Group Health Insurance Program for Members in the SMP Plan

Schedule of Benefits

Effective January 1, 2024

State of Wisconsin	Local Health Plan (PO6/16)	Local Annuitant Health Program (LAHP)

The Schedule of Benefits explains what medical services the Group Health Insurance Program (GHIP) covers and what you pay for covered services. See your Uniform Benefits Certificate of Coverage (ET-2180) for complete coverage details. The Schedule of Benefits is divided into the following sections:

Annual Deductible and Limits

In-Network and Out-of-Network Out-of-Pocket limits accumulate separately.

Annual Medical Deductible

The amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services.

	In-Network		**Out-of-Network**
Individual:	$250	Individual:	$5,000
Family:	$500	Family:	$10,000
Applies to:	✓ In-Network Annual Out-of-Pocket (OOPL) ✓ Maximum Out-of-Pocket Limit (MOOP)	Does not apply to:	× Out-of-Network OOPL × Prescription Drugs
Does not apply to:	× Preventive services × Prescription drugs		

- The family deductible is embedded – no one family member will contribute more than the individual amount to the family deductible.

Annual Medical Out-of-Pocket Limit (OOPL)			
The most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.			
	In-Network		**Out-of-Network**
Individual:	$1,250	Individual:	None, your payments have no limit
Family:	$2,500	Family:	None, your payments have no limit
Applies to:	✓ Maximum Out-of-Pocket Limit (MOOP)		
Does not apply to:	× Prescription Drugs		

- This Plan uses a provider network. You pay less if you use the plan's provider network. Check your provider directory before you receive services.
- The OOPL is embedded for family plans – no one family member will contribute more than the individual amount to the family OOPL.

Annual Maximum Out-of-Pocket Limit (MOOP)			
This is the yearly amount set by the federal government as the most an Individual or Family is required to pay in cost sharing during the plan year for covered, in-network services.			
	In-Network		**Out-of-Network**
Individual:	$9,450	Individual	Not Applicable
Family:	$18,900	Family	Not Applicable

- The amount listed is the most you could pay for services you receive from in-network providers. Your out-of-pocket costs for services received from in-network providers will count toward this limit.
- The MOOP is embedded for family plans – no one family member will contribute more than the individual amount to the family MOOP.

Copayments & Coinsurance

In-Network and Out-of-Network Out-of-Pocket limits accumulate separately.

Medical Copayments			
Additional costs for deductible or coinsurance may apply after you pay the copay, based on the services your provider orders during your visit.			
	In-Network		**Out-of-Network**
You pay:	$0 copayment per certain telehealth visits $15 copayment per primary care visit $25 copayment per specialist or urgent care visit $75 copayment per emergency room visit	You pay:	All services subject to deductible and coinsurance
Applies to:	✓ In-Network OOPL ✓ MOOP		

Medical Coinsurance			
The percentage of costs for a covered service you pay after meeting your deductible except for Durable Medical Equipment and Medical Supplies.			
	In-Network		**Out-of-Network**
You pay	10% after deductible is met	You pay:	50% after deductible is met
Plan pays	90% after deductible is met	Plan pays:	50% after deductible is met
	Applies to: ✓ In-Network OOPL ✓ MOOP		Does not apply to: × Out-of-Network OOPL × Prescription drugs
	Does not apply to: × Preventive services × Prescription drugs × DME & Medical Supplies		

Durable Medical Equipment (DME) and Medical Supplies Coinsurance		
The percentage of costs you pay after meeting your deductible for equipment or supplies ordered by your provider. DME and Medical Supplies Coinsurance applies to the Covered Services listed below as indicated in each section.		
	In-Network	**Out-of-Network**
You pay:	20% after deductible is met	50% after deductible is met
Plan pays:	80% after deductible is met	50% after deductible is met
	Applies to: ✓ In-Network OOPL ✓ MOOP	
• See DME below for additional information. May include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.		

Covered Services

Commonly used services appear below. This is not a complete list. If you have questions about other specific benefits, contact your health plan. Some services may be paid as In-Network as required by law. *See your Uniform Benefits Certificate of Coverage (ET-2180)*.

Ambulance	
Also known as paramedic services, these are emergency services that provide urgent pre-hospital treatment and stabilization for serious illness, injuries, and transport to definitive care.	
You pay:	In-Network Deductible, then In-Network Medical Coinsurance
• Applies to each one-way trip.	

Chiropractic Care

Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). This also includes Occupational therapy (helping with daily living tasks caused from illnesses and injuries to your brain and body).

	In-Network	Out-of-Network
You pay:	$15 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

- × Maintenance visits are not covered.

Cochlear Implant Devices – Under Age 18

An electronic device that partially restores hearing. For coverage for participants over the age of 18, see Cochlear Implant Devices – Over Age 18 in the Additional Covered Services section.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

- ✓ Includes all charges related to implantation surgery and follow-up training sessions.

Diagnostic Services and Labs

Tests to figure out what your health problem is. Make sure to verify anticipated costs with your provider prior to receiving services. Note: some advanced imaging like MRI or CT scans may require prior authorization.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

Covered diagnostic services include:

- ✓ Diagnostic radiology (x-rays, PET, MRI, MRA, and CT scans)
- ✓ Lab tests

Durable Medical Equipment and Supplies

Equipment and supplies ordered by a health care provider for everyday or extended use.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** Durable Medical Equipment and Medical Supplies Coinsurance	Out-of-Network Deductible, **then** Durable Medical Equipment and Medical Supplies Coinsurance

- ✓ Includes Durable Diabetic Equipment and related supplies.

Does not apply to the following. See Additional Covered Services.

- × Adult hearing aids
- × Adult cochlear implant devices
- × Dental implants

Emergency and Urgent Care

Certain medical conditions require expedited medical care. You can work with your provider to determine the best level of care to meet your urgent or emergent needs.

Emergency Care

Care for a life-threatening illness, injury, or condition that requires immediate attention. You should seek care at an in-network Emergency Room whenever possible.

You pay:	$75 copayment per visit For emergency room visit related services, In-Network Deductible, then In-Network Medical Coinsurance

- The copayment is waived if you are admitted as an inpatient or for observation for 24 hours or more.
- You may be responsible for other charges in addition to the visit copayment.

Urgent Care Visit

Care for an illness, injury, or condition serious enough that it requires attention within 24 hours but is not life-threatening. You should seek care at an in-network Urgent Care whenever possible.

You pay:	$25 copayment per visit For urgent care visit related services, In-Network Deductible, then In-Network Medical Coinsurance

Hearing Aids – Under Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants over the age of 18, see Hearing Aids – Over Age 18 in the Additional Covered Services section

	In-Network	**Out-of-Network**
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

Home Care Benefits

Medically necessary nursing care, home health aide services, and other home care benefits provided by a medical professional at home as part of a care plan.

	In-Network	**Out-of-Network**
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

- Up to 50 visits per participant per calendar year
- Your plan may review your first 50 visits to verify progress is being made
- Up to a maximum of 50 additional visits per participant, per calendar year may be available with prior authorization from your health plan

Inpatient Hospital Services

Services necessary for your admission to a hospital, as well as diagnosis and treatment.

	In-Network	**Out-of-Network**
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

- Your health plan may require prior authorization for hospital and/or inpatient services.
- This includes inpatient hospitalization for medical and/or mental health needs.
- Your plan covers a semi-private room, ward, or intensive care unit, as well as any medically necessary miscellaneous hospital expenses, including prescription drugs administered during the confinement.
- Private rooms are only covered if medically necessary, as determined by your health plan.

Mental Health Counseling Visits

These services include behavioral health, psychiatric counseling, and substance use disorder services.

	In-Network	Out-of-Network
You pay:	$15 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

Applies to:

- ✓ Individual therapy office visits
- ✓ Outpatient groups
- ✓ Telehealth visits

Occupational, Physical, Speech Therapy

Physical therapy (PT) involves treatments for the prevention and management of injuries or disabilities. PT helps to relieve pain, promote health, and restore function/movement. This includes Occupational therapy (OT), which helps with daily living tasks caused from illnesses and injuries to the brain and body; and Speech/Language therapy (ST), which helps to relearn how to communicate and swallow to prevent aspiration.

	In-Network	Out-of-Network
You pay:	$15 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

- Up to 50 visits per participant for all therapies combined per calendar year.
- Up to a maximum of 50 additional visits per therapy, per participant, per calendar year may be available with prior authorization from your health plan.

Applies to:

- ✓ Comprehensive outpatient rehabilitation facility visits
- ✓ Hospital outpatient department visits
- ✓ Independent therapist office visits

Outpatient Cardiac Rehabilitation

Rehabilitation following an inpatient hospital stay for a heart attack, bypass surgery, angina, heart valve surgery, angioplasty, or heart transplant.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, then Medical Coinsurance	Out-of-Network Deductible, then Medical Coinsurance

Outpatient Hospital & Ambulatory Surgery Center Services

Services necessary for your admission to an outpatient hospital or Ambulatory Surgery Center, as well as diagnosis and treatment.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** Medical Coinsurance	Out-of-Network Deductible, then Medical Coinsurance

Preventive Care Services

Routine health care, including screening, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems – as required by federal law. Federal law specifies at what age and how frequently a service can be paid with no cost to you. See healthcare.gov/preventive-care-benefits for more details.

	In-Network	Out-of-Network
You pay:	$0 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

- Services – diagnostic or otherwise – for specific conditions found during a preventive exam may be subject to Deductible, then Medical Coinsurance.
- Your preventive check-up can be used to fulfill activities for the annual Well Wisconsin incentive program. See https://etf.wi.gov/well-wisconsin-members for more details.

The plan covers the following federally required preventive services including, but not limited to:

- ✓ Alcohol misuse counseling
- ✓ Breast cancer screening (mammogram)
- ✓ Cholesterol screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ HIV screening
- ✓ Immunizations, including flu, hepatitis A & B shots, pneumococcal and other shots
- ✓ Obesity screening and counseling
- ✓ Blood pressure screening
- ✓ Cervical cancer screening
- ✓ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- ✓ Hepatitis C screening
- ✓ Lung cancer screening
- ✓ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- ✓ Well child exam

Primary Care

Primary care includes preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. Your primary care provider (PCP) or primary care clinic (PCC) will provide or arrange for most of your health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services.

	In-Network	Out-of-Network
You pay:	$15 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

- You must select a PCP or PCC at the time or enrollment or when you change health plans; your PCP may be a physician, physician assistant, nurse practitioner, or any other provider that manages your primary care services.
- If you do not choose a PCP or PCC, your health plan will assign a PCP or PCC for you. Contact your health plan directly to change your current PCP or PCC selection.

Skilled Nursing Facility

Admission to a licensed Skilled Nursing Facility for continued treatment after a hospital stay.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, then Medical Coinsurance	Out-of-Network Deductible, **then** Medical Coinsurance

- ✓ Up to 120 calendar days per benefit period

Telemedicine and Remote Care

Certain telehealth and remote care services are covered. These remote services should maintain the quality, safety, and effectiveness of an in-person visit. You should work with your provider to determine the best technology solution(s) to meet your care needs.

E-Visit

An evaluation and treatment by a provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An E-Visit is also called a digital visit or a virtual visit.

	In-Network	**Out-of-Network**
You pay:	$0 copayment per visit	Out-of-Network Deductible, **then** Medical Coinsurance

- Must be initiated by the member seeking services, not the provider, in order to be covered.
- E-Visits are covered when the same service would be covered if provided in person when performed by one of the following provider types:
  - Doctor
  - Nurse practitioner
  - Physician assistant
  - Licensed clinical social worker
  - Clinical psychologist or psychiatrist
  - Occupational therapist
  - Speech / language pathologist

Telehealth

Telehealth is a service delivered via real-time audio and video. Telehealth may also be called telemedicine, online or virtual evaluation and management, or a video visit. Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care provider who is located elsewhere using interactive two-way, real-time audio and video technology. Telehealth can be provided in your home, as well as at a health care facility.

	In-Network	**Out-of-Network**
You pay:	$15/$25 copayment per visit, depending upon provider specialty	Out-of-Network Deductible, **then** Medical Coinsurance

- Telehealth will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.
- If you and your provider determine that you cannot successfully complete a Telehealth visit with full audio and video, you may opt to change to a Telephone Visit.

Telephone Visit

Telephone Visit is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

	In-Network	**Out-of-Network**
You pay:	$15/$25 copayment per visit, depending upon provider specialty	Out-of-Network Deductible, **then** Medical Coinsurance

- Telephone visits will be covered if the provider can successfully provide the service without a reduction in quality, safety, or effectiveness.

Remote Patient Monitoring

Remote Patient Monitoring is a series of services whereby a provider collects and interprets a person's physiologic data that is sent digitally to support treatment and management of medical conditions.

	In-Network	**Out-of-Network**
You pay:	$15 copayment per visit for initial setup of device including patient education	Out-of-Network Deductible, **then** Medical Coinsurance

- Device must meet home-use medical device as defined by the Food and Drug Administration and be provided as part of the monitoring service.
- Devices are provided as a lease; they cannot be lease-to-own, purchased to own, or already owned.

Virtual Check-In		
A brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than Telehealth, Telephone Visits, or E-Visits.		
	In-Network	**Out-of-Network**
You pay:	$0/$15/$25 copayment per visit, depending upon vendor and provider specialty	Out-of-Network Deductible, **then** Medical Coinsurance
• Covered as a Virtual Check-In as long as the check-in is not related to another medical visit within the past 7 days, and as long as the check-in does not lead to a medical visit within the next 24 hours or the next available appointment.		
Vision Services		
Yearly eye exam to diagnose and treat diseases and conditions of the eye. Does not include frames or any other vision related expenses. For supplemental vision coverage, including prescription glasses and contacts, see the Supplemental Vision Benefit.		
	In-Network	**Out-of-Network**
You pay:	$25 copayment per visit per visit	Out-of-Network Deductible, **then** Medical Coinsurance

• Coverage is limited to one eye exam per participant per calendar year
• Non-routine eye exams are covered if considered medically necessary by your health plan
• Child vision screenings:
  ○ Under age 5 – Federally covered and considered preventive are not subject to deductible or copayment
  ○ Age 6 or older – Not considered preventive, subject to provider and specialist provider office visit copayment		

Additional Covered Services

Cochlear Implant Devices – Over Age 18		
An electronic device that partially restores hearing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.		
	In-Network	**Out-of-Network**
You pay:	In-Network Deductible, then 20% coinsurance for implant devices, professional surgery for implantation, and follow-up device training 10% coinsurance for hospital charges Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, **then** Medical Coinsurance

Dental Implants

Dental implants are artificial tooth roots placed in the jaw to hold a replacement tooth or bridge after the loss of a tooth or teeth.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** 10% coinsurance Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, **then** Medical Coinsurance

× Dental implants are only covered following accident or injury.
× Maximum benefit plan payment of $1,000 per tooth.

Hearing Aids – Over Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants under the age of 18, see Hearing Aids – Under Age 18 in the Covered Services section.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** 20% coinsurance after deductible is met Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, **then** Medical Coinsurance

- One hearing aid per ear, no more than once every 3 years.
- Maximum benefit plan payment of $1,000 per hearing aid.

Temporomandibular Joint Disorders – Diagnosis and Non-Surgical Treatment

Coverage for diagnostic procedures and medically necessary surgical or non-surgical for the correction of temporomandibular disorders, provided all coverage criteria are met.

	In-Network	Out-of-Network
You pay:	In-Network Deductible, **then** Medical Coinsurance Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)	Out-of-Network Deductible, **then** Medical Coinsurance ✓

- Maximum benefit plan payment of $1,250 per participant per plan year

Dental, Pharmacy, and Supplemental Plans

Dental Benefit

The Uniform and Preventive Dental Benefit provides coverage for basic procedures such as cleanings, fluoride treatments, fillings, and orthodontia. This benefit is offered through Delta Dental. Learn more at deltadentalwi.com/state-of-wi.

Uniform Dental Benefit

If your employer offers this benefit as part of your health insurance, you may enroll in the Uniform Dental Benefit (UDB). Premiums are included in your health insurance rates. If you have individual health insurance coverage, you will have individual UDB coverage. If you have family, you will have family.

Preventive Dental Benefit

If your employer offers this Delta Dental benefit you are solely responsible for premiums in this plan; your employer will not provide any contribution. You may select any level of coverage, that is individual or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage.

If your employer offers these Delta Dental benefits, you can enhance your UDB or Preventive plan with supplemental dental. You can enroll in a supplemental dental benefit without enrolling in UDB or Preventive. You are solely responsible for premiums in this plan. Your employer will not provide any contribution. You may select any level of coverage, that is individual, individual plus spouse, individual plus child(ren) or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage. You may only enroll in either the Select Plan or Select Plus Plan, not both.

Select Plan

Covers dental services considered Major and Restorative Dental Services. Examples of this are crowns, bridges, dentures and implants. This plan does not cover orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.

Select Plus Plan

In addition to coverage of dental services considered Major and Restorative Dental Services like crowns, bridges, dentures and implants, this plan also covers orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.

Uniform Pharmacy Benefit

Your coverage for most medications is provided by Navitus Health Solutions, a Pharmacy Benefit Manager (PBM). You must obtain pharmacy benefits at a participating Navitus pharmacy, except when not reasonably possible because of Emergency or Urgent Care. For full detail on services covered by the PBM, please see the 2024 Uniform Pharmacy Benefits Certificate of Coverage.

Supplemental Vision Benefit

The supplemental DeltaVision Plan provides coverage for eye exams, prescription glasses, contacts, and more. This benefit is offered through Delta Dental, in partnership with EyeMed Vision Care. Learn more at visiting deltadentalwi.com/state-of-wi-vision.

Accident Plan

Provides employees and their dependents with a cash payment to help cover out-of-pocket expenses regardless of any other insurance coverage. Your employer has to opt-in to offer this to you. This plan does not disqualify you for medical coverage. Learn more at Accident Plan.

Wellness and Chronic Condition Management

Uniform Wellness Benefits
The Uniform Wellness Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include a health assessment, health screenings, flu vaccines, unlimited health coaching (weight management, nutrition, exercise, tobacco cessation, stress resiliency, sleep hygiene, alcohol use), digital well-being education, challenges, and learning modules. Participants can earn an annual incentive. For more details on services included in the program, please see the Well Wisconsin for Members webpage.

Uniform Chronic Condition Management Benefits

The Uniform Chronic Condition Management Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include unlimited coaching for asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. A diabetes prevention program, and resources for chronic pain management are also available. For more details on services included in the program, please see the Well Wisconsin for Members webpage.

Plan Year 2024

Certificate of Coverage

State of Wisconsin Group Health Insurance Program

Effective January 1, 2024

ET-2180 (Revised November 8, 2023)

Certificate of Coverage

This **Certificate of Coverage** is your summary plan description and contains the Uniform Benefits offered under the **Group Health Insurance Program (GHIP)**. *Keep this document with your other insurance papers.*

The purpose of this **Certificate of Coverage** is to help you (the **Subscriber**) and your **Dependents** understand the **Benefits** covered under the **GHIP**.

All **Health Plans** that participate in the **GHIP** must offer the same coverage described in this **Certificate of Coverage**. Your **Health Plan** may adopt policies, procedures, or rules to help determine **Benefits** covered under this **Certificate of Coverage.**

If any part of this **Certificate of Coverage** is or becomes prohibited by law, it will no longer apply; the rest of this **Certificate of Coverage** will continue in full force.

The **Benefits** described herein comply with state of Wisconsin and federal minimum benefits requirements, and any additional coverage requirements made by the **Group Insurance Board** (**Board**).

*This **Certificate of Coverage** should be used in conjunction with the **Schedule of Benefits** for your specific health plan. Visit the Department of Employee Trust Funds' website at www.etf.wi.gov or select the appropriate link below to view the **Schedules of Benefits**. Please note this Certificate of Coverage is subject to updates at any time. Please visit www.etf.wi.gov for the most current version.*

- Access High Deductible Health Plan (HDHP – PO1, PO7, PO17)
- Access Plan for State of Wisconsin, Local Health Insurance and LAHP Members (PO1, PO6, PO8, PO16)
- Health Plan Medicare and Local Traditional Plan (PO1, PO2, PO6, PO7, PO8, PO12, PO16, PO17)
- High Deductible Health Plan (HDHP – PO1, PO7, PO17)
- IYC Health Plan (PO1, PO6, PO8, PO16)
- Local Deductible Access Plan (PO4, PO14)
- Local Deductible Plan (PO4, PO14)
- Local Traditional Access Plan (PO2, PO12)

Table of Contents

1. Glossary of Terms

When spelled with capital letters and bolded, the following terms refer to the specific statements or ideas below:

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.

Advance Care Planning: means making decisions about the healthcare you want to receive and your goals for care if you were facing a medical crisis.

Allowed Amount: means the maximum dollar amount that your **Health Plan** will pay a **Provider** for services, based upon the contract agreement between the **Health Plan** and the **Provider**.

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 **Health Plan**. When a **Health 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, 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**.

Ambulatory Surgery Center (ASC): means a free-standing facility where surgeries are performed that allows patients to go home the same day. **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 Section 2.A. Subscriber Eligibility for more information.

> **Local Annuitant:** means any currently insured retired **Employee** of a participating **Employer** receiving an immediate annuity under the Wisconsin Retirement System, or a long-term disability benefit under Wis. Adm. Code § ETF 50.40, or a disability benefit under Wis. Stat. § 40.65, or a person with twenty (20) years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by **ETF** under Wis. Stat. § 40.19 (4) (a). It can also refer to a retired public **Employee** under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long-Term Disability Insurance (LTDI)), or any **Dependent** of such an **Employee**, who is receiving a continuation of the **Employee's** annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP). See Section 2.A. Subscriber Eligibility for more information.
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> **State Annuitant:** means any retired **Employee** of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a currently insured

recipient of a disability benefit under Wis. Stat. § 40.65, or a terminated **Employee** with twenty (20) years of creditable service.

Bed and Board: means the costs of rooms, meals, and general care needed by patients who are in the **Hospital**.

Benefit Period: means the total duration of **Confinements** that are separated from each other by less than sixty (60) calendar days.

Benefit Plan: means the package of coverage and cost-sharing levels that you are enrolled in under the State of Wisconsin **Group Health Insurance Program**.

Benefits: means the services that are paid for as a part of your coverage under the State of Wisconsin **Group Health Insurance Program**.

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 (Certificate): means this document, as may be updated as required by the Department, which includes details on the services that are covered by your **Benefit Plan** under the State of Wisconsin **Group Health Insurance Program**.

Charge: means an amount for a health care service from a **Provider** that is reasonable, as determined by the **Health Plan**. **Charges** include all taxes for which the **Participant** can legally be billed, including but not limited to sales tax.

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 the **GHIP** or any part of a year before the date the **Coordination of Benefits** provision or a similar provision takes effect.

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

Coinsurance: means a specified percentage of the **Allowed 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**.

Confinement: means the period of time between admission as an **Inpatient** or outpatient to a **Hospital**, covered residential center, **Skilled Nursing Facility** or licensed **Ambulatory Surgery Center** on the advice of the **Participant's** physician; and discharge therefrom, or the time spent receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**.

Congenital: means a condition which exists at birth.

Continuant: means any **Subscriber** enrolled under federal or **State** continuation provisions.

Coordination of Benefits (COB): means the process health plans use to determine which plan will pay first for covered medical services or prescription drugs and what the second plan will pay after the first plan has paid.

Copayment: means a specified dollar amount that the **Participant** or family must pay each time those covered services are provided, subject to any limits specified in the **Schedule of Benefits**.

Custodial Care: means the provision of **Bed and Board**, nursing care, personal care or other care designed to assist an individual who, in the opinion of an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this), has reached the maximum level of recovery. **Custodial Care** is provided to patients 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 **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this), that the medical or surgical treatment will enable that person to live outside an institution. **Custodial Care** also includes rest cures, respite care, and home care provided by family members.

Deductible: means the amount the **Participant** owes for health care services the **Participant's Benefit Plan** covers before the **Benefit Plan** begins to pay. For example, if the **Participant's 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.

Employee Trust Funds (ETF): means the State of Wisconsin Department of Employee Trust Funds, also referred to as the Department.

E-Visit: means an evaluation and treatment by a **Provider** using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An **E-Visit** is also called a digital visit.

Dependent: means any eligible member or beneficiary of the **GHIP** who is not the **Subscriber**. See Section 2.B. Dependent Eligibility for more information.

Durable Medical Equipment: means physical tools, implements, or items which are prescribed by a **Provider** and used primarily to treat an **Illness** or **Injury**. They are generally not useful to a person in the absence of an **Illness** or **Injury**.

Effective Date: means the date, as certified by **ETF** (or as shown on the records of the **Health Plan** for **Participants** who pay premium directly to the **Health Plan**), on which the **Participant** becomes enrolled and entitled to the **Benefits** specified in this **Certificate of Coverage.**

Employee: means a person who is working for pay. See also **Local Employee** and **State Employee**. See Section 2.A. Subscriber Eligibility for more information.

> **Local Employee:** means a person who is working for pay for a city, county, or other municipal unit of government in Wisconsin that has opted to participate in the State of Wisconsin **Group Health Insurance Program**, and eligible as defined under Wis. Stat. § 40.02 (46) or 40.19 (4) (a), of an **Employer** as defined under Wis. Stat. § 40.02 (28), other than the State, which has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its **Employees**.
>
> **State Employee:** means a person who works for a State of Wisconsin agency, the University of Wisconsin, or UW Hospitals and Clinics, and an eligible **Employee** as defined under Wis. Stat. § 40.02 (25).

Employer
When not specified, **Employer** or **Employers** means **State Employer** and **Local Employer**.

> **State Employer** means an eligible State agency as defined in Wis. Stat. § 40.02 (54).
>
> **Local Employer** means a Wisconsin Public Employer who has acted under Wis. Stat. § 40.51 (7), to participate in the GHIP for its Employees.
>
> **State Employer** means an eligible State agency as defined in Wis. Stat. § 40.02 (54).

Embedded: means when a **Participant** within a family plan meets the individual portion of **Participant** financial responsibility (e.g., **Deductible**) within the family's total financial responsibility, that **Participant** is no longer responsible for any further out of pocket costs. The remaining family **Deductible** in this example will still apply to other family **Participants**.

Emergency: means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:

a. Serious jeopardy to the **Participant's** health. With respect to a pregnant person, it includes serious jeopardy to the unborn child.
b. Serious impairment to the **Participant's** bodily functions.
c. Serious dysfunction of one or more of the **Participant**'s body organs or parts.

Additional detail on **Emergency Care** appears in Section 4.F. Covered Services.

Experimental: means the use of any service, treatment, procedure, facility, equipment, drug, device or supply for a **Participant**'s **Illness** or **Injury** that, as determined by the **Health Plan** and/or **PBM** requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used, or isn't yet recognized as acceptable medical practice to treat that **Illness** or **Injury** for a **Participant**'s **Illness** or **Injury**. Additional detail on the criteria used by **Health Plans** to determine what is **Experimental** is included in Section 5.A. Excluded Services, Experimental and Investigational Treatments.

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 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**. Some examples would be a rejection of a claim, denial of a formal **Referral**, etc.

Group Health Insurance Program (GHIP): means the **Benefits** program offered by the **Group Insurance Board** that provides medical, pharmacy, and wellness **Benefits** to enrolled public workers.

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

Habilitation Services: means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy,

speech-language pathology, and other services for people with disabilities in a variety of **Inpatient** and/or outpatient settings.

Health Plan: means the health insurer that is under contract with the **Group Insurance Board** to provide benefits and services to **Participants** of the **Group Health Insurance Program.**

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

Hold/Held Harmless: means the **Participant** is not responsible for any additional **Charges** out of pocket beyond the **Copayment, Coinsurance,** or **Deductible** that is required per the **Participant's Schedule of Benefits.**

Home Care Benefits: means health care services provided in your home that are intended to help you recover from an **Injury** or **Illness**. The intention of **Home Care Benefits** is to help you get better, regain your independence, become as self-sufficient as possible, maintain your current condition or level of function, or slow decline.

Hospice Care: means services provided to a **Participant** whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided to ease pain and make the **Participant** as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care **Provider** approved by the **Health Plan**.

Hospital: means an institution that:

a. Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to **Hospitals**;
b. maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, **Injury** and **Illness**;
c. provides this care for fees;
d. provides such care on an **Inpatient** basis;
e. provides continuous 24-hour nursing services by registered graduate nurses, or qualifies as a psychiatric or tuberculosis **Hospital**;
f. is a **Medicare Provider**; and
g. is accredited as a **Hospital** by the Joint Commission of Accreditation of Hospitals.

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

Hospital Confinement or **Confined in a Hospital:** means being registered as a bed patient in a **Hospital** on the advice of an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this) or receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**.

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.

In-Network Provider: means a **Provider** who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to members of the **Health Plan**. The **Provider's** written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a **Participant**.

Inpatient: means **Participant** admitted as a bed patient to a healthcare facility or in twenty-four (24)-hour home care.

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.

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. Payments for out-of-network services or other expenses do not accumulate toward this limit.

Medical Supplies: means non-durable or disposable health care materials that are ordered or prescribed by a **Provider** for medical purposes.

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.

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, and **Medicare Part B** refers to coverage for outpatient services. **Medicare Part D** refers to prescription drug coverage.

Medicare Advantage: means a **Benefit Plan** created by Title 18, Part C of the U.S. Social Security Act of 1965 that is only available to retired **Participants** who are enrolled in **Medicare.**

Miscellaneous Hospital Expense: means **Usual and Customary Hospital** ancillary **Charges**, other than **Bed and Board**, made because of the care necessary for an **Illness** or other condition requiring **Inpatient** or outpatient hospitalization for which benefits are available under this **Health Plan**.

Natural Tooth: means a tooth that would not have required restoration in the absence of a **Participant's** trauma or **Injury**.

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 Pharmacy.**

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** with a higher **Copayment**.

Open Enrollment: means the yearly period where all members may make changes to their **Benefits**. The dates for this time period are set each year by **ETF** and the **Group Insurance Board.**

Out-of-Area Service: means any services provided to **Participants** outside the **Service Area**.

Out-of-Network Provider: means a provider who does not have a signed participating **Provider** agreement and is not listed on the most current edition of the **Health Plan**'s professional directory of **Providers**. Care from an **Out-of-Network Provider** may require prior-authorization from the **Health Plan** unless it is **Emergency** or **Urgent Care** (except under the **Access Plan** or other **PPO Plans**).

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

Palliative Care: specialized medical care for people living with an advanced life-limiting illness, focused on providing relief from the symptoms and stress of the illness.

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

Participating Pharmacy: means a pharmacy that has agreed in writing to provide the services to **Participants** that are administered by the **PBM** and covered under the **GHIP**. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the **GHIP** are provided to a **Participant**.

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 the **Group Health Insurance Program**. 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.

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

a. 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.
b. A governmental plan that provides healthcare coverage that is required or provided by law. However, such a plan does not include:
    - **Medicare Advantage** as this provision is preempted by federal 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).

- Any plan whose benefits, by law, are in excess of those of any private insurance program or other non-governmental program is not included in the definition of a Plan. Each contract or other arrangement for coverage is a separate **Plan**. Also, if an arrangement has two parts and **Coordination of Benefits (COB)** rules apply only to one of the two, each of the parts is a separate **Plan**.

Post-Stabilization Care: means care that is related to an **Emergency** service that is provided after a **Participant** is stabilized to maintain the stabilized condition, or, under certain circumstances, to improve or resolve the **Participant's** condition.

Postoperative Care: means the medical observation and care of a **Participant** necessary for recovery from a covered surgical procedure.

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 the **GHIP**.

Preferred Provider Organization (PPO) and **PPO Network**: means **Health Plans** such as the **Access Plan** and **SMP** that include both **In-Network** and **Out-of-Network Providers**. These **Health Plans** usually cover **In-Network Provider** services with lower costs to **Participants** than **Out-of-Network Providers**. The different levels of **Benefits** for the **Access Plan** are described in their **Schedule of Benefits**.

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.**

Preoperative Care: means the medical evaluation of a **Participant** prior to a covered surgical procedure. It is the immediate preoperative visit in the **Hospital**, or elsewhere, necessary for the physical examination of the **Participant**, the review of the **Participant**'s medical history and assessment of the laboratory, x-ray, and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

Primary Care Clinic (PCC): means an **In-Network** clinic that can be named as the center where a **Participant**'s **Primary Care Providers** are co-located.

Primary Care Provider (PCP): means an **In-Network Provider** who is named as a **Participant's** primary health care contact. They provide entry into the health care system. They also evaluate a **Participant**'s total health needs and provide medical care in one or more medical fields. When medically needed, they then preserve continuity of care. They are also in charge of coordinating other **Provider** health services and refer the **Participant** to other **Providers**.

Primary Plan/Secondary Plan: the order of benefit determination rules state whether the **GHIP** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person. When the **GHIP** is a **Secondary Plan**, the **GHIP** benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits. When the **GHIP** is a **Primary Plan**, the **GHIP's** 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, the **GHIP** 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**. See Section 6. **Coordination of Benefits** for more information.

Prior Authorization: means obtaining approval from the **Health Plan** before obtaining the services. This is a request for coverage of a service or procedure. While the authorization is to a specific **Provider**/clinic, it is for the services that a **Provider** or clinic will perform. Unless otherwise indicated by the **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**. Some prescriptions may also require **Prior Authorization**, which must be obtained from the **PBM** and are at its discretion.

Provider: means a doctor, **Hospital**, clinic; or any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more **Benefits**.

Referral: when a **Participant**'s **Primary Care Provider** sends them to another **Provider** for services. A referral is a written order from your **Primary Care Provider** for you to see a specialist or receive certain medical services. Many **Plans** require you to get a **Referral** before you can receive medical care from anyone except your **Primary Care Provider**. If you don't receive a **Referral** first, the **Plan** may not pay for the services.

Rehabilitation Services: means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of **Inpatient** and/or outpatient settings.

Remote Patient Monitoring: means the collection and interpretation of a person's physiologic data that is sent digitally to a health care **Provider** to support treatment and management of medical conditions.

Schedule of Benefits: means the document that is issued to accompany this **Certificate of Coverage** which details specific benefits for covered services provided to **Participants** by the **Benefit Plan** elected. To determine which **Benefit Plan** you have, see the **Schedule of Benefits** attached to this **Certificate of Coverage**, or visit **ETF**'s website at http://etf.wi.gov/benefits-by-employer and search for your **Employer**.

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.

Service Area: means specific zip codes in the counties in which the **In-Network Providers** are approved by the **Health Plan** to provide professional services to **Participants** covered by the **GHIP**.

Shared Decision Making (SDM): means a program offered by a **Health Plan** or health care **Provider** that **Participants** must complete when considering whether to undergo certain medical or surgical interventions. **SDM** programs are designed to inform **Participants** about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that **Participants** can decide the best possible course of treatment. The **Health Plan** or health care

Provider will provide the **Participant** with written Patient Decisions Aids (PDAs) as part of the **SDM** program.

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**.

Skilled Nursing Facility: means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a **Skilled Nursing Facility**.

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.

State: means the State of Wisconsin.

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** are high, as described on **SMP's** plan description page. The **SMP** offers **Uniform Benefits** and the **HDHP Uniform Benefits.**

Subscriber: means an eligible **Employee** or **Annuitant** who is enrolled in the State of Wisconsin **Group Health Insurance Program**.

Telehealth: means a service delivered via real-time audio and video. **Telehealth** may also be called telemedicine, online or virtual evaluation and management, or a video visit.

Telephone Visit: means an evaluation and treatment by a **Provider** using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

Urgent Care: means care for an accident or **Illness** which is needed sooner than a routine doctor's visit. This does not include follow-up care unless such care is necessary to prevent a **Participant's** health from getting seriously worse before they can reach their **Primary Care Provider**. It also does not include care that can be safely postponed until the **Participant** returns to the **Service Area** to receive such care from an **In-Network Provider**. 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: means 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.

Uniform Benefits: means the Benefits described within this document and in the Schedule of Benefits.

Virtual Check-In: means a brief discussion either by telephone or real-time audio and video between a **Provider** and an established patient to manage a medical condition. These are services separate from and less intensive than **Telehealth, Telephone Visits, or E-Visits**.

2. Eligibility, Enrollment, and Termination

A. Subscriber Eligibility

The following people may enroll as **Subscribers** in the State of Wisconsin **Group Health Insurance Program**:

1. Active Wisconsin State agency and University of Wisconsin **Employees** who participate in the Wisconsin Retirement System (WRS), as described in Wis. Stat. § 40.02 (25) (a).
2. Elected state officials, including members of the legislature (Wis. Stat. § 40.02 (25) (a) 2).
3. Employees of the legislature (Wis. Stat. § 40.02 (25) (a) 2).
4. Any blind employees of Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.
5. The following in the University of Wisconsin (UW) System and UW Hospitals and Clinics Authority (Wis. Stat. § 40.02 (25) (b)):
    a. Any teacher who is expected to be employed by the UW System for at least six (6) months on a minimum of one-third (33%) full-time appointment.
    b. Any teacher who is a participating **Employee** and who is expected to be employed by the UW System for at least six (6) months on a minimum of one-third (33%) full-time appointment.
    c. Certain visiting faculty members in the UW System.
    d. Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.
    e. Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least:
        i. one (1) semester for academic year (nine (9) month); or
        ii. six (6) months for annual (twelve (12) month) appointments.
    f. Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim appointment of twenty-eight percent (28%) or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one percent (21%) or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.
    g. Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.
    h. Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospitals and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.
6. **Local Employees** as described in Wis. Stat. § 40.02 (46) or 40.19 (4) (a).
7. **Annuitants** and **Continuants** (Wis. Stat. § 40.02 (25) (b)), which include the following:
    a. Any covered **Participant** who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b. The surviving spouse of a **Subscriber**.
c. Covered **Participants** who terminate employment, have attained minimum retirement age, have twenty (20) years of WRS creditable service, and defer their annuity (if a timely application is submitted).
d. Any participating **State Employee** who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant, and is ineligible for an immediate annuity (that is, under the minimum retirement age). See Section 2.I. Re-Enrollment below for more information.
e. Any rehired **Annuitant** electing to return to active WRS participation is immediately eligible to apply for coverage through their **Employer**.
f. Any **Local Employee** under Wis. Stat. § 40.02 (25) (b) 11 who retires and is receiving an annuity under the Wisconsin Retirement System (but not those only receiving a duty disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)).
g. Any **Dependent** of a **Local Annuitant**, who is receiving a continuation of the **Local Annuitant's** annuity, and, if eligible, who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).
h. Any **Local Annuitant** receiving an annuity through a program administered by **ETF** under Wis. Stat. § 40.19 (4) (a).
i. **Participants** who meet federal or **State** continuation provisions. See Section 260.

8. Disabled persons entitled to benefits under Wis. Adm. Code § ETF 50.40 or Wis. Stat. § 40.65 including:
   a. Insured **Employees** or former **Employees** who choose to continue coverage when the **Employee's** Long-Term Disability Insurance (LTDI) benefit under Wis. Adm. Code § ETF 50.40 or a duty disability benefit under Wis. Stat. § 40.65 is approved.
   b. Previously insured **Employees** or former **Employees** whose coverage lapsed and who are eligible and apply for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65.

B. Dependent Eligibility

A **Subscriber** may also be able to enroll certain family members in the **GHIP** as a part of their plan. These **Participants** are generally described as **Dependents.** A **Dependent** can be a **Subscriber's:**

1. Spouse.
2. Child.
3. Legal ward who becomes a permanent legal ward of the **Subscriber** or **Subscriber's** spouse prior to age 19.
4. Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
5. Stepchild.
6. Grandchild if the parent is a **Dependent** child.

A **Dependent's** eligibility for coverage may change, based on age or a change in legal relationship to the **Subscriber**. See Section 2.H. Qualifying Life Events for more information on when **Dependent** eligibility for coverage can change.

Most children cease to be eligible for health insurance coverage when they turn 26, but there are some exceptions.

Under Wisconsin law, a **Dependent** child who is called to federal active duty in the military when they are under age 27 and enrolled in full-time higher education can remain covered regardless of age, as long as they are still attending school full time (see Wis. Stat. § 632.885).

Over-Age Disabled Child Eligibility

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 (at least one year) or indefinite duration is an eligible **Dependent**, regardless of age, as long as the child remains disabled and is **Dependent** on the you (or the other parent) for at least 50% of their support and maintenance. This is demonstrated by the support test done for federal income tax purposes, whether you claim the child on your taxes. If you die, your disabled adult **Dependent** must still meet the remaining disabled criteria and be incapable of self-support. Your **Health Plan** will follow up no more than once per year to verify that your child still qualifies for coverage. If your child no longer qualifies because either their disability improves or they become able to support themselves, their coverage under your plan will end. If you disagree with a **Health Plan's** determination of disability, you can appeal that decision to **ETF**.

The **Health Plan** shall notify the **ETF** of individual over-age disabled child reviews per **ETF** submission instructions. The **Health Plan** may perform the annual individual reviews at any time of the year. If it is found that your child no longer meets the criteria for an over-age disabled child, termination of the child's coverage must be prospective. **ETF** must be copied on the notification of the **Health Plan's** review as described in the **Health Plan** submission instructions.

In addition, the **Health Plan** must report and certify to **ETF** the total results from its process to verify the eligibility of over-age disabled children age twenty–six (26) or older, which includes checking that the:

1. Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year (reviewed annually except if the child has **Medicare Parts A** and **Part B**, or has been found permanently disabled; if so, the medical review must be done at least once every 3 years); and
2. Support and maintenance requirement is met (per IRS Publication 501 worksheet 2, the worksheet for determining support) (reviewed annually); and
3. Child is not married (reviewed annually).

C. Program Option Eligibility

The **GHIP** offers different **Benefit Plans,** sometimes called Program Options. The **Benefit Plans** available to you will depend upon your status (e.g., **Employee, Annuitant**) and the **Employer** who is providing your **Benefits** (e.g., **Local, State**).

State Employees may choose between two **Benefit Plan** designs – HDHP and non-HDHP.

To determine which **Benefit Plan** you have, see the **Schedule of Benefits** attached to this **Certificate of Coverage**, or visit **ETF**'s website at http://etf.wi.gov/benefits-by-employer and search for your **Employer**.

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

D. Individual and Family Coverage

Individual Coverage

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

Family Coverage

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

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

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

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

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

F. Medicare Enrollment for Annuitants and Continuants

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

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

your eligible **Dependents**) must enroll in **Medicare Part A** and **Part B** as soon as you are eligible. You must provide your Medicare enrollment information to **ETF.**

You and your **Medicare**-eligible **Dependents** must remain enrolled in **Medicare Parts A and Part B** once you retire. If you are not enrolled in **Part B** when you retire or if you disenroll from **Part B**, you will have to pay all of the costs for services your receive out of pocket that **Part B** would have covered.

If your **Health Plan** discovers that you are eligible for **Medicare Part A** and **Part B** and have either not enrolled in **Part B** coverage or have disenrolled in **Part B** coverage, your **Health Plan** is required to provide information, including the total dollars in claims you have used, and any other documentation needed to **ETF**. Your **Health Plan** will then contact you to explain the financial impacts to you of disenrolling in **Part B** coverage, and will provide assistance to you to re-enroll in **Part B**. If you refuse to re-enroll in **Part B** coverage, your **Health Plan** will notify **ETF** for additional follow up.

If you are an **Annuitant** or **Continuant** who is enrolled in **Medicare Part A** and **Part B**, you are eligible to enroll in the IYC Medicare Advantage or IYC Medicare Plus for individual coverage. If you would like to enroll in family IYC Medicare Advantage or IYC Medicare Plus coverage, your **Dependents** must also enroll in **Medicare Parts A** and **B.** If you or a **Dependent** on your family plan is not eligible for and enrolled in **Medicare**, you may be able to split your coverage so that **Participants** with **Medicare** can enroll in the IYC Medicare Plus or IYC Medicare Advantage plan; and non-**Medicare Participants** can be enrolled in a non-**Medicare** benefit plan.

If you or your **Dependent** enroll in IYC Medicare Advantage, your plan will verify that you are enrolled in **Medicare Part A** and **Part B** continuously. If you drop either part of **Medicare** while you are enrolled in the IYC Medicare Advantage plan, your **Health Plan** will notify **ETF**, and you will be moved to IYC Medicare Plus. In addition, you will be responsible for any claims costs that would have been paid by **Medicare**. **ETF** strongly recommends that you *do not disenroll* from **Part A** or **Part B** once you have enrolled unless you return to work and gain coverage from your employer.

If you remain enrolled in the same **Health Plan** you had when you were an **Employee** after you retire, your **Health Plan** will provide **Benefits** and services as described in this document to you once you are enrolled in **Medicare**, carving out the benefits paid by **Medicare.** This means you will receive the same **Benefit** level provided to you when you were an **Employee**. As a retiree, when you gain eligibility for **Medicare**, you may also opt to enroll in IYC Medicare Advantage or IYC Medicare Plus; these programs have slightly different benefits but offer robust coverage. See **ETF's** Health Benefits in Retirement webpage for more information (https://etf.wi.gov/retirement/living-retirement/health-benefits-retirement).

G. Exceptions to Mandatory Medicare Enrollment

Mandatory enrollment in Medicare is waived if you or your Medicare age **Dependent** would be required to pay premiums for **Part A** coverage. However, if you or your Medicare-age **Dependent** do not enroll in **Part A**, you will not be eligible for the reduced **Premium** rate or for enrollment in the **Medicare Advantage** plan regardless of the requirement to pay premium.

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

H. Open Enrollment

Open Enrollment means the time period that occurs at least annually to allow:

1. **Subscribers** the opportunity to change **Health Plans** and/or coverage; and
2. eligible individuals the opportunity to enroll for coverage in the **GHIP**.

I. Qualifying Life Events

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

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

1. Marriage

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

2. Divorce

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

3. New Dependent

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

a. *Children Born Outside of Marriage*

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

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

- The date of a court order declaring paternity; or;
- The date the acknowledgement of paternity is filed with the Wisconsin Department of Health Services (or equivalent if the birth was outside of Wisconsin).

You should file an application within sixty (60) calendar days of the child's birth, court order, or paternity acknowledgement. When an acknowledgment of paternity is filed within 60 calendar days of the birth, and an application is received or online enrollment performed within the 60 calendar day time frame, family coverage is effective on the date of birth.

b. *Dependent Grandchildren*

If your minor **Dependent** child has a child while they are covered by your **GHIP** policy, you may add your grandchild as a **Dependent**. Your grandchild will no longer be a **Dependent** at the end of the month in which your **Dependent** child (the grandchild's parent) turns age 18.

4. Adult Children Aging Out

Your children cease to be **Dependents** at the end of the month in which they turn 26 years of age, unless they are disabled or in some cases where a child is called to active duty, as described in Section 2. B. Dependent Eligibility above.

5. Adult Children Who Become Eligible Employees

If your **Dependent** child enrolls in their own **GHIP** insurance policy because they start working for a participating **Employer**, they are no longer eligible to be covered by your policy.

6. Eligibility for Other Coverage

If you become eligible for group coverage through your spouse, you are able to cancel your **GHIP** coverage. You must file an application to change within thirty (30) calendar days of enrolling in the other coverage.

7. Involuntary Loss of Employer Contribution

If you or one of your **Dependents** either lose eligibility for coverage or lose all employer contributions for other health insurance coverage, you may enroll in the **GHIP**. You must file an application to join or change your policy within thirty (30) calendar days of the involuntary loss of coverage or contribution. This does not apply if you or your **Dependent** voluntarily drop coverage.

8. Increased Employer Contribution

If your job changes such that your **Employer** would increase their contribution to your health insurance (e.g., moving from less than half to full time employment), you may enroll in the **GHIP**. You must file your application to join within thirty (30) calendar days of this change.

9. Move to New County or Out-of-State

If you move to a new county where you will be for at least three months, you can change which **Health Plan** you receive your **GHIP** coverage through. You must file to change **Health Plans** within thirty (30) calendar days before or after your move.

10. Retirement

If you were not already covered by the **GHIP** when you decide to retire, you may be able to enroll to help preserve your sick leave credits if that is available to you through your employer. You will be limited to enrolling in the **Access Plan** and you will need to have coverage for one (1) calendar month before you terminate employment, therefore, you should discuss this as soon as possible with your Human Resources department and/or at your **ETF** retirement counseling appointment before you retire. You may choose to cancel the **Access Plan** after you have retired.

If you are covered by the **GHIP** when you become a retiree, you may be able to move from family to single coverage or cancel your coverage. If you do not cancel your coverage, your coverage will automatically continue for you into retirement.

If you are already retired and you become **Medicare** eligible, you must enroll in **Parts A and B** (See Section 2. F. Medicare Enrollment). When you first enroll in **Medicare**, you could also choose to move to a different **Benefit Plan**, such as IYC Medicare Advantage or IYC Medicare Plus, or you may choose to cancel your **GHIP** coverage. You must file an application within thirty (30) calendar days of enrolling in **Medicare**, or you may submit an application up to three months before your **Medicare** coverage takes effect.

11. Death of a Spouse

If your spouse dies while they are enrolled in the **GHIP**, you may change from family coverage to single if no one else is on your policy. If you have other **Dependents**, you must keep your family coverage. If you were enrolled in your spouse's non-**GHIP** insurance and lost eligibility or all the employer contribution due to the death, you may enroll in the **GHIP**. You should submit your application within thirty (30) calendar days of losing your other coverage.

If you are enrolled in a **Medicare** coordinated **Benefit Plan** in the family **Premium** category and one or more family members enrolled in **Medicare Part A** and **Part B** dies, the family **Premium** category in effect shall not change solely as a result of the death.

12. Death of Subscriber

If you die with **Dependents** (spouse or children) enrolled on your plan, your **Dependents** can continue coverage under the **GHIP**. If your **Dependent** regains eligibility and was previously covered under your policy when you die, if you were in the process of adopting a child when you die, or if you have a child who was born within nine (9) months of your death, those **Dependents** will be eligible to enroll in coverage in the **GHIP** for as long as they continue to be eligible. No other new **Dependents** are eligible.

New coverage for your **Dependents** would be effective on the first day of the calendar month following the date of your death. It will continue until coverage would normally end for a **Dependent**. See above for situations that might change a **Dependent's** eligibility.

I. Re-Enrollment (State Employees Only)

Any participating **State Employee** who terminates employment after reaching twenty (20) years of WRS creditable service, remains an inactive WRS participant, and is not eligible for an immediate annuity because they are less than minimum retirement age, may enroll in the **GHIP** after they become eligible for their annuity. They must enroll during the **Open Enrollment** period for coverage effective the following January 1 unless there is a different qualifying event.

J. COBRA / Continuation

If you leave employment, you may be eligible for COBRA Continuation of your **GHIP** coverage. Your **Employer** will provide you with the paperwork you need to file. You must submit a completed application to the **ETF** that is postmarked within sixty (60) calendar days of the date you were notified of the right to continue, or sixty (60) calendar days from the date your coverage would otherwise end, whichever is later.

If you or your **Dependent** ceases to be eligible for coverage, you may elect COBRA continuation for a maximum of thirty-six (36) months from the date of the qualifying event or the date your **Employer** notifies you regarding the end of eligibility, whichever is later.

The COBRA continuation coverage election form will be sent to you by your **Employer's** Human Resources department or may be included in your end-of-service paperwork. Your **Employer** is required to send this notice to you within five (5) **Business Days** of notice of your qualifying event. Contact your **Employer** if you have not received this form.

Your continuation coverage will end in the following circumstances:

- When coverage is canceled;
- When **Premiums** are not paid when due; or
- When coverage is terminated as permitted by State or federal law.

K. Layoffs and Leaves of Absence

If you are laid off or you take a leave of absence, you may continue your health insurance coverage. You may also choose to let it lapse, meaning you do not pay your premiums. It may not be in your best interest to cancel coverage. You should discuss this with your Human Resources department.

A leave of absence under Wisconsin law is, "any period during which an employee has ceased to render services for a participating employer and receive earnings and there has been no formal termination of the employer-employee relationship" (see Wis. Stat. § 40.02 (40)). If you are on leave of absence, you may continue coverage as long as your **Premiums** are paid. A leave of absence cannot last more than three years under Wisconsin law.

You may also continue your coverage if you are on layoff. In some cases, **State Employees** may be able to use their accumulated unused sick leave to pay **Premiums** (see Wis. Stat. § 40.02 (40)).

L. Benefits Are Not Assignable

This **Certificate of Coverage** and the **Schedule of Benefits** is the personal policy for you and your **Dependents**. You cannot give your benefits to any other person not named as a **Participant** on this **Benefit Plan**.

3. Premiums and Financial Responsibility

A. Premium Payment

For **Employees** and most **Annuitants**, your **Premium** payments will be arranged through deductions from salary, your accumulated sick leave account (**State Employees** only), your annuity, or by converting your life insurance under certain circumstances. If you are no longer working and do not have a large enough annuity, sick leave, or converted life insurance policy, you must pay your **Premiums** directly to your **Health Plan.** If you are paying your **Health Plan** directly and you want to cancel, you may either stop paying **Premiums** or inform **ETF** that you no longer want coverage.

B. Premium Tiers

Health Plan Premiums will differ by **Health Plan** due to a variety of factors, including which counties are included in the **Health Plan**'s network **Service Area** and what **Provider** systems are included. To help you navigate **Health Plan Premium** costs, **ETF** and the **Board** divide **Premiums** into three tiers. The most efficient plans will be placed in Tier 1, which will have the lowest **Employee Premium** contribution level. Moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest **Employee Premium** contribution level.

If you are a **State Employee** or a **Local Employee** whose employer uses tiering**,** your **Premium** contribution will be a fixed amount or percentage per tier, as determined by which **Employer** (**State** or **Local**) you work for. Your **Employer** shall contribute the balance of the total **Premium**. Contact your **Employer** for more information on what your **Premium** contribution will be in a given year.

Retirees pay the full amount of their **Premium**.

For **State Employees** the State of Wisconsin's contribution toward the total **Premium** for **Employees** (non-retired) for individual and family coverage is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The Division of Personnel Management (DPM) in the Wisconsin Department of Administration sets the **Employee** contribution amounts annually. **State Employees** should watch for information provided as a part of the annual **Open Enrollment** period to determine what the cost is for their plan.

The **Premium** share that **Employees** pay for individual and family coverage levels differs; if you change coverage levels, your share of **Premium** will change. In the case of marriage, coverage level can change on the date of the marriage, versus the first of the month. When this happens, the difference in **Premium** between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

Local Employers may base their **Employer** contribution on a percentage of the average of the lowest cost qualified plans instead of tiering. The **Employer** must pay at least 50% but no more than 88% for qualified **Health Plans** in the **Local Employer's** county (exceptions may apply for employees who are less than half time or employees who are part of a collective bargaining agreement).

C. Medicare Participant Premiums for Retirees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Recovery of Premium Overpayments

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

4. Benefits and Coverages

This section describes the **Benefits** and services provided under the **GHIP**. Services and **Benefits** are available to you and your enrolled **Dependents** if they are received after the date your enrollment in **GHIP** becomes effective and your **Premiums** are paid.

Medicare Advantage benefits may differ slightly based upon **CMS** requirements; see your Evidence of Coverage issued by your **Medicare Advantage Health Plan** for details.

A. Services Must be Received In-Network

Except in limited circumstances that are specifically described below in B. Exceptions to In-Network Care Requirement, you and your **Dependents** must receive services from **Providers** that are a part of your **Health Plan's** defined **Provider** network (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). If you are having trouble finding an **In-Network Provider** to provide a service, you should contact your **Health Plan** for assistance.

B. Exceptions to In-Network Care Requirement

1. Specialty Care Not Available In-Network

If you have a medical condition that requires highly specialized care that is not available in your **Health Plan's** network, you may be able to request access to an **Out-of-Network Provider**. All **Out-of-Network** care requires written **Prior Authorization** from your **Health Plan** before any services are received, unless you are enrolled in the **Access Plan** or other **PPO Plan**. You should contact your **Health Plan** before receiving any **Out-of-Network** care to verify your coverage.

2. Urgent or Emergency Room Care

If you require **Urgent Care** or **Emergency Room** services, and you are not able to return to your network for services (e.g., you are traveling out of **State** or out of country), your **Out-of-Network** services will be covered by your **Health Plan**. Please note that only services that require immediate or **Urgent Care** will be covered; services that might safely be delayed in order for you to return to your **Health Plan's Service Area** may be denied by your **Health Plan**.

3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit

Sometimes after a visit to an **Emergency Room** or **Urgent Care**, you may need additional follow-up appointments to manage an **Illness** or **Injury**. In most cases, you will be required to return to your **Health Plan's Service Area** for follow-up care unless you are enrolled in the **Access Plan** or other **PPO Plan**. Some limited exceptions might be granted if you are physically unable to return to the **Service Area**. You must notify your **Health Plan** immediately if follow-up care is necessary, and your **Health Plan** will provide written **Prior Authorization** on a case-by-case basis for any follow-up care that is received from an **Out-of-Network Provider**. If you do not receive written **Prior Authorization** before an **Out-of-Network** follow-up appointment, you will be responsible for the full cost of the visit.

4. Out-of-Network Coverage for Full-Time Students

If your **Dependent** is a full-time student attending school outside of your **Health Plan's Service Area**, certain outpatient mental health services and treatment of alcohol or drug abuse will be

covered **Out-of-Network**, as required by Wis. Stat. § 609.655. See Mental Health and Substance Use Disorder Services below for more information.

Your **Dependent** may have a clinical assessment by an **Out-of-Network Provider** with **Prior Authorization** in writing from your **Health Plan**. If outpatient services are recommended, your **Dependent** will be allowed coverage for five (5) visits outside of the **Service Area** with **Prior Authorization** from your **Health Plan**. Your **Health Plan** may approve additional visits. If your student **Dependent** is unable to maintain full-time student status, they must obtain services from an **In-Network Provider** for treatment to be covered unless you are enrolled in the **Access Plan** or other **PPO Plan**.

5. Benefit Plans With Out-of-Network Access

Some **Benefit Plans** offered by **ETF** may include **Out-of-Network** coverage as a part of the **Benefit Plan**; these include the **Access Plan,** and any **Health Plan** that is considered a **PPO**. In addition, benefit designs for the **Medicare Advantage Plan** and Medicare Plus Plan also offer **Out-of-Network** coverage. Please refer to your **Access Plan Schedule of Benefits** or your **Evidence of Coverage** if you are enrolled in **Medicare Advantage** or the certificate of coverage for Medicare Plus (ET-4113). For the **Access** and **PPO Plans**, see the **Provider** directory supplied by your **Health Plan** for information about **In-Network Providers.**

6. Balance Billing When Out-of-Network

In cases where you are eligible for **Out-of-Network** coverage (e.g., your **Health Plan** has given **Prior Authorization** for care at an **Out-of-Network Provider**), the amount your **Health Plan** determines is reasonable to pay for your **Out-of-Network** services may be less than the amount your **Provider** billed. In these cases, you are held harmless for the difference between the billed and paid **Charge(s)**, other than the **Copayments**, **Coinsurance,** or **Deductibles** specified on your **Schedule of Benefits**.

The only exception to this is if you accepted financial responsibility in writing for specific treatment or services (that is, diagnosis and/or procedure code(s) and related **Charges**) before receiving services. This provision applies to all **Participants** including those in the **Access Plan** or other **PPO Plan**.

You may be responsible for costs beyond **Usual and Customary Charges** for services obtained from **Out-of-Network Providers** that are non-**Emergency** or non-**Urgent** and which were not previously approved for **In-Network** reimbursement by your **Health Plan** unless you are a **Participant** in the **Access Plan** or other **PPO Plan**.

If you receive **Emergency** or **Urgent Care,** or if you receive ancillary services from an **Out-of-Network Provider** as part of an **In-Network** service (for example, an **Out-of-Network** anesthesiologist for a surgery by an **In-Network** surgeon), you cannot be charged any more than your **In-Network Copayments, Coinsurance,** or **Deductible**. In the case of **Emergency** care, this includes **Post-Stabilization Care**. For more information about ancillary service coverage, see 4.F. Covered Services.

C. Cost Sharing May Apply

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

D. Medical Necessity

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

a. consistent with the symptom(s) or diagnosis and treatment of the **Participant**'s **Illness** or **Injury**; and
b. appropriate under the standards of acceptable medical practice to treat that **Illness** or **Injury**; and
c. not solely for the convenience of the **Participant**, physician, **Hospital** or other health care **Provider**; and
d. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the **Participant** and accomplishes the desired end result in the most economical manner.

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

E. Disease Management, Prior Authorizations, and Utilization Review

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

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

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

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

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

F. Covered Services

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

1. Advance Care Planning

Your policy covers **Advance Care Planning,** which can include developing healthcare directives, living wills, healthcare proxies, and healthcare power of attorney.

To assist you with documenting your future healthcare wishes in case of illness, accident, or sudden medical event, please contact your health plan or your Provider for more information.

2. Ambulance Services

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

3. Ancillary Services

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

4. Anesthesia Services

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

5. Autism Spectrum Disorders

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

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

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

a. Psychiatrist;
b. Psychologist;
c. Social worker;
d. Behavior analyst;
e. Paraprofessional working under the supervision of any of the above four types of **Providers**;
f. Professional working under the supervision of an outpatient mental health clinic
g. Speech-language pathologist; or
h. Occupational therapist.

Physical Therapy, Occupational Therapy, and Speech-Language Therapy limits do not apply to this benefit.

6. Back Surgeries

Prior Authorization may be required for **Referrals** to orthopedists and neurosurgeons if you have a history of low back pain but have not completed an optimal regimen of conservative care. **Prior Authorization** is not required if you have a clinical diagnosis that requires immediate or expedited orthopedic, neurosurgical or other specialty **Referral,** or for **Medicare Advantage**-enrolled **Participants**.

7. Bariatric Surgery

Bariatric surgery is covered for **Participants** with a body mass index (BMI) of 35 or greater, provided the **Participant** meets all criteria established by the **Health Plan**. Surgeries may be covered for **Participants** with a BMI of less than 35 as approved by the **Health Plan**. All bariatric surgery services may require **Prior Authorization** to obtain the surgery and associated preparatory services. **Prior Authorization** criteria is determined by the **Health Plan**.

8. Biofeedback

Biofeedback is covered when provided to treat the following conditions:

a. Headaches;
b. Spastic torticollis; or
c. Urinary incontinence.

Biofeedback is not covered for treatment of any other conditions; see Section 5. Exclusions, for additional information.

9. Cancer Clinical Trials

Your policy will cover routine patient care administered if you participate in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

10. Cardiac Rehabilitation

Phase I and Phase II cardiac **Rehabilitation Services** are covered by your **Benefit Plan.** Phase II services may require **Prior Authorization** from your **Health Plan** and provided in an outpatient department of a **Hospital**, in a medical center, or through a clinic program.

11. Case Management / Alternate Treatment

Your **Health Plan** employs a professional staff to provide case management services to help you manage complex medical conditions. As part of this case management, your **Health Plan** or your **Provider** may recommend that you consider receiving treatment for an **Illness** or **Injury** which differs from your current treatment if it appears that:

a. The recommended treatment offers at least equal medical therapeutic value, and
b. The current treatment program may be changed without jeopardizing your health, and
c. The costs (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If your **Health Plan** agrees to the **Provider's** recommendation, or if you or your authorized representative and the **Provider** agree to your **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, payment of **Benefits** will be as determined by the **Health Plan**.

12. Chiropractic Services

Chiropractic services are covered when performed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services) to treat an acute **Injury** or **Illness**. **Maintenance Care** is not covered. Your **Health Plan** may periodically review the treatment progress information provided by your **Provider** to ensure that your treatment plan is progressing.

13. Colorectal Cancer Screenings and Tests

Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m) and the Affordable Care Act are covered by your policy. Screening tests may be provided at no cost to you if you are in the age group recommended by the United States Preventive Services Task Force (USPSTF). Diagnostic tests or tests done outside of the recommended age group may be subject to cost sharing. See your **Schedule of Benefits** for details.

14. Congenital Defects and Birth Abnormalities

Treatment of **Congenital** defects and birth abnormalities is covered as required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d). Coverage includes treatment for the repair or restoration of any body part when necessary to achieve normal functioning. If required by Wisconsin law, this includes orthodontia and dental procedures if necessary to restore normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

15. Diagnostic Services

Medically necessary testing and evaluations are covered, including, but not limited to:

a. Radiology and lab tests given with general physical examinations;
b. Vision and hearing tests to determine if correction is needed;
c. Annual routine mammography screening; and
d. Home or laboratory sleep studies when ordered and performed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

Prior Authorization may be required for high-tech radiology tests including MRI, CT scans, and PET scans, except for **Medicare Advantage**-enrolled **Participants**. **Prior Authorization** may be required for other diagnostic services as determined by the **Health Plan**.

16. Drugs Administered in a Home Health or Health Care Setting

Your **Health Plan**, not the **PBM**, will be responsible for covering prescription drugs that are administered during home care, in an office setting, during a **Confinement**, **Emergency** room visit or **Urgent Care** setting, if those drugs are covered under the **GHIP**. Injectable and infusible medications, except for **Self-Administered Injectable** medications, are included in this coverage.

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

17. Durable Diabetic Equipment and Related Supplies

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

Durable diabetic equipment includes automated injection devices, continuous glucose monitoring devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year..

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

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

18. Durable Medical Equipment and Medical Supplies

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

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

a. Initial acquisition of artificial limbs, including replacements due to significant physiological changes, such as physical maturation, when medically necessary and when refitting of any existing prosthesis is not possible.
b. Casts, splints, trusses, crutches, prostheses, orthopedic braces, and appliances.
c. Custom-made orthotics, limited to one orthotic per foot per calendar year.

d. Rental or, at the option of the **Health Plan**, purchase of equipment including, but not limited to, wheelchairs and **Hospital**-type beds.
e. IUDs and diaphragms.
f. An initial external lens per eye when determined medically necessary to heal from surgery or needed due to a malformation of or injury to the eye.. Any subsequent lenses after the first lens will not be covered (See Section 5. Exclusions).
g. Elastic support hose, for example, JOBST, when prescribed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services). Limited to two pairs per calendar year.
h. One hearing aid per ear, as described in the **Schedule of Benefits**. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
i. Ostomy and catheter supplies.
j. Oxygen and respiratory equipment for home use.
k. Other medical equipment and supplies as approved by your **Health Plan**. Rental or purchase of equipment/supplies is at the option of the **Health Plan**.
l. Repairs, maintenance, and replacement of covered **Durable Medical Equipment** and **Medical Supplies**, including replacement of batteries. When determining whether to repair or replace the **Durable Medical Equipment** or **Medical Supplies**, your **Health Plan** will consider whether:
    1. The equipment/supply is still useful or has exceeded its lifetime under normal use, or
    2. Your condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Durable Medical Equipment models or devices that have features over and above that which are medically necessary will be limited to the standard model as determined by your **Health Plan**. This includes the upgrade of equipment, models, or devices to better or newer technology when the existing equipment, models, or devices are sufficient and there is no change in your condition nor is the existing equipment, model, or device in need of repair or replacement.

Cost sharing will apply as described in your **Schedule of Benefits**.

19. Emergency and Urgent Care

a. Emergency Care

Medical care for an **Emergency** is covered under your policy. When you go to an **Emergency** room, you may receive additional tests or treatments as a part of the **Emergency** room visit. Those tests or treatments are often billed separately from the visit itself, and you may be responsible for a **Copayment** or **Coinsurance** associated with those tests and treatments, in addition to your **Emergency** room visit **Copayment**. See your **Schedule of Benefits** for more details.

You should use an **In-Network Emergency** room whenever possible. If you are not able to go to an **In-Network Emergency** room, go to the nearest appropriate medical facility. You will be held harmless for any charges unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will

work with **Out-of-Network Emergency Providers** to settle claims and manage or reduce costs.

If you must go to an **Out-of-Network Emergency** room for care, you should call your **Health Plan** as soon as possible and tell your **Health Plan** where you received **Emergency** care. You must receive non-urgent follow-up care from an **In-Network Provider** unless you have received written **Prior Authorization** from your **Health Plan** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services without **Prior Authorization**)**.** If you have not received written **Prior Authorization** for **Out-of-Network** follow up care from your **Health Plan**, it will not be covered (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services without **Prior Authorization**). **Prior Authorization** for the follow-up care is at the sole discretion of the **Health Plan**. See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

To help ensure that your claims process correctly, it's recommended that you or another person on your behalf notify your **Health Plan** of any **Hospital** admissions or facility **Confinements** that happen following an **Out-of-Network Emergency** room visit as soon as reasonably possible.

Emergency services include reasonable accommodations for repair of **Durable Medical Equipment** if repairs are medically necessary.

b. Urgent Care.

If you experience an **Illness** or **Injury** that is not an **Emergency** but cannot safely wait to be treated until you can see your regular **Primary Care Provider**, you may choose to seek **Urgent Care** instead. You should seek care at an **In-Network Urgent Care** whenever possible. If you are not able to go to an **In-Network Urgent Care** because you are outside of your **Health Plan's Service Area**, you should visit the nearest, appropriate facility unless you are able to travel back to your **Health Plan's Service Area**.

If you must go to an **Out-of-Network Urgent Care**, you should notify your **Health Plan** by the next **Business Day** or as soon as otherwise possible and tell your **Health Plan** where you received care. This will help ensure your claims are paid. You will be held harmless for any charges unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will work with **Out-of-Network Urgent Care Providers** to settle claims and manage or reduce costs. Any follow-up care you need must be received from an **In-Network Provider** unless **Prior Authorization** was given by your **Health Plan** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services without **Prior Authorization**). See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

20. Extraction and Replacement of Teeth Due to Injury

Total extraction and/or total replacement (limited to bridge, denture or implant) of **Natural Teeth** by an **In-Network Provider** is covered when these services are needed because of an **Injury** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide

covered services). Crowns or caps for broken teeth instead of extraction and replacement may be considered if **Prior Authorization** was given by the **Health Plan** before the service is performed.

Your policy covers one retainer or mouth guard when medically necessary as part of prep work provided prior to covered tooth repair. **Injuries** caused by chewing or biting are not considered to be accidental for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

21. Gender Confirmation Treatments

Based on a permanent injunction issued on October 11, 2018 and the summary judgment decision issued on September 18, 2018 by the federal district court for the Western District of Wisconsin, all procedures, services, and supplies related to surgery and sex hormones associated with gender confirmation should be reviewed by the **Health Plan** for medical necessity. See Section 4. D. Medical Necessity for more information on this determination.

22. Genetic Testing/Genetic Counseling

Genetic testing and genetic counseling will only be covered when necessary to diagnose and treat an **Illness**. Testing for informational purposes that cannot reasonably lead to a course of treatment will not be covered.

23. Home Care Benefits

Home Care Benefits may be covered when medically necessary with a plan of care in place. An **In-Network Provider** must establish the plan of care, approve it in writing, and review it at least every two months unless the **Provider** determines that less frequent reviews are sufficient (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may establish the plan of care).

You are eligible for a maximum of fifty (50) visits per calendar year. Fifty (50) additional visits per calendar year may be available when **Prior Authorization** is received from the **Health Plan**.

Home Care Benefits means one or more of the following:

a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
c. Physical, occupational and speech therapy. These apply to the therapy maximum described in your **Schedule of Benefits.**
d. **Medical Supplies**, drugs and medicines prescribed by an **In-Network Provider** and lab services by or for a **Hospital** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe covered supplies, etc.). These are covered to the same extent as if you were **Confined** in a **Hospital**.
e. Nutritional counseling provided or supervised by a registered dietician.

This **Certificate of Coverage** also covers the assessment of the need for a home care plan and its development. A registered nurse, physician extender or medical social worker must do this. An attending physician must ask for or approve this service.

Home Care Benefits will not be covered unless the attending physician certifies that:

a. **Hospital Confinement** or **Confinement** in a **Skilled Nursing Facility** would be needed if home care were not provided.
b. The patient's **Immediate Family**, or others living with the patient, cannot provide the needed care and treatment without undue hardship.
c. A state licensed or **Medicare**-certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

If you are under **Hospital Confinement** when home care is requested, the home care plan must be approved at its start by the **Provider** who was the primary **Provider** of care during your **Hospital Confinement**.

Each visit by a person providing services under a home care plan, evaluating current needs, or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

Your **Health Plan** may give **Prior Authorization** for up to fifty (50) additional home care visits per calendar year if the visits continue to be medically necessary and are not otherwise excluded.

24. Hospice Care

Hospice Care, which may be **Inpatient** or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. **Hospice Care** is covered if your **Primary Care Provider** certifies that your life expectancy is 6 months or less and the care is palliative in nature. **Hospice Care** must be authorized by your **Health Plan**. **Hospice Care** includes, but is not limited to, **Medical Supplies** and services, counseling, bereavement counseling for one year after the patient's death, **Durable Medical Equipment** rental, home visits, and **Emergency** transportation. Coverage may be continued beyond a 6-month period if authorized by the **Health Plan**.

Hospice Care is available to you when you are **Confined**. **Inpatient Charges** are payable for up to a total lifetime maximum of thirty (30) calendar days of **Confinement** in a **Health Plan**-approved or **Medicare** certified **Hospice Care** facility.

When benefits are payable under both this **Hospice Care** benefit and **Home Care Benefits**, benefits payable under this subsection shall not reduce any benefits payable under the Home Care subsection.

Hospice Care must be provided through a licensed **Hospice Care Provider** approved by the **Health Plan**.

25. Hospital Services and Inpatient Confinements

Hospital services must be received at an **In-Network Hospital** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). In the case of non-**Emergency** care, your **Health Plan** reserves the right to determine in a reasonable manner the **Provider** to be used. In cases of **Emergency** or **Urgent Care** services, **In-Network Providers** and **Hospitals** must be used whenever possible and reasonable (See Emergency and

Urgent Care sections above). However, your **Health Plan** must hold you harmless from any effort by third parties to collect from the amount above the **Usual and Customary Charges** for services.

Hospital swing bed **Confinement** is considered the same as **Confinement** in a **Skilled Nursing Facility**.
Services necessary for your admission to a **Hospital**, as well as diagnosis and treatment are covered when they are provided by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). When you are in a health care facility, you agree to conform to the rules and regulations of that institution. Your **Health Plan** may require that your **Hospital** services receive **Prior Authorization.**

When you are **Confined** as an **Inpatient** in a **Hospital**, the **GHIP** covers a semi-private room, ward or intensive care unit and medically necessary miscellaneous associated **Hospital** expenses, including prescription drugs administered during the **Confinement**. A private room is payable only if medically necessary, as determined by the **Health Plan**.

If you are transferred or discharged to another facility for continued treatment of the same or a related condition, it is considered one **Confinement** for the purposes of determining coverage. Your **Health Plan** will administer claims and medical management services if you transfer between facilities.

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 that might occur during the **Confinement**.

If you change **Health Plans** while you are **Confined** as an **Inpatient**, your coverage at the current facility will continue under your prior **Health Plan**.

Except in cases where your coverage ends because you have voluntarily canceled your policy or you have not paid your **Premiums,** your **Benefits** will continue if you are **Confined** as an **Inpatient** until your attending physician determines that **Confinement** is no longer medically necessary, your maximum benefit is reached, the end of twelve (12) months after the date of termination, or the **Confinement** ceases, whichever occurs first.

26. Kidney Disease Treatment

Inpatient and outpatient kidney disease treatment is covered. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (additional information in Transplants below), donor-related services, and related physician **Charges**.

Treatments for end stage renal disease are also covered by your policy. If you are eligible for **Medicare** due to permanent kidney failure or end-stage renal disease, see Section 3.D. End Stage Renal Disease and Medicare Enrollment to learn more about how this may impact your **Premium** costs.

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

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

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

28. Mental Health and Substance Use Disorder Services

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

a. Outpatient services, meaning non-residential services provided by **In-Network Providers**, as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This benefit also includes services for a full-time student attending school in Wisconsin but out of the **Service Area,** as required by Wis. Stat. § 609.655.

   Outpatient services can include, but are not limited to:
   - Evaluation, diagnosis, medical services and psychotherapy.
   - Intervention and Presentation efforts
   - Day treatment
   - Lab tests, such as bloodwork
   - Consultations or follow-ups with a specialist

b. Transitional Services, meaning services provided in a less restrictive manner than **Inpatient** services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA.
   - An example includes, but is not limited to, when a patient leaves one care setting (e.g., hospital, nursing home, assisted living facility, skilled nursing facility, primary care physician, home health, or specialist) and moves to another.

   Inpatient services, provided by an **In-Network Provider** as described in **Schedule of Benefits** and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This includes court-ordered services as required by Wis. Stat. § 609.65, and these services are covered if performed by an **Out-of-Network Provider** if provided as required by an **Emergency** detention or on an **Emergency** basis. The **Provider** must notify the **Health Plan** within 72 hours after the initial provision of service.

   Inpatient services include, but are not limited to:
   - Hospital setting
   - Residential treatment environment
     - Psychiatric residential centers
     - Alcohol and drug rehabilitation facilities

- Detoxification Services
- Methadone Treatment

c. Family Counseling when it is part of developing or supporting you or your **Dependent's** treatment plan. (For **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

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

29. Nutritional Counseling

Nutritional Counseling is covered when provided by a participating registered dietician or an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). Nutritional Counseling specific to preparation for a covered bariatric surgery, with **Prior Authorization** from the **Health Plan**, is included.

Nutritional Counseling consists of the following services:

a. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician;
b. Re-assessment and intervention (individual and group);
c. Diabetes outpatient self-management training services (individual and group sessions); and
d. Dietitian visit.

Coverage limitations apply; see Section 5. Exclusions and Limitations below for detail.

30. Oral Surgery and Other Dental Services

Oral Surgery is covered in limited situations by your **GHIP** policy. You should contact your **Health Plan** prior to any oral surgery to determine if the service will be covered and if **Prior Authorization** by the **Health Plan** is required.

When performed by **In-Network Providers** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services), approved surgical procedures are as follows:

a. Surgical removal of impacted teeth and surgical or non-surgical removal of third molars.
b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
c. Frenotomy (Incision of the membrane connecting tongue to floor of mouth).
d. Surgical procedures required to correct accidental **Injuries** to the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
e. Apicoectomy (Excision of apex of tooth root).
f. Excision of exostoses of the jaws and hard palate.
g. Intraoral and extraoral incision and drainage of cellulitis.
h. Incision of accessory sinuses, salivary glands or ducts.
i. Reduction of dislocations of, and excision of, the temporomandibular joints.

j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related medically necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.
k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under this Certificate of Coverage) and associated osseous (removal of bony tissue) surgery.
l. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
m. Retrograde fillings when medically necessary following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

Coverage under the **GHIP** will also include **Hospital** or **ASC Charges** and related anesthetics for dental care if services are provided to a **Participant** who is under 5 years of age, has a medical condition that requires hospitalization or general anesthesia for dental care, or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

31. Palliative Care

A Participant's **Palliative Care** team may include **Providers** such as doctors, nurses, or social workers. These services are coordinated by a **Palliative Care** provider and must be Medically Necessary.

Note: Prior Authorization may be required for in-home **Palliative Care** services.

32. Physical, Speech and Occupational Therapy

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

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

33. Prescription Drugs and Other Benefits Administered by the PBM

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

34. Preventive Care and Immunizations

The **GHIP** covers all preventive care services that have received an A or B grade by the United States Preventive Services Task Force (USPSTF) without cost sharing to you when received

from an **In-Network Provider** as required by the Affordable Care Act, regardless of the **Benefit Plan** in which you are enrolled. Check with your **Provider** and your **Health Plan** to verify which services are recommended for you and your family.

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

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

35. Primary Care

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

Your **Health Plan** is required by **ETF** to ensure you have an assigned, **In-Network PCP** or **PCC**. If you do not choose a **PCP** or **PCC**, or your **PCP** or **PCC** is no longer available, your **Health Plan** will assign a **PCP** or **PCC**, notify you in writing, and provide instructions for changing the assigned **PCP** or **PCC** if you are not satisfied with their selection.

If you select a **PCP** or **PCC** that is **Out-of-Network**, your **Health Plan** will contact you within five (5) Business Days and will assist you in selecting an **In-Network PCP** or **PCC**.

36. Pulmonary Rehabilitation Therapy

Phase I and Phase II pulmonary **Rehabilitation Services** are covered as medically necessary by your **Benefit Plan** when provided by physicians, therapists, and other qualified providers**.** Phase II services may require **Prior Authorization** from the **Health Plan** and be provided in an outpatient department of a **Hospital**, in a medical center, or through a clinic program.

37. Radiation Therapy and Chemotherapy

These services are covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes, and chemotherapy drugs, are administered and billed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

38. Reproductive Services and Contraceptives

The services included in this section do not require a **Referral** to an **In-Network Provider** who specializes in obstetrics and gynecology; however, your **Health Plan** may require that you obtain **Prior Authorization** for some services or they may not be covered.

a. Maternity Services

Maternity services for prenatal and postnatal care are covered, including services such as normal deliveries, ectopic pregnancies, cesarean sections, abortions allowable under Wis. Stat. §40.03 (6) (m), and miscarriages. Maternity benefits are also available for a **Dependent** child who is covered under the **GHIP** as a **Participant**. However, this does not extend coverage to the newborn if the **Dependent** child is age 18 or older at the time of the birth.

In accordance with the federal Newborns' and Mother' Health Protection Act, an **Inpatient** stay for a birth will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer **Inpatient** stay is medically necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician and in consultation with the mother.

If you are in your second or third trimester of pregnancy when your **Provider** ends participation in your **Health Plan's Service Area**, you will continue to have access to that **Provider** until completion of postpartum care for you and your baby. **Prior Authorization** is not required for the delivery, but the **Health Plan** may request notification of the **Inpatient** stay prior to the delivery or shortly thereafter.

b. Contraceptive Services

Elective sterilization is covered by this policy, as are contraceptive methods as required by Wis. Stat. § 632.895 (17), including, but not limited to:

i. Oral contraceptives, or cost-effective **Formulary** equivalents as determined by the **PBM**, and diaphragms, as described under the prescription drug benefit in the Uniform Pharmacy Benefit.
ii. IUDs and diaphragms, as described under the Durable Medical Equipment section of this document.
iii. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

39. Second Opinions/Consults

In advance of a surgery or following a diagnosis, you may wish to seek a second opinion before proceeding with treatment. A second opinion is covered from an **In-Network Provider** or another **Provider** when **Prior Authorization** is received by your **Health Plan**.

40. Skilled Nursing Facilities

Confinement in a licensed **Skilled Nursing Facility** is covered as long as you are admitted within twenty four (24) hours of discharge from a **Hospital** for continued treatment of the same condition. Only **Skilled Care** is covered; **Custodial Care** is excluded.

Benefits include prescription drugs administered during the **Confinement**. **Confinement** in a swing bed in a **Hospital** is considered the same as a **Skilled Nursing Facility Confinement**. A maximum of one hundred twenty (120) calendar days per **Benefit Period** is covered for **Skilled Care**.

41. Speech and Hearing Screening Exams

Speech and hearing screening examinations are limited to the routine screening tests performed by an **In-Network Provider** for the purpose of determining the need for correction (for **Access**

Plan or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

42. Smoking Cessation

Coverage includes pharmacy products that require a written prescription and are described under the prescription drug benefits in the 2024 Uniform Pharmacy Benefits. Coverage also includes one (1) office visit for counseling and to obtain a prescription, and four telephonic counseling sessions per calendar year. Additional counseling and/or extension of pharmacological products may require **Prior Authorization** by the **Health Plan**.

43. Surgical Services

Surgical procedures, wherever performed, are covered when needed to care for an **Illness** or **Injury**. Coverage includes **Preoperative** and **Postoperative Care** and needed services of surgical assistants or consultants.

Prior Authorization may be required for **Referrals** to orthopedists and neurosurgeons for surgeries related to back pain for any **Participant** who has not completed an optimal regimen of conservative care for low back pain. **Prior Authorization** is not required for a **Participant** who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty **Referral**. This limitation does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

Participants seeking surgical treatment of low back pain must participate in a credible **Shared Decision-Making** program provided by the **Health Plan** or its contracted **Providers** consistent with the **Prior Authorization** requirement. This requirement does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

44. Telemedicine and Remote Care

Your **GHIP** coverage includes coverage for services provided remotely. Such services must provide at minimum consultation services that assist you in determining whether additional treatment for a condition should be sought. Such consultation services that result in a **Referral** to a different site of care rather than definitive treatment must be provided at no cost to you. Services that have definitive diagnoses and/or treatment may result in a cost. See your **Schedule of Benefits** for details.

The **Telemedicine** and remote care service types listed below are covered when provided by an **In-Network Provider** and results in no reduction in quality, safety, or effectiveness (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** provide covered services). **Health Plans** may create a review process to ensure that services provided by any of these methodologies meet quality, safety, and effectiveness standards.

a. E-Visits

E-Visits are covered by your plan. An **E-Visit** must be initiated by the **Participant** seeking services, not the **Provider**, in order to be covered. **E-Visits** are covered when the same service would be covered if provide in person when performed by:

i. A doctor
ii. A nurse practitioner
iii. A physician assistant

iv. Licensed clinical social workers
v. Clinical psychologists or psychiatrists
vi. Physical therapists
vii. Occupational therapists
viii. Speech language pathologists

Because **E-Visits** can be completed via messaging services, they may happen over several hours or even days.

b. Remote Patient Monitoring

Remote Patient Monitoring is covered by your plan under certain circumstances. The remote monitoring device that is used for services must be a home-use medical device as defined by the Food and Drug Administration (FDA), and must be provided as a part of the monitoring services, not billed separately. Devices are provided as a lease to you, and cannot be lease-to-own, purchased to own, or already owned by you. **Remote Patient Monitoring** is intended for long term conditions for which regular measurements need to be taken and must take place for a minimum of 16 calendar days for the service to be covered; monitoring for shorter time periods will not be covered. Devices may require **Prior Authorization** by your **Health Plan** in order to be covered.

c. Telehealth

Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care **Provider** who is located elsewhere using interactive two-way, real-time audio and video technology. **Telehealth** can be provided in your home, as well as at a health care facility.

Telehealth will be covered by your **Health Plan** if those services are delivered:

i. Outside of your physical presence (e.g., remotely);
ii. When both audio and video elements are present; and
iii. When there is no reduction in the quality, safety, or effectiveness of the service.

If you and your **Provider** determine that you cannot successfully complete a **Telehealth** visit with full audio and video, you may opt to change to a **Telephone Visit**.

Any service that is currently covered by your **Benefit Plan** and that can be administered remotely with no reduction in quality, safety, or effectiveness is covered when provided via **Telehealth**.

d. Telephone Visits

Telephone Visits will be covered if your **Provider** can successfully provide the service without a reduction in quality, safety, or effectiveness. **ETF** encourages **Participants** and **Providers** to determine the best technology solutions to fit their care needs. **Health Plans** may create review processes and criteria to ensure that services provided by audio only meet quality, safety, and effectiveness standards.

e. Virtual Check-Ins

Virtual Check-ins will be covered on their own as long as they are not related to a medical visit within the past seven (7) calendar days, and as long as they do not lead to a medical visit within the next twenty-four (24) hours or the next available appointment.

45. Temporomandibular Disorders

With **Prior Authorization**, as required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures involving a bone, joint, muscle, or tissue, and for any medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a. A **Congenital**, developmental, or acquired deformity, disease or **Injury** caused the condition;
b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care **Provider** rendering the service; and
c. The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.

This includes coverage of non-surgical treatment but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the **Durable Medical Equipment Coinsurance** as outlined in your **Schedule of Benefits**. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

46. Transplants

Transplants and related services are covered when ordered by a physician. All transplants except corneal transplants may require **Prior Authorization**. The medical necessity and appropriateness of a transplant will be determined by medical professionals reviewing each case on behalf of the **Health Plan**.

Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ procurement costs include organ transplantation, compatibility testing, hospitalization, and surgery (when a live donor is involved).

Donor expenses are covered only when the recipient of the transplant is a **Participant** in the **GHIP** and when such charges are included as part of the **Participant's** (as the transplant recipient) bill.

Transplants must be performed at a facility designated by the **Health Plan**.

47. Travel-Related Preventive Care

Medically necessary travel-related preventive treatment is covered by your **GHIP** policy. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever, and Hepatitis A vaccinations are covered if determined to be medically appropriate by your **Health Plan**. Coverage does not apply to travel required for work. (See Section 5. Exclusions below.)

48. Vision Services

Coverage is limited to one routine eye exam per **Participant** per calendar year. Non-routine eye exams are covered as medically necessary, as determined by your **Health Plan**. Contact lens fittings are not part of the routine exam and are not covered.

Vision screenings for **Participants** age 5 and younger are considered preventive and are not subject to **Deductible** or office visit **Copayments** when provided by an **In-Network Provider**.

Vision screenings for **Participants** age 6 and older are not considered preventive and are subject to **Deductible** and specialty **Provider** office visit **Copayment** as applicable.

Two visits for orthoptic eye training are covered per lifetime per **Participant;** the first session for training, the second for follow-up. All additional visits are excluded.

5. Exclusions and Limitations

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

A. Excluded Services

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

1. Administrative and Clerical Charges

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

2. Care Needed for Employment

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

3. Cosmetic Treatments and Services

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

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

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

v. humidifiers
vi. physical fitness equipment
vii. physician's equipment
viii. disposable supplies
ix. alternative communication devices (for example, electronic keyboard for a hearing impairment)
x. self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons
xi. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts
xii. Customization of buildings for accommodation (for example, wheelchair ramps)
xiii. Replacement or repair of **Durable Medical Equipment** or **Medical Supplies** damaged or destroyed by the **Participant** or lost or stolen
xiv. Cold therapy and continuous passive motion devices
xv. Home testing and monitoring supplies unless **Prior Authorization** is received from your **Health Plan**
xvi. Equipment required for **Telehealth** visits

5. Experimental and Investigational Treatments

a. **Experimental** services, treatments, procedures, equipment, drugs, devices or supplies, 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).
b. 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:
   i. whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis
   ii. 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
   iii. the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply
   iv. whether other, more conventional methods of treating the **Illness** or **Injury** have been exhausted by the **Participant**
   v. whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated
   vi. 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
c. Coma stimulation programs.

6. Holistic/Homeopathic Treatments

a. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
b. Hypnotherapy.

7. Hospital Inpatient Services
    a. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.
    b. **Hospital** stays which are extended for reasons other than medical necessity.
    c. A continued **Hospital** stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, **Skilled Nursing Facility**.

8. Included or Bundled Services
    a. Treatment, services and supplies for which the **Participant** has no obligation to pay or which would be furnished to a **Participant** without charge. These include services or supplies that are typically billed as a part of another service when the service cannot be provided without using the supply or service (e.g., gauze used during surgeries, remote monitoring appliance, etc.). These are sometimes referred to as “bundled services.”

9. Informational Medical Exams and Testing
    a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in Section 4. F. Covered Services.
    b. Genetic testing and/or genetic counseling services not medically necessary to diagnose and treat and **Illness**.

10. Injuries Resulting from Military Action
    a. **Injury** or **Illness** caused by an atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
    b. 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.

11. Non-Medically Necessary Residential and Personal Care Services
    a. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the **GHIP**.
    b. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
    c. Residential care except residential care and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.
    d. Private Duty Nursing / Personal Care.
    e. Services provided by members of the **Subscriber’s Immediate Family** or any person residing with the **Subscriber**.

12. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in Section 4.F. Covered Services, Oral Surgery and Other Dental Services above, or which would be covered if it was performed by a physician and is within the scope of the dentist's license.
b. All dental, periodontal, endodontic, or oral surgical procedures not specifically listed in Section 4.F. Covered Services above.

13. Other Non-Covered Services

a. Services provided by **Out-of-Network Providers**, unless you are enrolled in the **Access Plan** or other **PPO Plan**. This includes non-physician services provided by an **Out-of-Network Provider**, unless you have received **Prior Authorization** from your **Health Plan**, the service is an **Emergency** or **Urgent Care** service outside of the **Service Area**, or an **Emergency** in the **Service Area** when your **Primary Care Provider** cannot be reached. See Section 4. B. Exceptions to In-Network Care Requirement for more information.
b. Services of a specialist without an **In-Network Provider's** written **Referral**, except in an **Emergency** or by written **Prior Authorization** of the **Health Plan.**
c. Any **Hospital** or medical care or service not provided for in this document unless authorized by the **Health Plan**.
d. Charges directly related to a non-covered service, 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 has received **Prior Authorization** from the **Health Plan**. The treatment of the complication must be a covered benefit of the **Health Plan** and **PBM**.
e. Any smoking cessation program, treatment, or supply that is not specifically covered in Section 4. F. Covered Services, Smoking Cessation.
f. Marriage/couples/family counseling. See Mental Health and Substance Use Disorder Services for exceptions.

14. Reproductive Services

a. Infertility services which are not for treatment of **Illness** or **Injury** (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an **Illness**.
b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
c. Services for storage or processing of sperm; donor sperm.
d. Harvesting of eggs and their cryopreservation.
e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related **Hospital**, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
f. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
g. Services of home delivery for childbirth.
h. Sexual counseling services related to infertility.

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

15. Routine Foot Care

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

16. Services Covered by Other Payors

a. Services to the extent the **Participant** is eligible for all **Medicare** benefits, regardless of whether or not the **Participant** is actually enrolled in **Medicare**. This exclusion only applies if the **Participant** enrolled in **Medicare** coordinated coverage and does not enroll in **Medicare Parts A and/or B** when they are first available as the primary payor, or who subsequently cancels **Medicare** coverage, or is not enrolled in a **Medicare Part D Plan**. See Section 2. F. Medicare Enrollment.
b. Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which the **GHIP** is the primary payor, and the VA is the secondary payor under applicable federal law. **Benefits** are not coordinated with the VA unless specific federal law requires such coordination.
c. Treatment, services, and supplies to which the **Participant** would be entitled to have furnished or paid for, fully or partially, under any law, regulation, or agency of any government.
d. Treatment, services, and supplies to which the **Participant** would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government if this contract was not in effect.
e. Services that a child's school is legally obligated to provide, whether the school actually provides the services and whether the **Participant** chooses to use those services.
f. Services to the extent a **Participant** receives or is entitled to receive, any **Benefits**, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means the **Participant** is actually insured under Worker's Compensation.

17. Services Not Medically Necessary

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

18. Services Outside of Enrollment

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

19. Services Related to the Commission of a Crime

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

20. Therapies Not Covered

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

21. Transplants and Donor-Related Services

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

22. Travel and Transportation

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

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

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

c. Food or food supplements except when provided during a covered outpatient or **Inpatient Confinement**.

24. Vision Correction

a. Eyeglasses or corrective contact lenses and fitting of those contact lenses, except lenses that are medically necessary to heal from a surgery or are needed due to a malformation of or injury to the eye.
b. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens.
c. Keratorefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.

B. Coverage Limitations

1. Major Disaster, Epidemic, or Pandemic

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

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

2. Circumstances Beyond the Health Plan's Control

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

6. Coordination of Benefits

A. Applicability

This **Coordination of Benefits** (**COB**) provision applies to the **GHIP** when a **Participant** has health care coverage under more than one **Plan** at the same time.

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

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

B. Order of Benefit Determination Rules

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

1. The other **Plan** has rules coordinating its benefits with those of the **GHIP**, and
2. Both those rules and the **GHIP's** rules described in the Rules subsection below require that the **GHIP's** benefits be determined before those of the other **Plan**.

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

1. Non-**Dependent**/**Dependent**
   a. The benefits of the **Plan** which covers the person as an employee or **Participant** are determined before those of the **Plan** which covers the person as a **Dependent** of an **Employee** or **Participant**.

2. **Dependent** Child/Parents Not Separated or Divorced
   Except as stated in paragraph 3. below, when the **GHIP** and another **Plan** cover the same child as a **Dependent** of different persons, called "parents":
   a. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year are determined before those of the **Plan** of the parent whose birthday falls later in that calendar year; but
   b. If both parents have the same birthday, the benefits of the **Plan** which covered the parent longer are determined before those of the **Plan** which covered the other parent for a shorter period of time.

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

3. **Dependent** Child/Separated or Divorced Parents
   If two or more **Plans** cover a person as a **Dependent** child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the **Plan** of the parent with custody of the child;
   b. Then, the **Plan** of the spouse of the parent with the custody of the child; and

c. Finally, the **Plan** of the parent not having custody of the child.

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

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

4. Active/Inactive Employee
   The **Benefits** of a **Plan** which covers a person as an employee who is neither laid off nor retired or as that employee's **Dependent** are determined before those of a **Plan** which covers that person as a laid off or retired employee or as that employee's **Dependent**. If the other **Plan** does not have this rule and if, as a result, the **Plans** do not agree on the order of benefits, this paragraph 4. is ignored.

5. Continuation Coverage
   If a person has continuation coverage under federal or State law and is also covered under another **Plan**, the following shall determine the order of benefits:
   a. First, the benefits of a **Plan** covering the person as an employee, member, or **Subscriber** or as a **Dependent** of an employee, member, or **Subscriber**.
   b. Second, the **Benefits** under the continuation coverage.

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

6. Longer/Shorter Length of Coverage
   If none of the above rules determines the order of benefits, the **Benefits** of the **Plan** which covered an employee, member or **Subscriber** longer are determined before those of the **Plan** which covered that person for the shorter time.

C. Effect on the Benefits of the GHIP

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

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

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

When the **Benefits** of the **GHIP** are reduced as described above, each **Benefits** is reduced in proportion. It is then charged against any applicable benefit limit of the **GHIP**.

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

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

G. Subrogation

Each **Participant** agrees that the payor under the **GHIP**, whether that is a **Health Plan** or **ETF**, shall be subrogated to a **Participant's** rights to damages, to the extent of the **Benefits** the **Health Plan** provides under the policy, for **Illness** or **Injury** a third party caused or is liable for. It is only necessary that the **Illness** or **Injury** occur through the act of a third party. The **Health Plan's** or **ETF's** rights of full recovery may be from any source, including but not limited to:

1. The third party or any liability or other insurance covering the third party;
2. The **Participant's** own uninsured motorist insurance coverage;
3. Under-insured motorist insurance coverage; and
4. Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

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

In the event the **Participant** can recover any amounts, for an **Injury** or **Illness** for which the **Health Plan** or **ETF** provides **Benefits**, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee **Benefit** act, the **Participant** shall either assert and process such claim and immediately turn over to the **Health Plan** or **ETF** the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the **Health Plan** or **ETF** in writing to prosecute such claim on behalf of and in the name of the **Participant**, in which case the **Health Plan** or **ETF** shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a **Participant** fails to comply with the subrogation provisions of this **Agreement**, particularly, but without limitation, by releasing the **Participant's** right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee **Benefit** act, as part of settlement or otherwise, the **Participant** shall reimburse the **Health Plan** or **ETF** for all amounts theretofore or thereafter paid by the **Health Plan** or **ETF** which would have otherwise been recoverable under such acts and the **Health Plan** or **ETF** shall not be required to provide any future **Benefits** for which recovery could have been made under such acts but for the **Participant's** failure to meet the obligations of the subrogation provisions of this **Agreement**. The **Participant** shall advise the **Health Plan** or **ETF** immediately, in writing, if and when the **Participant** files or otherwise asserts a claim for **Benefits** under any workmen's or worker's compensation act, disability benefit act, or other employee **Benefit** act.

7. Member Rights and Responsibilities

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

A. New Rights to Benefits Transparency (Rules Pending)

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

B. Disenrollment Due to Fraud

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

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

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

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

C. Enrollment Change Due to Member Behavior

In situations where a **Participant** has committed acts of physical or verbal abuse or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate

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. 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 within the **Health Plan** and/or **PBM** but also disclosures to:

1. Health care **Providers** as necessary and appropriate for treatment;
2. Appropriate **ETF** employees as part of conducting quality assessment and improvement activities, or reviewing the **Health Plan's** or **PBM's** claims determinations for compliance with contract requirements, or other necessary health care operations; and
3. The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

E. 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 under the **GHIP** (including, without limitation, issues relating to subrogation and **Coordination of Benefits**). By execution of an application for coverage under the **Health Plan**, 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.

F. Proof of Claim

It is the **Participant's** responsibility to notify their **Providers** of participation in the **Health Plan** and **PBM**.

The **Participant's** failure to notify an **In-Network Provider** of membership in the **GHIP** may result in claims not being filed on a timely basis (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This could result in a delay in the claim being paid.

If a **Participant** received allowable covered services (in most cases only emergencies or urgent care) from an **Out-of-Network Provider** outside the **Service Area**, the **Participant** must obtain and submit an itemized bill and submit to the **Health Plan** clearly indicating the **Provider's**

name and address (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may submit claims for covered services to the vendor). 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 the 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 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.

8. Grievances and Appeals

A. Grievance Process

All participating **Health Plan**s and the **PBM** are required to make a reasonable effort to resolve **Participants'** problems and complaints. If the **Participant** has a complaint regarding the **Health Plan**'s and/or **PBM's** administration of these **Benefits** (for example, denial of claim or **Referral**), the **Participant** should contact the **Health Plan** and/or **PBM** and try to resolve the problem informally. If the problem cannot be resolved in this manner, the **Participant** may file a written **Grievance** with the **Health Plan** and/or **PBM**. Contact the **Health Plan** and/or **PBM** for specific information on its **Grievance** procedures.

If the **Participant** exhausts the **Health Plan's** and/or **PBM's Grievance** process and remain dissatisfied with the outcome, the **Participant** may appeal to the **ETF** by completing an ETF Insurance Complaint form (ET-2405). The **Participant** should also submit copies of all pertinent documentation including the written determinations issued by the **Health Plan** and/or PBM. The **Health Plan** and/or **PBM** will advise the **Participant** of their right to appeal to the **ETF** within sixty (60) calendar days of the date of the final **Grievance** decision letter from the **Health Plan** and/or **PBM**. Ombudsperson Services can provide additional information and assistance with this process.

However, the **Participant** may not appeal to **ETF** issues which do not arise under the terms and conditions of this **Certificate of Coverage**, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, **Experimental** treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or State law. The **Participant** may request an external review. In this event, the **Participant** must notify the **Health Plan** and/or **PBM** of their request. Any decision rendered through an external review is final and binding in accordance with applicable federal or State law. The **Participant** has no further right to administrative review once the external review decision is rendered.

B. Appeals to the Group Insurance Board

After exhausting the **Health Plan's** or **PBM's Grievance** process and review by **ETF**, the **Participant** may appeal **ETF's** determination to the **Board**, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or State law. The **Board** does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of this **Certificate of Coverage**, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, **Experimental** treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or State law. These appeals are reviewed only to determine whether the **Health Plan** and/or **PBM** breached its contract with the **Board**.