of the other PLAN and without considering the other PLAN'S benefits.

When there are more than two PLANS covering the person, THIS PLAN may be a PRIMARY PLAN as to one or more other PLANS and may be a SECONDARY PLAN as to a different PLAN or PLANS.

THIS PLAN: means the part of YOUR Summary Plan Description (group contract) that provides benefits for health care and pharmaceutical expenses.

C. Order of Benefit Determination Rules

1) General
When there is a basis for a claim under THIS PLAN and another PLAN, THIS PLAN 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 THIS PLAN, and

b) Both those rules and THIS PLAN'S rules described in subparagraph 2 require that THIS PLAN'S benefits be determined before those of the other PLAN.

2) Rules

THIS PLAN determines its order of benefits using the first of the following rules which applies:

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 subparagraph 2, c below, when THIS PLAN 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.

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

c) DEPENDENT Child/Separated or Divorced Parents
If two or more PLANS cover a person as a DEPENDENT child of divorced or separated parents, benefits for the child are determined in this order:

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

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

iii) Finally, the PLAN of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' PLANS have actual knowledge of those terms, benefits for the DEPENDENT child shall be determined according to C, 2, b.

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 or as that employee's DEPENDENT are determined before those of a PLAN which covers that person as a laid off or retired employee or as that employee's DEPENDENT. If the other PLAN does not have this rule and if, as a result, the PLANS do not agree on the order of benefits, this paragraph d is ignored.

e) Continuation Coverage

i) 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:

(1) First, the benefits of a PLAN covering the person as an employee, member, or SUBSCRIBER or as a DEPENDENT of an employee, member, or SUBSCRIBER.

(2) Second, the benefits under the continuation coverage.

ii) If the other PLAN does not have the rule described in subparagraph 1, 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 THIS PLAN

1) When This Section Applies
This section applies when, in accordance with Section C, Order of Benefit Determination Rules, THIS PLAN is a SECONDARY PLAN as to one or more other PLANS. In that event, the benefits of THIS PLAN may be reduced under this section. Such other PLAN or PLANS are referred to as "the other PLANS" in subparagraph 2 below.

2) Reduction in THIS PLAN'S Benefits
The benefits of THIS PLAN 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 THIS PLAN 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 or not claim is made. Under this provision, the benefits of THIS PLAN 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 THIS PLAN are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of THIS PLAN.

E. Right to Receive and Release Needed Information

The PBM 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 THIS PLAN must give the PBM any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the PBM 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 THIS PLAN. The PBM 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 PBM is more than it should have paid under this COB provision, it may recover the excess from one or more of:

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

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

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

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

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

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the PBM'S claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Case Management/Alternate Treatment

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

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the 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 (for example weight loss medications), payment of benefits will be as determined by the PBM.

C. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the 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.

D. Recovery of Excess Payments

The HEALTH PLAN and/or PBM might pay more than the HEALTH PLAN and/or PBM owes under the policy. If so, the HEALTH PLAN and/or PBM can recover the excess from YOU. 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.

E. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

F. Severability

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

G. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a 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 the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The HEALTH PLAN'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

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

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the 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 INJURY or ILLNESS 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 this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the 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 this contract. 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.

H. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the HEALTH PLAN and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the HEALTH PLAN, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

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

I. Grievance Process

All participating HEALTH PLANs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the HEALTH PLAN and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. YOU may request an external review. In this event, YOU must notify the TPA and/or PBM of YOUR request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. YOU have no further right to administrative review once the external review decision is rendered.

J. Appeals to the Group Insurance 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 Group Insurance Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.
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VII. Non-Discrimination Notice

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The Wisconsin Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 711; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).
Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 711).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：711）
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).
Arabic:ملاحظة :إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف :اتصل بالرقم
خدمة الصم والبكم :711) 1-877-533-5020 (
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услугиперевода. Звоните 1-877-533-5020 (телетайп: 711).
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).
Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).
Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).
French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi: ध्यान द□: य□द आप ि◌हंदी बोलते ह□ तो आपके ि◌लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह□। 1-877-533-5020 (TTY: 711) पर कॉल कर□।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë.
Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711).