



STATE OF WISCONSIN  
Department of Employee Trust Funds  
Eric O. Stanchfield  
SECRETARY

801 W Badger Road  
PO Box 7931  
Madison WI 53707-7931

1-877-533-5020 (toll free)  
Fax (608) 267-4549  
TTY (608) 267-0676  
<http://etf.wi.gov>

**CORRESPONDENCE MEMORANDUM**

**DATE:** April 2, 2007  
**TO:** Group Insurance Board  
**FROM:** Bill Kox, Director, Health Benefits & Insurance Plans  
Joan Steele, Manager, Alternate Health Plans  
**SUBJECT:** Guidelines and Uniform Benefits for the 2008 Benefit Year

**Background**

Annually, the Group Insurance Board (Board) reviews its Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program (ET-1136). As part of this review, necessary changes are made to the health insurance contract and the Uniform Benefits package. As in the past, there will be no net material change in the overall benefit level.

A study group met on February 20 and March 8 to establish recommendations contained in this memo for the Board's consideration. The attached tables also include other relevant clarifications that are not specifically discussed in this memo.

The study group was attended by Barb Belling, Office of Commissioner of Insurance (OCI); Paul Hankes, Office of State Employment Relations (OSER); Jim Pankratz, OSER; Paul Ostrowski, OSER; and the following Department of Employee Trust Funds (Department) staff: Tom Korpady, Bill Kox, Joan Steele, Arlene Larson, Jeff Bogardus, Ron Harms, Nancy Nankivil Bennett, Bob Conlin, Steve Hurley, Liz Doss-Anderson, and Christina Keeley.

**Action Requested**

**The study group recommends that the Board adopt the changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.**

Please note that as staff continues to refine Uniform Benefits, further contract changes may be necessary. For example, we may need to further clarify the coordination of the pharmacy benefit for participants with other health insurance coverage. Staff will bring any notable changes back to the Board but is also requesting authority to proceed with any needed technical clarifications.

Reviewed and approved by Tom Korpady, Division of Insurance Services.	
_____	_____
Signature	Date

Board	Mtg Date	Item #
GIB	4/17/2007	2

Attached are the following:

- **Attachment A** – This table explains the basis for any notable changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B** – Excerpts from the Guidelines, Addendum, and State and Local Contracts with recommended modifications for 2008. There are no net cost implications for these recommended changes.
- **Attachment C** – This table explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** – Excerpts from Uniform Benefits, with recommended modifications for contract year 2008.

The impetus for these proposals comes from the Board, participants, health plans and staff. Health plans were informed of some proposed changes via e-mail on January 23. In response to comments from plan administrators, some minor revisions were considered and/or made when developing the recommendations contained in this memo. Comments on these recommendations from specific plan administrators are available from staff upon request.

Some changes are clarifications or specific statements of existing practice; other revisions are more substantive. Changes under discussion are shown with **redlining** of new language and ~~striking out~~ of language to be deleted. There are also a few changes shown in Attachments B (Guidelines/Addendum/Contracts) and D (Uniform Benefits) that are not described on the tables or discussed below. We consider these to be minor modifications or clarifications of current practice.

Where appropriate, the recommendations also apply to the Wisconsin Physicians Service (WPS) contracts for the Standard Plans and staff will make the necessary changes.

### **RECOMMENDED CHANGES TO THE GUIDELINES AND STATE AND LOCAL CONTRACTS**

- 1) **Quality Initiatives:** The group discussed language changes and clarifications for health plans to further support quality and recommends adding a provision for health plans to support technology and automation, for example, a diabetes registry.
- 2) **Incorporating Value-Added Data into Addendum Submission:** The group discussed and recommended advancing the addendum due date by two weeks to allow the Board's actuary more time to analyze the data and requesting that data related to spine care and emergency room care be provided by a later due date. Health plans prefer not to have an earlier due date but did not explain why. Staff nevertheless recommends these changes, which the group supports.
- 3) **Review of Provider Criteria for Determining Tier 1, Qualified Plan:** In follow-up to a request from an employer, the group discussed the determination of the Tier 1, qualified plan. It is believed that current process allows flexibility to ensure the Tier 1, qualified plan provides adequate access. However, the group recommends a contract language clarification. Staff will discuss this in greater detail at the meeting.

### **RECOMMENDED CHANGES TO THE LOCAL CONTRACT:**

- 1) **Underwriting:** In the past, the Board has approved implementing an underwriting process to protect the program from large employers (100 or more eligible employees) with poor risk characteristics from adversely affecting the pool when they join the program by assessing a

variable surcharge for up to 24 months based on the risk of the group. The group recommends that the underwriting be expanded to employers with 51 or more eligible employees. While some employers that want to enter the program may be affected, we believe that the employers currently in the program would support this change. The Board's actuary is in favor of this change, stating it is the standard in the industry and will help protect the program. Health plans are also in favor of this change. Staff recommends this change.

- 2) **Deductible Option:** To prevent its value from compressing over time, the group considered increasing the deductible amounts on the deductible option in the local employer plan from \$500 per individual/\$1000 per family to \$600 per individual/\$1200 per family. This is based on the recommendation of the Board's actuary. Staff has contacted the employers who would be affected by such a change and only one employer was in favor of the change. The remaining responses ranged from neutral to opposed. As an alternative, the ratio for the premium bid range can be modified to 92% of the non-deductible option plan. Currently, the upper range is 90%. Thus, while the deductible plan was intended to be a 10% savings over the non-deductible option plan, it is now approximately an 8% savings. Staff recommends that this be set by the actuary upon review of the claims information due in June.

### **RECOMMENDED CHANGES TO UNIFORM BENEFITS**

Cost-neutral recommendations. As described below, the group recommends the following benefit change that is cost-neutral. The group recommended the pharmacy out-of-pocket (OOP) maximum either be increased for its full relative value or be revised to be a plateau, at which point, after the OOP is met, the copayment for Level 2 drugs would be reduced. Staff believes the plateau provides a more appropriate benefit design structure.

- 1) **Pharmacy Annual OOP Maximum:** The annual OOP maximum is currently \$320 per individual/\$640 per family. Although it was increased for 2007, it was not increased from 2004 through 2006 in accordance with the change in relative value of the original Uniform Benefits maintenance drug list. According to the Board's actuary, if the OOP maximum is increased according to the change in its relative value for the three years during which it was not adjusted, it should be \$410 per individual/\$820 per family in 2008. Alternatively, it could be increased enough to maintain its value for one year and to keep it from falling further behind. To maintain the OOP value from last year, the OOP maximum would be \$340/\$680.

As an alternative to increasing the OOP maximum, it could be changed to a plateau. Under this alternative, after the plateau is met, the copayment for Level 1 drugs is waived, and the copayment for Level 2 drugs is reduced from \$15 to \$6. This would create a stronger incentive for participants to utilize drugs in Level 1 whenever possible. The Department's Medical Adviser believes the high number of generics that have been made available on the market in the past few years makes this a viable option as there are more drugs in Level 1. The Board's actuary indicates adopting the plateau with the Level 2 copayment reduced to \$6 is cost-neutral as an alternative to raising the OOP maximum. The group acknowledges the plateau may make it more difficult for participants to predict expenses for their medical flexible spending accounts for the upcoming year. However, there is now a grace period that allows participants to incur expenses through March 15 and be reimbursed from the previous year's contributions.

Recommendations affecting costs. As described below, the group recommends the following benefit changes with a cost impact. If the Board decides to add coverage for flu shots administered at employer sites, coverage can also be added for dental implants following an accidental injury. These benefit increases can be offset by charging a differential for the use of brand name drugs over the generics when it is requested.

- 2) **Pharmacy Brand-Generic Differential:** The group discussed charging participants the difference between brand name and generic drugs when the participant specifically requests the brand name drug. The per member per month (PMPM) savings is \$0.20. The pharmacy benefit manager (PBM) indicates this would affect approximately 1100 members. The group recommends pursuing this change if necessary to offset costs for other benefit additions.
  
- 3) **Flu Shots Administered at Employer Sites:** Most health plans currently provide coverage for flu shots administered at employer sites when the flu shot providers are in their networks. As requested by the Office of State Employment Relations, the group discussed requiring health plans to cover flu shots administered at employer sites, even when the flu shot provider is not in the health plan's network. The PMPM cost is \$0.05 to add this benefit with the health plan paying up to its negotiated fee and the participant paying the balance. This assumes a 5% increase in flu shot utilization. If the benefit is added with the health plans bearing the full cost of the flu shot when administered by a provider that is not in their network, the Board's actuary indicates in the long-term, the health plans could bear additional costs of up to \$0.03 through increased utilization and weakened bargaining power of health plans to negotiate the most cost-effective rates with flu shot providers.

Health plans expressed concerns over the administration of this benefit if required to coordinate with providers that are not part of their network. Concerns include cost-effective ways to administer the benefit, the ability for flu shot providers to charge excessive fees, and concern that this is an employer-directed service that is typically not covered by health insurance. Staff is not supportive of this benefit change because it impedes the health plans' ability to provide cost-effective care. If the Board chooses to include this benefit, staff recommends the benefit be limited to the health plan's negotiated fee.

- 4) **Dental Implants Following Accidental Injury:** The group considered allowing coverage for dental implants under the accidental loss of teeth provision, as dental implants are becoming a standard of care as well as a more cost-effective treatment option in some situations. If the benefit is capped at \$1100 per incident, the cost impact is \$0.12 PMPM. The group recommends this benefit change if offsetting cost savings are identified.

**Summary of Cost Impact of Recommended Changes**

<b>Benefit Increases</b>	<b>PMPM</b>
Flu Shots at Employer Sites	\$0.05 -.08
Dental Implants (\$1100 cap/incident)	<u>\$0.12</u>
<b>Total</b>	<b>\$0.17 - .20</b>

<b>Benefit Reductions</b>	<b>PMPM</b>
Pharmacy Brand/Generic Differential	<u>\$0.20</u>
<b>Total</b>	<b>\$0.20</b>

**DISCUSSION OF OTHER ISSUES**

Other issues were considered by the study group but did not result in recommended benefit changes. Staff will provide additional information about any of these issues upon request.

- 1) **Premium Refunds Upon Termination of Contract:** The group discussed limiting premium refunds to health plans and employers when they do not timely notify the Department of the contract termination date. This will help limit the liability for prescriptions that were paid by the pharmacy benefit manager (PBM) due to the untimely reporting. Health plans generally offered mild support for this change as long as it was not too punitive and indicated reporting delays may occur due to the paper-laden process. The group recommends staff continue to work with health plans and employers on this topic and to pursue this in the future if it continues to be problematic.
- 2) **Removal of Opt-Out Provisions for Local Employers:** It is our understanding some local employers have been unsuccessful in removing opt-out provisions from labor agreements. Opt-out provisions provide financial incentives to employees who decline coverage in the local program. To protect this program from the adverse selection caused by the opt-out provisions, the group considered adding a surcharge to the premium for those local employers. The group recommends the surcharge be pursued at a future date, which will provide local employers a final opportunity to remove opt-out provisions from labor agreements to avoid a surcharge.
- 3) **Malocclusion Benefit:** The group discussed including as a benefit the surgical treatment of malocclusions when there is not a diagnosis of temporomandibular joint (TMJ). The cost impact to add coverage for surgical treatment of Class II and Class III malocclusions, assuming a typical medical policy is implemented, is \$0.45 - \$0.50 PMPM during the initial year due to pent-up demand, and \$0.35 in subsequent years. The Department's Medical Adviser indicated there is a lack of evidence-based documentation on the effectiveness of the surgery. In general, health plans did not support this change because of difficulty in determining medical necessity. Because coverage is available under the Standard Plan when medically necessary and under the Uniform Benefits when there is a diagnosis of TMJ, the group does not recommend adding coverage in Uniform Benefits for the surgical treatment of malocclusion.
- 4) **Emergency Room Visit Copayments:** The group considered increasing the emergency room visit copayment from \$60 to \$75, which would result in a PMPM savings of \$0.22. In addition, the group discussed whether contract language should be changed to specify that the emergency room visit copayment is waived for admissions coded as observation but lasting 24 hours or more. The group decided not to recommend either change. While the higher copayment may help direct care to more appropriate settings, some felt it might also hinder some from getting appropriate medical care in emergency situations. Also, it is believed the coding of observation stays lasting more than 24 hours is an issue with one particular hospital, which will be addressed with the assistance of the health plan.
- 5) **Imaging Copayment:** The group discussed adding a copayment for imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans, based on trends of increased utilization and costs. The PMPM savings from a \$20 copayment per visit is \$0.15 for MRIs and \$0.22 for CT scans. The Board's actuary and health plans were in favor of adding a copayment. However, the group felt the health plans should work with their doctors who over-utilize the service and that the benefit should be re-designed so that a copayment would not apply to the first imaging service but only to subsequent services. This will be pursued in future years.

- 6) **Kidney Disease Benefit:** If the current benefit for kidney disease were revised to follow the Wisconsin mandate, it would result in a PMPM savings of \$0.40. While health plans are in favor of this change, it may negatively affect the few annuitants and foreign students who are not eligible for Medicare. Thus, the group does not recommend pursuing it at this time.
- 7) **Weight Loss Surgery (Gastric Bypass) Benefits:** The group again considered whether Uniform Benefits should include coverage for the surgical treatment of obesity (e.g., gastric bypass), which has been requested by numerous participants as well as a provider group, UW Health Bariatric Program. The PMPM cost to add the benefit is \$5.39 initially due to pent-up demand, and \$3.59 thereafter. If benefits were added for 80% coverage, the PMPM cost is \$4.20 initially and \$2.80 thereafter. The group concurred that adding a benefit to Uniform Benefits for the surgical treatment of obesity will require substantial benefit decreases in order to maintain the overall benefit level as required by statute. As the treatment may be covered under the Standard Plan if it meets WPS's medical necessity criteria, the group does not recommend adding this benefit for 2008. The group does recommend clarifications to related exclusions.
- 8) **Alcohol and Other Drug Abuse (AODA) Benefits:** The group discussed increasing the benefits for AODA services. In light of the Governor's budget recommendations for coverage of mental health and substance abuse, the group decided not to pursue benefit changes at this time.
- 9) **Developmental Delay Benefits:** The group discussed adding a limited benefit for treatment of developmental delay. In light of the Governor's budget recommendations for coverage of autism and pervasive developmental disorders, the group decided not to pursue benefit changes at this time.
- 10) **Bone Marrow/Transplants Benefits:** Periodically, the transplant benefit is reviewed to ensure it meets the standards of care. Specifically, the issue has been raised by a participant that harvesting and preserving bone marrow is a standard of care and is not covered under Uniform Benefits in some situations. The majority of health plans indicated the current contract language reflects current standards of care. Thus, no benefit changes are recommended for 2008. However, to ensure a thorough, evidence-based review, the Department's Medical Adviser anticipates reviewing this benefit with a medical advisory group later in the year with any recommended changes to be considered for 2009.
- 11) **Cranial Orthotics (Cranial Band/Soft-Shell Helmet) Benefits:** The group discussed whether language should be added specifying coverage of cranial orthotics due to a request from a participant. Currently, the overwhelming majority of health plans provide coverage of cranial orthotics when they determine it to be medically necessary. The group decided not to pursue any contractual changes as current language allows for the benefit.
- 12) **Specialty Drugs Benefit Administration:** The group discussed changing the administration of certain high-cost specialty drugs given in physician offices from the health plans to the PBM. This will be pursued in 2009 to allow time to work through the detailed changes necessary for a smooth transition.

Staff will be available at the Board meeting to respond to any questions or concerns. We again thank the guidelines discussion group members for their participation in this process.

## Notable Changes Under Consideration for the 2008 Guidelines, Addendum, and State and Local Contracts

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	State Contract	Local Contract		
Guidelines I. & II., D., 15. Page 1 & 4			Updated language to reflect state employees are under the tiered approach for determining premium contribution share.	To reflect current practice.
Guidelines II., D. Page 2			<ul style="list-style-type: none"> <li>a) Clarified language for the quality initiatives in which plans are expected to participate.</li> <li>b) Add language requiring plans to submit annual reports on their activities to manage care, e.g., disease management.</li> </ul>	<ul style="list-style-type: none"> <li>a) To be consistent with changes made in past to the Addendum 1C.</li> <li>b) To reflect the new requirement for plans to submit this information annually.</li> </ul>
Guidelines II., D. Page 3			<ul style="list-style-type: none"> <li>a) Added language requiring plans to demonstrate their support for technology and automation.</li> <li>b) Clarified language on holding members harmless when applying usual and customary charges and added language for plans to make available their nationwide network when there is no cost for doing so.</li> </ul>	<ul style="list-style-type: none"> <li>a) Refer to discussion item #1 on page 2 of the memo.</li> <li>b) To clarify hold harmless due to misinterpretations by a plan and to allow for more options for care outside the plan's service area, e.g., guest memberships.</li> </ul>
Guidelines II., D., 17. Page 4	Article 2.4 (3) Page 12	Same	Expanded language to include all data requests beyond those for the PBM.	To allow for the Department to specify a file format that is compatible with its systems for sharing of data.
Guidelines II., E., 6. Page 5			Added language clarifying provider agreements for transplants are expected to cover retransplantation due to immediate rejection.	To clarify the benefit administration.
Guidelines II., H. Page 6			Added language specifying plans are to rate the state and local groups separately and shall not create claims data for individual local employers because they are rated as part of a pool.	To clarify existing practice.
Guidelines II., I. Page 7			Added language requiring proposals to include a description of case/disease management activities and an organizational chart.	To make this a requirement, as the Department has requested the information in past proposals.
Guidelines II., J. Page 8			Moved the due date for the Addendum 1A submission forward two weeks.	Refer to discussion item #2 on page 2 of the memo.

## Attachment A

Page 2

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	State Contract	Local Contract		
Addendum 2 Page 9			Moved language on reviewing qualification requests on an individual basis.	Refer to discussion item #4 on page 3 of the memo.
Addendum 2 Page 10			Added language for plans to submit the National Provider Identifier with their provider listings.	To use the unique provider identifier pursuant to federal regulations.
	Article 1.4 Page 11	Same	Added a definition of "CONTINUANT" and used the defined term where appropriate in the contract.	To clarify current practice.
	Article 1.7 Page 11	Same	Clarified the definition of an eligible "DEPENDENT" when marriage is terminated by divorce or annulment and when attending on-line programs.	To clarify current practice.
	Article 1.17 Page 13	Same	Clarified the definition of "PREMIUM" to specify it includes the amount paid by the employer when the employer contributes toward the premium.	To clarify current practice.
	Article 2.10 (2) Page 14	Same	Added language requiring plans to notify the Department when an Independent Review Organization (IRO) renders a decision and the amount billed for the review.	As the rendering of the IRO decision is final, it allows staff to close any related pending complaints and to track costs of the IRO process.
	Article 2.10 (6) Page 14	Same	Added language clarifying language plans are to provide in final grievance decision letters.	To increase awareness and compliance from plans.
	N/A	Article 3.1 (2) Page 15	Added language clarifying employers assessed a surcharge can join the program at the beginning of a quarter.	To clarify current practice.
	Article 3.3 (6) Page 16	Same	Added language clarifying enrollment opportunities as required by National Medical Support Notices.	To clarify current practice.
	Article 3.11 Page 17	Same	Added language clarifying coverage for spouse when combining contracts.	To clarify current practice.
	Article 3.12 Page 17	Same	Added language clarifying that retro-active premium refunds and coverage terminations are not allowed during an unpaid leave of absence.	To clarify current practice when premium is paid on behalf of the employee who does not reimburse the employer.
	Article 3.16 (2) & (4) Page 18	Same	Clarified the Medicare reduced premium is available when Medicare is the primary payor.	To clarify current practice.

The Board determines the premium rate for its self-insured Standard, fee-for-service, group health benefit plan. This premium is established after review of claims experience, secular trends, etc., and after consultation with the Board's actuary. Once the Board has established the premium rates for the standard health plan, the Board opens the sealed "bids" for the alternate health benefit plans. The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure ~~or, as determined by Statute and collective bargaining, the lesser of 90% of the standard plan in the employee's residence county or 105% of the lowest cost "qualified" alternate plan in the county where the subscriber's primary care provider is selected.~~ Under the tiered structure, the Office of State Employment Relations has determined the Standard Plan to be placed in Tier 2 for purpose of determining premium contribution share for those subscribers who are active employees residing out of state. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation.

Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

The tiered premium structure is based on recommendations from the Board's appointed actuary whereby each alternate plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the Board's actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The 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. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total premium. Plans are determined to be qualified on a county by county basis. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 and/or Tier 2 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists. The Department may take such action as necessary to implement this intent.

In the event that the contribution is based on a percentage of the lowest cost qualified plan, if an alternate plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total alternate plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The Board is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health-care delivery system. A health care plan with efficient, highly qualified providers, who effectively practice peer-review and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health care plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the Board to participate under the State of Wisconsin's Group Health Benefit program.

**D. Comprehensive Health Benefit Plans Eligible for Consideration**

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.
2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):
  - a. Independent practice association HMO (IPA's).
  - b. Prepaid group practice HMO.
  - c. Staff model HMO.

Plans that will be considered under these guidelines to be offered in any county also include:

- a. Point of service HMOs (POS-HMO).
- b. Preferred Provider Plan (PPP).

Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

3. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4.
4. Plans must demonstrate their efforts in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog, Checkpoint, Wisconsin Hospital Association quality accountability initiative and others as identified by the Department.
5. Plans must demonstrate their efforts in encouraging and/or requiring network providers, large multi-specialty groups, small group practices and systems of care to participate in such quality standards as the Wisconsin Collaborative for Quality Healthcare and others as identified by the Department.
6. Plans must demonstrate their support for the Department's initiatives in monitoring and improving quality of care, such as collecting HEDIS measures and submitting quality improvement plans as directed by the Department.
67. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians, such as ~~(Utilization Review (UR),~~ chronic care/disease management and wellness/prevention. Each plan shall report annually to the Board its utilization capabilities and effectiveness.

Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

- Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.
- Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
- Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
- Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
- Procedure to monitor emergency admissions to non-plan hospitals.
- Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.

In its report, plans must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

8. Plans must demonstrate their support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.). Each plan shall report to the Board its capabilities and effectiveness.

79. Plans must cover emergency and urgent care and related catastrophic medical care received from plan or non-plan providers at the in-plan level of benefits. The emergency room copayment is applicable if the participant is not admitted to the hospital. This out-of-service area care may be subject to usual and customary charges while holding the participant harmless as described in Section II., E., 5. unless the participant accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. Plans shall make every effort to settle claim disputes in a reasonable time frame. Plans affiliated with larger nationwide networks may offer coverage through affiliated plan networks as long as there is no additional cost to the plan or participants for doing so.

810. Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the state group health benefit program as a result of such termination of employment. (See Wis. Stat. § 632.897)

811. Plans must agree to participate in the regular "dual-choice" enrollment offering. A regular dual-choice enrollment offering is scheduled approximately 90 days prior to the end of each contract period. During such dual-choice enrollments the plan will accept any individual (active employee, continuant or retiree) who transfers from one health benefit plan to another without requiring evidence of insurability, or waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3). Any individual who is confined as an inpatient at the time of such transfer shall become the liability of the

**Attachment B**

Page 4

succeeding plan

**Guidelines**  
**Section II., D.**

135. Non-qualifying plans. This section applies only to those for whom contributions are based on a percentage of the lowest cost qualified plan. ~~The state contribution toward premium is determined separately on a county by county basis. That amount is equal to the lesser of 90% of the premium rate for Standard coverage or 105% of the lowest cost qualified alternate plan providing care in a county.~~ Local government employers must pay at least 50% but not more than 105% of the lowest cost qualified plan in the employer's area (except for eligible employees who work less than half-time for whom the minimum contribution shall be at least 25% of premium). Local government employers who determine the employee premium contribution based on the tiered structure established for state employees must do so in accordance with Wis. Adm. Code § ETF 40.10. The county of the employer is considered the service area for local employers. At the request of a participating employer, the Department will review the service area used to determine the least cost qualified plan used for determining the employer's maximum premium contribution. If the Department reviews the service area, it will be based on the zip code locations that includes at least 80% of the covered employees of the participating employer. Once the Department has made such an assessment, that service area will determine the least cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria. A non-qualifying plan approved by the Board for participation in the state Group Health Insurance Program may market its plan in any area. However, only the lowest cost qualified plan's premium rate would be used in the above calculations. No plan may qualify for determining employer contributions in its first year of operation under the Board's program. PPPs are not qualified in areas served by SMP. The service area for PPPs will be considered the subscriber's county of residence.

The Standard Plan premium rates for state employees will be the same statewide. However, premium rates for the Standard Plan for the local government program will depend upon the geographic location of the municipality. The state has been divided into the following premium areas:

<u>Geographic Area</u>	<u>Cost Factor</u>
Balance of State	1.0
Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix Counties	1.03
Kenosha, Ozaukee, Racine, Washington, Waukesha Counties	1.07
Milwaukee County, Out of State	1.1

146. Subscriber premium payments will be arranged through deductions from salary, accumulated sick leave account (state employees only), or annuity. For all other subscribers, premiums will be paid directly to the plan and plans must notify the Department of subscribers terminating or reinstating coverage as described in Section I.
157. Plans will ~~assist with~~ provide and receive all reasonable requests for data and other information as needed ~~for the PBM to administer the pharmacy benefit program and receive any necessary data~~ in a file format as identified by the ~~PBM and~~ Department after seeking input from plans. This includes requests for the pharmacy benefit manager to administer the pharmacy benefit program.
168. Plans shall not recoup any payments it has made for prescriptions filled by participants on

**Attachment B**

Page 6

and after January 1, 2004.

## **E. Provider Agreements**

Any organization seeking approval under these Guidelines must provide the following information:

1. If professional services are provided through contractual arrangements, such as an Independent Practice Association (IPA), a sample copy of the actual contractual agreement established between the organization and the participating physicians who will be providing professional services. If more than one type of contract is used then include a sample of each.
2. Detailed explanation of any relationship between the plan and hospitals which would be involved under the group health benefit program. Each applicant must specify whether there is a contractual relationship between the plan and the hospital(s) involved or if the relationship is limited only to the extent that physicians providing services under the program have staff privileges with the hospital(s).
3. Detailed explanation of how physicians and hospitals are compensated under the program including a description of any and all incentives involved. If physicians are salaried, a detailed explanation of how salaries are established, reviewed and changed, and who is the authorizing party for such action. The intent is to secure information on how a plan reimburses its providers; the Board is not interested in specific fees or salary information.
4. Detailed explanation of medical specialties associated directly or indirectly with the plan. For those plans where medical specialists are used as referral physicians rather than primary care, the plans must submit documentation to demonstrate that the referral physician(s) has, in fact, agreed to accept such referrals. If there is a contractual arrangement where an organization has contracted with a clinic/individual practitioner to provide either primary or referral care, such contractual agreements must be identified and included with the proposal.
5. Except for those benefits which require the enrollee to satisfy a deductible or be subject to co-payment, the contract for professional or hospital services must contain a provision whereby the physician and/or hospital and/or health care provider (as defined under Wis. Stat. § 655.001 (8)) agrees to accept the payments provided by the plan as full payment for covered services. Each plan must certify that it will "hold harmless" the enrollee from any effort(s) by third parties to collect payments for medical/hospital services.

This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee from being held liable for hospital or professional charges except for those benefits which require the enrollee to satisfy a deductible; be paid on a co-payment basis; or in those instances where the individual failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of published plan requirements shall not be subject to the "hold-harmless" provision.

6. Provider agreements for transplants are expected to specify that retransplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered and is not subject to the Uniform Benefits exclusion on retransplantation.

**Guidelines**  
**Section II., H.**

**H. Rate-Making Process**

Each plan must include in its proposal to the Board a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the Board insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans may separate higher cost providers within geographic areas under the tiered structure into separate plans. The state and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. Plans shall provide rates for both the regular and deductible options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The Department reserves the right to audit, at the expense of the plan, the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)
- Family (Employee Plus Eligible Dependents)
- Medicare Coordinated
  - Individual
  - Family (2 Medicare Eligible)
  - Family (1 under Medicare, at least 1 other not under Medicare)
- Graduate Assistants<sup>1</sup>:
  - Individual
  - Family

1. Family rates (regular coverage) must be 2.5 times the individual rate.
2. Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed 50% of the single rate for regular coverage; 2 eligible rate shall be 2 times the

---

<sup>1</sup> Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

**Guidelines**  
**Section II., H. & I.**

individual Medicare coordinated rate; family rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate.
4. The Board will consider rate proposals outside of these standards if the variation is supported by evidence of genuine demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the Board upward or downward to the nearest within range percentage to conform with these Guidelines. The plan will then have the option of accepting the adjusted rates or withdrawing from the program.
5. The Board will assess administration fees to cover expenses of the Department of Employee Trust Funds. This charge is added by the Board to the rates quoted by each alternate plan and is collected prior to transmittal of the premiums to the alternate plans.
6. Include completed Table contained in Addendum #1A.

## I. Submission of Proposals

Proposals to participate in the state group health insurance program must be submitted to the Board and address each of the requirements in Section II of the Guidelines. In addition to requirements previously cited, each plan proposal must be received by April 15 and include:

1. Fifteen (15) copies.
2. Specific listing of the plan's pre-authorization and referral requirements.
3. A description of case management and disease management activities.
34. A list and count of providers under contract arranged by county of practice for state employees, and by zip code for local employees. The Board will expect an updated listing by July 26 in order to determine what areas will constitute your service area.
- 4.5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must be in writing and address the method used for providing services and processing claims under such circumstances.
6. An organizational chart.
57. Statement of agreement to abide by all the terms and conditions set forth in the "Terms and Conditions for Comprehensive Medical Plan, Uniform Benefits and Contract" document.
68. If a PPO, include a schedule of benefits.

## **Attachment B**

Page 10

The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

**J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds**

***(Note: Unless otherwise specified, if the “Due Date” listed below falls on a Saturday, materials should be received by the Department the previous Friday. If the “Due Date” falls on a Sunday, materials should be received by the Department the following Monday.)***

Due Date (Receipt by Dept)	Information Due	Date Submitted
April 16 <del>7</del> , 2007 <del>6</del>	<ul style="list-style-type: none"> <li>New plans only. Proposal to participate in the program (Section II., I, page 1-17). Contract to be executed by plan/Board. (Section 3)</li> </ul>	
<del>May 1</del> April 30, 2007	<ul style="list-style-type: none"> <li>Estimated premium rate proposal for next calendar year.</li> </ul>	
May 15, 2007 <del>6</del>	<ul style="list-style-type: none"> <li>For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.</li> </ul>	
June 1, 2007 <del>6</del>	<ul style="list-style-type: none"> <li>Documentation of financial stability (2 copies each):               <ol style="list-style-type: none"> <li>Balance sheet</li> <li>Statement of Operations</li> <li>Annual <u>audited</u> financial statement</li> </ol> </li> <li>Preliminary identification of planned service areas by county for the next calendar year.</li> <li>Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year.</li> <li>Addendum 1C – Utilization Review Worksheet.</li> <li>Actual contract language that specifies provider agreement or terms to participate in or report on Quality Improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.</li> <li>Objective documentation to determine credible programs/processes specific to those represented in the comparison of health plan features in the “It’s Your Choice” brochure.</li> <li><u>Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to:</u> <ul style="list-style-type: none"> <li><u>Julie Maendel</u></li> <li><u>Deloitte Consulting</u></li> <li><u>400 One Financial Plaza</u></li> <li><u>120 South Sixth St</u></li> <li><u>Minneapolis, MN 55402-1844</u></li> </ul> </li> </ul>	

**Attachment B**

Due Date (Receipt by Dept)	Information Due	Date Submitted
June 15, 2007 <del>6</del>	<ul style="list-style-type: none"> <li>HEDIS information is required for the prior calendar year <u>in the format as determined by the Department.</u></li> <li><del>Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to:</del> <ul style="list-style-type: none"> <li><del>Julie Maendel</del></li> <li><del>Deloitte Consulting</del></li> <li><del>400 One Financial Plaza</del></li> <li><del>421</del> <b>Addendum 2</b></li> <li><del>Minneapolis, MN 55402-1044</del></li> </ul> </li> <li>Addendum 1B and Tables 8A and 8B describing catastrophic data.</li> </ul>	

**ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE**

Providers Under Contract Physically Located in Each Major City/County/Zip Code  
State and Local Employees

Using the format provided by ETF, record the number of providers under contract sorted by zip-code who are physically located within each county and major city in the service area. Major cities are those that have over 33% of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior.

**Provider Guarantee:**

Providers listed here and/or on any of the plan's publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. If a participant is in her second or third trimester of pregnancy when the provider's participation in the plan terminates, the participant will continue to have access to the provider until the completion of postpartum care for the woman and infant. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department's request.

If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant's options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.

This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 1; the final copy is due on July 25. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward

premium. Upon request, the Department may review the qualification status of a plan on a county by county basis and make recommendations to the Board. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a county or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.
2. There must be at least one general hospital per county or major city. If a hospital is not present in the county, plans must sufficiently describe how they provide access to providers per standards set forth under Wis. Adm. Code § INS 9.34 (2). ~~The Department will review requests for qualification on an individual basis and make recommendations to the Board.~~

3. If optional dental coverage is offered, a dentist must be available in each county (or major city if applicable).
4. A chiropractor must be available in each county (or major city if applicable).
5. The plan must have a minimum of one year of operation.
6. After being offered to state employees for one year, the plan must have achieved an enrollment of 100 subscribers or 10% of the employees in the service area. Service area means the entire geographic area in which the plan is qualified.

Health plans are responsible for submitting two types of reports to ETF

- (1) A listing that includes all providers of any type. All providers should be listed by name and National Provider Identifier (NPI), as specified by the Department. Under no circumstances, should a clinic be listed in lieu of provider names.
- (2) Health plans must also submit counts of providers and institutions used by ETF to determine plan qualification by county. Summary counts must be provided for every County and Major City in which a health plan has at least one PCP. ETF not only determines qualification status from the provider counts, but also determines whether or not a health plan will be listed in the “It’s Your Choice” booklet as a non-qualified plan. Generally, if a health plan has at least one PCP in a county, the health plan will be listed in the “It’s Your Choice” booklet although ETF may choose not to list a plan if it is not practical to do so. For example, ETF would not list a health plan that has a low number of providers in a high population county.

Please note that all providers that health plans make available to participants or publish in the provider listings sent to members must be reflected in both the provider listing and the provider counts. Specific instructions on how to submit the information detailed above will be provided to the health plans in advance of the due date. ETF reserves the right to modify instructions and data requests as needed and may also request updated reports from health plans as needed.

**SAMPLE FORMAT**

Date

:

Plan:                     We-Care                      
                    (Name of Plan)

  La Crosse    
  (Location/Service Area)

Counties and Major Cities in Service Area	No. Dentists	No. Chiropractors	No. General Hospital Routinely Utilized	No. FTE Primary Care Providers*	Total Members
Crawford	17	3	0	4	560
Juneau	10	3	0	3	90
La Crosse (City)	7	2	2	29	340
La Crosse (County)	18	4	3	102	680

\* Primary care provider as defined in Uniform Benefits and utilized by the plan in the manner described in the definition.

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTINUANT" means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

1.54 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.65 "DEPARTMENT" means the Department of Employee Trust Funds.

1.76 "DEPENDENT" means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19 but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stat. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a dependent for federal income tax purposes (whether or not the child is claimed), and children of those DEPENDENT children until the end of the month of which the DEPENDENT child turns age 18. Adoptive children become DEPENDENTS when placed in the custody of the parent as provided by Wis. Stat. § 632.896. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other Children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) Children age 19 or over who are full-time students, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be DEPENDENTS:

(a) At the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

(b) At the end of the month in which they cease to be DEPENDENT for support or maintenance or marry, whichever occurs first.

(2) Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break); night schools and student commitments after the semester ends such as student teaching.

(3) If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at least one year or longer, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The HEALTH PLAN will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(5) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility not on the date of notification to the HEALTH PLAN.

1.87 "EFFECTIVE DATE" means the date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

1.98 "EMPLOYEE" means an eligible EMPLOYEE as defined under Wis. Stats. § 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.

1.109 "EMPLOYER" means an employer who has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

1.119 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.124 "HEALTH PLAN" means the alternate health care plan signatory to this agreement.

1.132 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.143 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.154 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

1.165 "PARTICIPANT" means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT to the HEALTH PLAN for enrollment and are entitled to BENEFITS.

1.176 "PREMIUM" means the rates shown on ATTACHMENT C which may be revised by the HEALTH PLAN annually plus the pharmacy rate and administration fees required by the BOARD, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the employer when the employer contributes toward the PREMIUM.

2.4 REPORTING.

(1) EMPLOYEES, ~~and~~ ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the employer or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish a report to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish like reports for each succeeding month that the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall collect from SUBSCRIBERS coordination of benefits information necessary to coordinate benefits under the Wisconsin Administrative Code and report this information to the Department at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

(4) Unless individually waived by the BOARD, each HEALTH PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire HEALTH PLAN membership and the state group membership where applicable. The HEALTH PLAN will include the state group membership prescription drug data from the pharmacy benefit manager in their reported prescription drug measures consistent with NCQA requirements. The data will be supplied in a format specified by the DEPARTMENT.

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than \$100 per day per occurrence, to begin on the 5th day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed \$5000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.10 GRIEVANCE PROCEDURE.

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S internal grievance process and may then, if necessary, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with the Quality Assurance Services Bureau.

The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

(2) The PARTICIPANT may also request an independent review as provided under Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.

(3) The HEALTH PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 days to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of ~~Determination~~ DEPARTMENT Administrative Review Rights.

In the final grievance decision letters, the HEALTH PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request a review by an Independent Review Organization in accordance with Wis. Adm. Code § INS 18.11, using the language approved by the DEPARTMENT. In the event they disagree with the grievance committee's final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the date of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of the PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

**Local Contract**  
**Article 3**

3.1 EFFECTIVE DATE.

(1) The group health insurance program pursuant to Wis. Stat. § 40.51 (7), and under which the HEALTH PLAN is participating according to the terms of this CONTRACT, shall be available beginning July 1, 1987. As recommended by the DEPARTMENT'S actuary and approved by the BOARD, requirements apply to municipalities joining the program and a surcharge applied when the risk is determined to be detrimental to the existing pool. The surcharge is determined by the BOARD's actuary and cannot be appealed.

(2) The governing body of an employer shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. The resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month, or the beginning of the quarter for employers receiving a rate differential as determined through underwriting. on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT.

At least 30 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the employer all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small employers as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void, unless the employer is granted a waiver of the participation requirement by the DEPARTMENT. EMPLOYEES who are on a leave of absence and not insured under the employer's plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the employer's current group health plan. Eligible EMPLOYEES who are not insured under the employer's current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT.

(3) Notwithstanding section 3.2, any employer for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months and any employer who files a resolution after December 20, 1990, and who offers a non-participating plan pursuant to sub. (4) shall be required to remain in the program a minimum of three years.

(4) The employer may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to employees in lieu of coverage under this program. EMPLOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision. However, the DEPARTMENT may allow any employer to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program; and (3) that the minimum number of all of the employer's Wisconsin

**Attachment B**

Page 20

Retirement System participating

(4) An EMPLOYEE enrolled for coverage at the time of being called into active military service shall be entitled to again enroll upon resumption of eligible employment with the same employer subject to the following:

(a) Employment is resumed within 180 days after release from active military service, and

(b) The application for coverage is received by the employer within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

(d) Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(5) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

(6) As required by state and federal law, a SUBSCRIBER enrolled in a single plan although eligible for family coverage, or an EMPLOYEE who deferred the selection of coverage, has a special enrollment opportunity to add eligible children as required by a National Medical Support Notice.

~~(6)~~(a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or under medical assistance (Medicaid), or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE loses eligibility for that other coverage or the employer's ~~premium~~-contribution towards the other coverage ceases, he/she may elect coverage under any plan by filing an application with the employer within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the other plan lose eligibility for that coverage or the employer's contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) An EMPLOYEE who deferred coverage may enroll for family coverage if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption or marriage, provided he or she submits an application within 60 days of that event.

(c) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event as described in b. above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

**3.11 COVERAGE OF SPOUSE.**

If both spouses are ANNUITANTS or employed through the same employer and both are eligible for coverage, each may elect individual coverage. Two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the employer receives the application. If the spouses have coverage with different HEALTH PLANS, at the time of marriage or when two single contracts are combined to one family contract, ~~the spouses have coverage with different HEALTH PLANS~~, they may elect family coverage with either HEALTH PLAN. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage without lapse if the employer received the application within 30 days of the divorce. An employer may, at its option, allow both spouses to enroll for family coverage or one for single and one for family and coverage can be changed from one spouse to the other without restrictions.

**3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE.**

(1) Any insured EMPLOYEE may continue coverage during any employer approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, coverage as an active EMPLOYEE shall not be resumed.

(2) Except as provided in section 3.21, the insured EMPLOYEE is responsible for payment of the full PREMIUM which must be paid in advance, and each payment must be received by the employer at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid. Retroactive employer refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE is not allowed.

(3) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the employer within 30 days of the return from leave. Coverage is effective the 1st day of the month on or after the date the employer receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

**3.13 COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE.**

(1) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from his or her position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be insured from the date of the contested discharge until a final decision has been reached. Within 30 days of the date of discharge the EMPLOYEE must submit to the employer the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the employer at least 30 days prior to the end of the coverage period for which PREMIUMS were

## State &amp; Local Contract

## Article 3

previously paid.

3.16 COVERAGE OF ANNUITANTS, ~~AND~~ SURVIVING DEPENDENTS ~~AND~~ CONTINUANTS ELIGIBLE FOR MEDICARE.

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the Medicare hospital, and medical insurance benefits (Parts A and B) become effective as the primary payor.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT who does not enroll in Medicare Part B when it is first available as the primary carrier shall be limited in accordance with Uniform Benefits IV, A., 12., b. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity and the Department will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV, A., 12., b. The plan will make claims adjustments prospectively.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by EMPLOYEES and ANNUITANTS who are eligible for those programs is waived if the EMPLOYEE remains covered as an active EMPLOYEE of the participating employer. Enrollment in Medicare Part B is required for the EMPLOYEE or DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active employee's group health insurance policy with another employer and that policy is the primary payor for Part A and Part B charges, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare rates for coverage under this program.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS, CONTINUANTS and their DEPENDENTS who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is required to pay a premium to enroll in the hospital portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

(6) If a Medicare coordinated family PREMIUM category has been established for a family, and one or more family members enrolled in both parts of Medicare dies, the family PREMIUM category in effect shall not change solely as a result of the death.

(7) If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this plan shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in Medicare. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this plan will again be the primary payor. No reduction in PREMIUM is available for active EMPLOYEES

**Attachment B**

Page 24

under this section.

## Notable Changes Under Consideration for the 2008 Uniform Benefits

Section Page Number (in Attachment D)	Description	Reason for Change
Schedule of Benefits I. Pages 1 - 3	<ul style="list-style-type: none"> <li>a) Added language clarifying the lifetime maximum benefit is per plan.</li> <li>b) Clarified the additional therapy visits plans can authorize.</li> <li>c) Clarified the mandated benefit for splints for Temporomandibular Disorders.</li> </ul>	<ul style="list-style-type: none"> <li>a) To clarify existing practice.</li> <li>b) Change requested by a plan to clarify existing practice and ensure benefit is administered consistently by plans.</li> <li>c) Change requested by a plan to clarify existing practice and ensure plans consistently administer the benefit mandate.</li> </ul>
Definitions II. Pages 4 – 11	<ul style="list-style-type: none"> <li>a) Moved language from “Usual and Customary Charge” to “Confinement/Confined”.</li> <li>b) Clarified the definition of an eligible “Dependent” when marriage is terminated due to divorce or annulment and when attending on-line programs.</li> <li>c) Clarified holding the member harmless under “Usual and Customary Charge”.</li> </ul>	<ul style="list-style-type: none"> <li>a) To clarify existing practice.</li> <li>b) To clarify existing practice.</li> <li>c) To clarify existing practice due to misinterpretations by a health plan.</li> </ul>
Benefits and Services III. Page 12	Added language explaining members may be responsible for services from non-plan providers in some situations. Bolded language for additional emphasis.	Change requested by a plan to clarify existing practice.
Benefits and Services III., A., 5., c. Page 14	Added language specifying coverage for routine patient care administered in cancer clinical trials per state mandate.	Pursuant to Wis. Stat. §632.87 (6).
Benefits and Services III., A., 5., g. Page 15	Added language specifically stating coverage is available for second opinions.	Change recommended by staff to clarify existing practice.
Benefits and Services III., C., 2. & 3. Page 22	<ul style="list-style-type: none"> <li>a) Revised description of benefit for diabetic/medical supplies and durable medical equipment.</li> <li>b) Removed the \$200 dollar limit from prior authorization requirements. Limits, if any, will now be determined by each plan.</li> </ul>	<ul style="list-style-type: none"> <li>a) Change requested by a plan to clarify existing practice.</li> <li>b) Change requested by plans to allow for administration of prior authorizations consistent with their commercial business.</li> </ul>
Benefits and Services III., C., 3. Page 23	Clarified language describing the benefit for one initial lens following cataract surgery.	Change recommended by staff to clarify existing practice.
Benefits and Services III., C., 4. Page 23 - 24	Clarified outpatient mental health services for full-time students pursuant to state mandate requires prior authorization by the plan.	Change recommended by staff to clarify existing practice.

## Attachment C

Page 2

Section Page Number (in Attachment D)	Description	Reason for Change
Benefits and Services III., D. Page 24 - 26	Revise the bullet format for the list describing how drugs will be dispensed.	Change recommended by staff to improve ability to reference language.
Exclusions and Limitations IV., A., 1., c. & 2., d. Page 27	<ul style="list-style-type: none"> <li>a) Clarified and bolded language describing listing of exclusions.</li> <li>b) Added example of excluded surgical treatment of obesity.</li> <li>c) Clarified covered nutritional counseling is not excluded under weight loss programs.</li> </ul>	<ul style="list-style-type: none"> <li>a) Change recommended by staff and a plan to clarify existing practice.</li> <li>b) Change requested by plans to clarify existing practice.</li> <li>c) To clarify existing practice.</li> </ul>
Exclusions and Limitations IV., A., 5., a. Page 28	Clarified the lengthening of the mandible is also excluded under the provision. Also clarified language explaining that state mandated TMJ benefits limit the exclusion.	Change requested by several plans to clarify existing practice.
Exclusions and Limitations IV., A., 7., d. Page 29	Added exclusion specifying harvesting of eggs and their cryopreservation are not covered.	Change requested by a plan to clarify existing practice.
Exclusions and Limitations IV., A., 10., c. Page 30	Added examples of devices excluded under the provision, such as shower chairs and reaches.	Change requested by a plan to clarify existing practice.
Exclusions and Limitations IV., A., 11., d. Page 31	Clarified FDA approved weight loss medications are excluded.	Change requested by the PBM to clarify existing practice.
Exclusions and Limitations IV., A., 12., n. & ac. Page 32 & 34	Clarified administration of benefits when a member is confined at the time the policy becomes effective and/or is terminated.	To ensure administration is consistent with the Office of the Commissioner of Insurance's interpretation.
Exclusions and Limitations IV., A., 12., ab. Page 33 – 34	Reorganized the provision that excludes charges directly related to non-covered services.	To clarify existing practice due to misinterpretations by health plans.
Exclusions and Limitations IV., B., 9. Page 35	Stated that the administration of the lifetime maximum benefit of the policy includes PBM charges and is per plan.	To clarify existing practice.
Miscellaneous Provisions VI., I. & J. Page 39	<ul style="list-style-type: none"> <li>a) Clarified language to require all claims for services to be submitted within 12 months or as soon as reasonably possible.</li> <li>b) Clarified language pertaining to independent review.</li> </ul>	<ul style="list-style-type: none"> <li>a) Change requested by the PBM so manual claims are submitted more timely.</li> <li>b) Change recommended by staff to clarify existing practice.</li> </ul>

**I. SCHEDULE OF BENEFITS**

---

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at \$0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits. This also does not include your lifetime maximum benefit if you were previously covered by the Health Plan, as your lifetime maximum benefit may include any benefits paid during all periods of coverage with the same Health Plan under this program.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin group health insurance program.

- NOTE:*
- *Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of \$500 per individual / \$1,000 per family, per calendar year. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.*
  - *For Participants enrolled in a Preferred Provider Plan (WPS Patients Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide you with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.*

**The benefits that are administered by the Health Plan are subject to the following:**

- Policy Deductible: **NONE**
- Policy Coinsurance: 100% of charges, except as described below
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: **\$2,000,000 per Participant**
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: **NONE**
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be prior authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per calendar year.

## Attachment D

Page 2

- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed \$500.00 annually per Participant.

One hearing aid per ear no more than once every three years payable at 80%, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.

- Cochlear Implants: Device, surgery for implantation of the device, and follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, payable at 80%. Hospital charges for the surgery are covered at 100%. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. Fifty additional Medically Necessary visits per calendar year may be authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is 6 months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of \$1,000,000 for transplants, including Preoperative and Postoperative Care.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services:

Outpatient Services: \$1,800 maximum per Participant per calendar year  
Transitional Services: \$2,700 maximum per Participant per calendar year  
Inpatient Services: 30 days or \$6,300, whichever is less, per Participant per calendar year

Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per Participant per calendar year.

The maximum is determined using the average amount paid to the Providers by the Health Plan and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to Copayment.

**Note: Annual dollar maximums for mental health only services are suspended. However, day limit maximums do apply, if applicable.**

**Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.**

- Vision Services: One routine exam per calendar year. Non-routine eye exams are covered as Medically Necessary.

- Oral Surgery: Limited to procedures listed in Benefits and Services Section.
- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.
- Dental Services: No Coverage provided under Uniform Benefits. However, each Health Plan may choose to provide a dental plan to all of its members.
- Hospital Emergency Room Copayment: \$60 per visit; waived if admitted as an inpatient directly from the emergency room. (An inpatient stay is generally 24 hours or longer.)

**The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:**

- Prescription Drugs and Insulin:
 

Level 1* Copayment for Formulary Prescription Drugs:	\$ 5.00
Level 2** Copayment for Formulary Prescription Drugs:	\$15.00
Level 3 Copayment for Covered Non-Formulary Prescription Drugs:	\$35.00

\*Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.

\*\*Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.

Annual Out-of-Pocket Maximum (The amount you pay for your Level 1 and Level 2 Prescription Drugs and Insulin):

\$320 per individual or \$640 per family for all Participants, except:

\$1,000 per individual or \$2,000 per family for State Participants enrolled in the Standard Plan, and

No annual out-of-pocket maximum for Wisconsin Public Employer Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

**NOTE: Level 3 Copayments do not apply to the out-of-pocket maximum and must continue to be paid after the annual out-of-pocket maximum has been met.**

Disposable Diabetic Supplies and Glucometers Coinsurance: 20% per purchase, which will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.

Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

## II. DEFINITIONS

---

The terms below have special meanings in this Plan. Defined terms are capitalized when used in the text of this Plan.

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

**CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.

- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a plan physician, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the plan physician, 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.

- **DEPENDENT:** Means the Subscriber's:
  - ▶ spouse
  - ▶ unmarried children
  - ▶ legal wards who become legal wards of the Subscriber prior to age 19, but not temporary wards
  - ▶ adopted children and children placed for adoption as provided for in Wis. Stat. § 632.896. Adoptive children become Dependents when placed in the custody of the parent
  - ▶ stepchildren
  - ▶ grandchildren if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

Dependent children must be dependent on the Subscriber (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a Dependent for federal income tax purposes, whether or not the child is claimed.

Children born outside of marriage become Dependents of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or the equivalent if the birth was outside of the State of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth.

A spouse and stepchildren cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment ~~decree is entered~~. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be Dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. Children age 19 or over who are full-time students, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be Dependents:
  - ▶ At the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.
  - ▶ At the end of the month in which they cease to be Dependent for support or maintenance or marry, whichever occurs first.

Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Service, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching.

2. If otherwise eligible, children who are, or become, incapable of self-support because of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at least one year or longer, continue to be, or resume their status of, Dependents regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to continue or resume coverage. The Health Plan will monitor mental or physical disability at least annually, but will only terminate coverage prospectively upon determining the Dependent is no longer so

## Attachment D

Page 6

disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
4. Legal Wards cease to be Dependents at the end of the month in which they cease to be wards.

Any Dependent eligible for benefits will be provided benefits based on the date of eligibility, not on the date of notification to the Health Plan and/or PBM.

- **DURABLE MEDICAL EQUIPMENT:** Means an item which can withstand repeated use and is, as determined by the Health Plan, primarily used to serve a medical purpose with respect to an Illness or Injury, generally not useful to a person in the absence of an Illness or Injury, appropriate for use in the Participant's home, and prescribed by a Plan Provider.
- **EFFECTIVE DATE:** The date, as certified by the Department of Employee Trust Funds and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:
  1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
  2. Serious impairment to the Participant's bodily functions.
  3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in Section III., A., 1., e.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.
- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment,

procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require prior authorization for certain formulary and non-formulary drugs before coverage applies.
- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this calendar year.
- **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 in order 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:
  1. (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
  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) 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 (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

## Attachment D

Page 8

- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses.
- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.
- **MAINTENANCE THERAPY:** Means ongoing therapy delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a therapist.
- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's illness or Injury; (2) appropriate under the standards of acceptable medical practice to treat that Illness or Injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care Provider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MEDICAID:** Means a program instituted pursuant to 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.
- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan 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, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
- **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.
- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.

- **NON-PLAN 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 Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Plan unless it is an Emergency or Urgent Care.
- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:
  1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
  2. Re-assessment and intervention (individual and group)
  3. Diabetes outpatient self-management training services (individual and group sessions)
  4. Dietitian visit
- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
- **PLAN PROVIDER:** 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 Participants. 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. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.
- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.
- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

## Attachment D

Page 10

- **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 PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

You must name Your Primary Care Provider on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from your Health Plan before obtaining the services. Unless otherwise indicated by your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
- **PROVIDER:** Means a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan 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 and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. The authorization from the health plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized 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.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.
- **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.

- **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 require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charge) prior to receiving services. ~~Charges for Hospital or other institutional Confinements are incurred on the date of admission. All others are incurred on the date a Participant receives the service or item. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.~~ Health Plan approved Referrals to Non-Plan Providers are not subject to usual and customary charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges while holding the member harmless.
- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

### **III. BENEFITS AND SERVICES**

---

The benefits and services which the Health Plan and PBM agrees to provide to Participants, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the Participant's Primary Care Provider (except in the case of plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a Plan Hospital. In the case of non-Emergency care, the Health Plan reserves the right to determine in a reasonable manner the Provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

**Except as specifically stated for Emergency and Urgent Care, you must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan Provider or You will be financially responsible for the services.** The Health Plan may also require Prior Authorization for other services or they will not be covered.

Subject to the terms and conditions outlined in this plan and the attached Schedule of Benefits, a Participant, in consideration of the Employer's payment of the applicable Health Plan and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any Copayment, Coinsurance and other limitations shown in the Schedule of Benefits; and (b) all other terms and conditions outlined in this plan. All services must be Medically Necessary, as determined by the Health Plan and/or PBM.

#### **A. Medical/Surgical Services**

##### **1. Emergency Care**

- a. Medical care for an Emergency, as defined in Section II. Refer to the Schedule of Benefits for information on the Emergency Room Copayment.
- b. Plan Hospital Emergency rooms should be used whenever possible. Should you be unable to reach your Plan Provider, go to the nearest appropriate medical facility. If you must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where you are receiving Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. In addition to the emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.
- c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

- d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.
- e. Some examples of Emergencies are:
  - ▶ Acute allergic reactions
  - ▶ Acute asthmatic attacks
  - ▶ Convulsions
  - ▶ Epileptic seizures
  - ▶ Acute hemorrhage
  - ▶ Acute appendicitis
  - ▶ Coma
  - ▶ Heart attack
  - ▶ Attempted suicide
  - ▶ Suffocation
  - ▶ Stroke
  - ▶ Drug overdoses
  - ▶ Loss of consciousness
  - ▶ Any condition for which you are admitted to the Hospital as an inpatient from the emergency room

## **2. Urgent Care**

- a. Medical care received in an Urgent Care situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- b. You must receive Urgent Care from a Plan Provider if you are in the Plan Service Area, unless it is not reasonably possible. If you are out of the Plan Service Area, go to the nearest appropriate medical facility unless you can safely return to the Plan Service Area to receive care from a Plan Provider. If you must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where you received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered.
- c. Some examples of Urgent Care cases are:
  - ▶ Most Broken Bones
  - ▶ Minor Cuts
  - ▶ Sprains
  - ▶ Most Drug Reactions
  - ▶ Non-Severe Bleeding
  - ▶ Minor Burns

## **3. Surgical Services**

Surgical procedures, wherever performed, when needed to care for an Illness or Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants.

**4. Reproductive Services**

The following services do not require a Referral to a Plan Provider who specializes in obstetrics and gynecology, however, the Health Plan may require that the Participant obtain Prior Authorization for some services or they may not be covered.

- a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, Cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of birth). In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay 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 in consultation with the mother.
- b. Elective sterilization.
- c. Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
- d. IUDs , as described under the Durable Medical Equipment provision.
- e. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the Participant is in her second or third trimester of pregnancy when the Provider's participation in the Health Plan terminates, the Participant will continue to have access to the Provider until completion of postpartum care for the woman and infant. A Prior Authorization is not required for the delivery, but the Health Plan may request that it be notified of the inpatient stay prior to the delivery or shortly thereafter.

**5. Medical Services**

Medically Necessary professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an approved Provider.

- a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

[c. Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 \(6\).](#)

~~e.d.~~ Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)

~~d.e.~~ Injectable and infusible medications, except for Self-Administered Injectable medications.

e.f. Nutritional Counseling provided by a participating registered dietician or Plan Provider.

g. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

#### **6. Anesthesia Services**

Covered when provided in connection with other medical and surgical services covered under this plan. It will also include anesthesia services for dental care as provided under item B., 1., c., of this section.

#### **7. Radiation Therapy**

Covered when accepted therapeutic methods, such as x-rays, radium and radioactive isotopes are administered and billed by an approved Provider.

#### **8. Detoxification Services**

Covers Medically Necessary detoxification services provided by an approved Provider.

#### **9. Ambulance Service**

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route, as described in the Schedule of Benefits. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.

#### **10. Diagnostic Services**

Medically Necessary testing and evaluations, including, but not limited to, x-rays and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

#### **11. Outpatient Physical, Speech and Occupation Therapy**

Medically Necessary services as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit maximum described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.

#### **12. Home Care Benefits**

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

All home care must be Medically Necessary as part of the home care plan. Home care means one or more of the following:

## Attachment D

Page 16

- 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, respiratory, occupational and speech therapy. (These apply to the therapy maximum.)
- d. Medical supplies, drugs and medicines prescribed by a Health Plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Hospital Confined.
- e. Nutritional Counseling. A registered dietician must give or supervise these services.
- f. 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. The attending physician must ask for or approve this service.

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

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

A Participant may have been Confined in a Hospital just before home care started. If so, the home care plan must be approved, at its start, by the physician who was the primary Provider of care during the Hospital Confinement.

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per calendar year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating your needs or developing a plan counts as one visit. Each period of four (4) straight hours in a twenty-four (24) hour period of home health aide services counts as one home care visit.

### **13. Hospice Care**

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice 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 includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for 1 year after the Participant'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.

#### **14. Phase II Cardiac Rehabilitation**

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

#### **15. Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury**

Total extraction or total replacement (limited to, bridge or denture) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within eighteen months of the accident. Crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the Health Plan before the service is performed. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision.

#### **16. Oral Surgery**

Participants should contact the Health Plan prior to any oral surgery to determine if Prior Authorization by the Health Plan is required. When performed by Plan Providers, approved surgical procedures are as follows:

- a. Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars when performed by an oral surgeon.
- 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, when such Injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.
- 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.

## Attachment D

Page 18

- 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 Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered 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.

### **17. Treatment of Temporomandibular Disorders**

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and Prior Authorized 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.
- 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 the Schedule of Benefits. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to \$1,250 per calendar year.

### **18. Transplants**

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the \$1,000,000 maximum lifetime benefit for transplants.

Limited to one transplant per organ per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease. Organ retransplantation, which applies to items b., e., f., and g. as listed below, is not a covered benefit.

- a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
  - ▶ Aplastic anemia
  - ▶ Acute leukemia
  - ▶ Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

- ▶ Wiskott-Aldrich syndrome
  - ▶ Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
  - ▶ Hodgkins and non-Hodgkins lymphoma
  - ▶ Combined immunodeficiency
  - ▶ Chronic myelogenous leukemia
  - ▶ Pediatric tumors based upon individual consideration
  - ▶ Neuroblastoma
  - ▶ Myelodysplastic syndrome
  - ▶ Homozygous Beta-Thalassemia
  - ▶ Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
  - ▶ Multiple Myeloma, Stage II or Stage III
  - ▶ Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
- b. Parathyroid transplantation
- c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.
- d. Corneal transplantation (keratoplasty) limited to:
- ▶ Corneal opacity
  - ▶ Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
  - ▶ Corneal ulcer
  - ▶ Repair of severe lacerations
- e. Heart transplants will be limited to the treatment of:
- ▶ Congestive Cardiomyopathy
  - ▶ End-Stage Ischemic Heart Disease
  - ▶ Hypertrophic Cardiomyopathy
  - ▶ Terminal Valvular Disease
  - ▶ Congenital Heart Disease, based upon individual consideration
  - ▶ Cardiac Tumors, based upon individual consideration
  - ▶ Myocarditis
  - ▶ Coronary Embolization
  - ▶ Post-traumatic Aneurysm
- f. Liver transplants will be limited to the treatment of:
- ▶ Extrahepatic Biliary Atresia
  - ▶ Inborn Error of Metabolism
    - Alpha -1- Antitrypsin Deficiency
    - Wilson's Disease
    - Glycogen Storage Disease
    - Tyrosinemia
  - ▶ Hemochromatosis
  - ▶ Primary Biliary Cirrhosis
  - ▶ Hepatic Vein Thrombosis

## Attachment D

Page 20

- ▶ Sclerosing Cholangitis
  - ▶ Post-necrotic Cirrhosis, Hbe Ag Negative
  - ▶ Chronic Active Hepatitis, Hbe Ag Negative
  - ▶ Alcoholic Cirrhosis, abstinence for 12 or more months
  - ▶ Epithelioid Hemangioepithelioma
  - ▶ Poisoning
  - ▶ Polycystic Disease
- g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.
- h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.
- i. Kidney Transplants. See item 19. below.

### **19. Kidney Disease Treatment**

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants section A., 18), donor-related services, and related physician charges.

### **20. Chiropractic Services**

When performed by a Plan Provider. Benefits are not available for Maintenance Therapy.

### **21. Women's Health and Cancer Act of 1998**

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:

- ▶ Reconstruction of the breast on which a mastectomy was performed;
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ▶ Prostheses (see DME in section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas.

### **22. Smoking Cessation**

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized by the Health Plan.

## **B. Institutional Services**

Covers inpatient and outpatient Hospital services and Skilled Nursing Facility services that are necessary for the admission, diagnosis and treatment of a patient when provided by a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Health Plan may require that the hospitalization be Prior Authorized.

### **1. Inpatient Care**

- a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription

drugs administered during the Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.

- b. Licensed Skilled Nursing Facility: Must be admitted within twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. 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.
- c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for Dental Care: Covered if services are provided to a Participant who is under five 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.

## **2. Outpatient Care**

Emergency Care: First aid, accident or sudden illness requiring immediate Hospital services. Subject to the Copayment described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the Copayment.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic Testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical Care: Covered.

## **C. Other Medical Services**

### **1. Mental Health Services/Alcohol and Drug Abuse**

Participants should contact the Health Plan prior to any services to determine if Prior Authorization or a Referral is required from the Health Plan.

#### **a. Outpatient Services**

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e).

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

#### **b. Transitional Services**

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is 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.

#### **c. Inpatient Services**

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided pursuant to an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

- 1) Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1. The charges for such drugs will not be applied the maximum benefit available for any mental health, alcohol or drug abuse services.
- 2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the Provider by the Health Plan.

**2. Durable and Disposable Diabetic Supplies**

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment ~~including insulin infusion pumps (limited to one pump in a calendar year and you must use the pump for thirty (30) days before purchase) and any supplies that are~~ and durable ~~or~~ and disposable supplies that are required for use with the durable diabetic equipment, will be covered ~~after~~ subject to a 20% Coinsurance as outlined in the Schedule of Benefits. ~~Automated injection devices are covered if Prior Authorized by the Health Plan.~~ The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for Durable Medical Equipment. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.
- Insulin infusion pumps, limited to one pump in a calendar year and You must use the pump for thirty (30) days before purchase.

All Durable Medical Equipment purchases or monthly rentals ~~that exceed \$200.00~~ must be Prior Authorized as determined by the Health Plan.

(Glucometers are available through the PBM. Refer to section D. for benefit information.)

**3. Medical Supplies and Durable Medical Equipment**

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, ~~for~~ medical supplies and durable medical equipment will be covered subject to 20% ~~after a~~ Coinsurance as outlined in the Schedule of Benefits. All ~~Durable Medical Equipment~~ purchases or monthly rentals ~~that exceed \$200.00~~ must be Prior Authorized as determined by the Health Plan. The following supplies and equipment will be covered:

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.

- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment such as, but not limited to: wheelchairs, hospital-type beds, and artificial respiration equipment.
- ~~Therapeutic contact lenses or a~~ An initial lens(es) per surgical eye, following cataract surgery (contact lens or framed lens).
- IUDs.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit.
- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Ostomy and catheter supplies.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, ~~R~~repairs, maintenance and replacement of covered Durable Medical Equipment/supplies ~~if Prior Authorized by the Health Plan~~, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

#### **4. Out-of-Plan Coverage For Full-Time Students**

If a Dependent is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

- a. Emergency or Urgent Care. Non-urgent follow-up care out of the Service Area must be Prior Authorized or it will not be covered; and
- b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, pursuant to Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by ~~that~~ the Health Plan ~~designates~~. If outpatient services are recommended, coverage will be provided for five (5)

visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the ~~dollar~~ limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

**5. Congenital Defects and Birth Abnormalities**

Pursuant to Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

**D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM)**

You must obtain benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, you may need to make a claim as described in the paragraph below.

If you do not show your PBM identification card at the pharmacy at the time you are obtaining benefits, you may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, you may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the Department. Contact the PBM if you have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the Health Plan.

**1. Prescription Drugs**

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed Illness or Injury; and are purchased from a PBM Network Pharmacy after a Copayment or Coinsurance amount, as described in the Schedule of Benefits. A Copayment will be applied to each prescription dispensed. The PBM may lower the copayment amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual out-of-pocket maximum applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket maximum, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full

for the rest of the calendar year. Further, if participating family members combined have paid ~~\$600~~ in a year the family annual out-of-pocket maximum as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket maximum ~~paid \$300 in Copayments~~, all family members will have satisfied the annual out-of-pocket maximum for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket maximum. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual out-of-pocket maximum for Level 1 and Level 2 Formulary prescription drugs.

The Health Plan, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, Confinement, emergency room visit or Urgent Care setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, Confinement, emergency room visit or Urgent Care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, Self-Administered Injectable).

Where a Medicare Prescription Drug Plan is the primary payor, the Participant is responsible for the copayment plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred Prescription Drug Plan administered by the PBM.

Notwithstanding the exclusion in Section IV., ~~Exclusions and Limitations-12.~~ (b) for Participants in the Wisconsin Public Employers' group, the PBM will pay prescription drug benefits for Medicare eligible members as secondary, regardless of whether or not the Participant is actually enrolled in a Medicare Part D prescription drug plan.

Prescription drugs will be dispensed as follows:

- a. In maximum quantities not to exceed a 30 consecutive day supply per Copayment.
- b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns).
- c. Single packaged items are limited to 2 items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d. Oral Contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary ~~(limited to, generic Zyban equivalents, nicotine inhaler, spray or patch)~~. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual out-of-pocket maximum. Coverage is limited to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.
- f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.

## Attachment D

Page 26

- h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- i. Tablet Splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.
- j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.
- k. The PBM reserves the right to designate certain over the counter drugs on the Formulary.
- l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

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

### **2. Insulin, Disposable Diabetic Supplies, Glucometers**

The PBM will list on the Formulary approved products. Prior Authorization is required for anything not listed on the Formulary.

- a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30 consecutive day supply for one prescription drug Copayment, as described on the Schedule of Benefits.
- b. Disposable Diabetic Supplies and Glucometers will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for prescription drugs.

### **3. Other Devices and Supplies**

Other devices and supplies administered by the PBM that are subject to a 20% Coinsurance and applied to the annual out-of-pocket maximum for prescription drugs are as follows:

- ▶ Diaphragms
- ▶ Syringes/Needles
- ▶ Spacers/Peak Flow Meters

## IV. EXCLUSIONS AND LIMITATIONS

---

### A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. **The exclusions are do not intended to apply solely to the category in which they are listed, unless otherwise specified except that subsection 11 applies only to the pharmacy benefit administered by the PBM.** Some of the listed exclusions may be Medically Necessary, but still are not covered under this plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

#### 1. Surgical Services

- a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- b. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct 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.
- c. Any surgical treatment or Hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
- d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

#### 2. Medical Services

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits section.
- b. Expenses for medical reports, including preparation and presentation.
- c. Services rendered (a) in 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) in the cutting, trimming or other nonoperative partial removal of toenails; (c) treatment of flexible flat feet; or (d) in connection with any of these except when prescribed by a Plan Provider who is treating the Participant for a metabolic or peripheral disease or if the skin or tissue is infected.
- d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits section.

## Attachment D

Page 28

- e. Work related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).
- f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.
- g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing illness.

### **3. Ambulance Services**

- a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.
- b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits Section.

### **4. Therapies**

- a. Vocational rehabilitation including work hardening programs.
- b. Maintenance Therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.
- c. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

- d. Physical fitness or exercise programs.
- e. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.
- f. Massage therapy.

### **5. 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 the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section. (Note: ~~Under some circumstances, m~~ Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may ~~supercede limit~~ this ~~benefit~~ exclusion.)
- b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits Section.

- c. All oral surgical procedures not specifically listed in the Benefits Section.

#### **6. Transplants**

- a. Transplants and all related services, except those listed as covered procedures.
- b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.
- c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.
- d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
- e. All separately billed donor-related services, except for kidney transplants.
- f. Non-human organ transplants or artificial organs.

#### **7. Reproductive Services**

- a. Infertility services which are not for treatment of Illness or Injury (i.e., which 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 semen (sperm); donor sperm.

#### **d. Harvesting of eggs and their cryopreservation.**

- de.** 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.
- ef.** Implantable birth control devices (for example, Norplant).
- fg.** Surrogate mother services.
- gh.** Maternity services received out of the Plan Service Area in the ninth month of pregnancy, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control (for example, family emergency)).
- hi.** Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

#### **8. Hospital Inpatient Services**

- a. Take home drugs and supplies dispensed at the time of Hospital discharge, which can reasonably be purchased on an outpatient basis.
- b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

## Attachment D

Page 30

- 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.

### **9. Mental Health Services/Alcohol and Drug Abuse**

- a. Hypnotherapy.
- b. Marriage counseling.
- c. Residential care except transitional care as required by Wis. Stat. § 632.89.
- d. Biofeedback.

### **10. Durable Medical or Diabetic Equipment and Supplies**

- a. All Durable Medical Equipment purchases or rentals ~~per month exceeding \$200~~ unless authorized by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless ~~Prior Authorized~~ authorized by the Health Plan.
- c. Medical supplies and Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices; and self-help devices not medically necessary, as determined by the Health Plan, -in nature including, but not limited to, shower chairs and reaches.
- d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.
- e. Equipment, models or devices that have features over and above that which are Medically Necessary for the Participant will be limited to the standard model as determined by the Health Plan.
- f. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Health Plan.
- g. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.
- h. Customization of buildings for accommodation (for example, wheelchair ramps).

### **11. Outpatient Prescription Drugs – Administered by the PBM**

- a. Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.
- b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.
- c. Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

- d. Any FDA medications approved ~~specifically prescribed~~ for weight loss (for example, appetite suppressants, Xenical).
- e. Anorexic agents.
- f. Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.
- g. All over the counter drug items, except those designated as covered by the PBM.
- h. Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- i. Charges for injectable medications, except for Self-Administered Injectable medications.
- j. Charges for supplies and medicines purchased from a Non-~~Network~~ Participating Pharmacy, except when Emergency or Urgent Care is required.
- k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l. Infertility and fertility medications.
- m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.
- n. Charges for spilled, stolen or lost prescription drugs.

### **12. General**

- a. Any additional exclusion as described in the Schedule of Benefits.
- b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.
- c. Treatment, services and supplies for which the Participant: (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.
- d. Injury or Illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
- e. Treatment, services and supplies for any Injury or Illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.

## Attachment D

Page 32

- f. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.
- g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- h. Treatment, services or supplies used in educational or vocational training.
- i. Treatment or service in connection with any Illness or Injury caused by a Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j. Care provided to assist with activities of daily living (ADL).
- k. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.
- l. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the Plan.
- m. Custodial, nursing facility (except skilled), or domiciliary care. This includes community re-entry programs.
- n. Expenses incurred, ~~or inpatient Confinements that begin~~ prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of subscriber cancellation or non-payment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a subscriber changing plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding plan will be the responsibility of the succeeding plan ~~continue~~ unless the facility in which the participant is confined is not part of the succeeding plan's network. In this instance, the liability will remain with the previous insurer.
- o. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye following cataract surgery.
- p. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and Medically Necessary or not required in accordance with accepted standards of medical, surgical or psychiatric practice.
- q. Charges for any missed appointment.
- r. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and

individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

- s. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- t. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:
  - 1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.
  - 2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.
  - 3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.
- u. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.
- v. Coma Stimulation programs.
- w. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.
- x. Any diet control program, treatment, or supply for weight reduction.
- y. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.
- z. Services to the extent a Participant receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation act, employer's liability insurance plan or similar law or act. Entitled means you are actually insured under Worker's Compensation.
- aa. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.
- ab. Charges directly related to a non-covered service, such as hospitalization charges, except when ~~Medically Necessary treatment of~~ a complication ~~results from the non-covered service~~ that could not be reasonably expected ~~is covered when and the complication requires Medically Necessary treatment that is~~ performed by a Plan Provider or ~~when~~ Prior a Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any ~~in~~ Emergency situations or when the original treatment or service that was covered and paid

## Attachment D

Page 34

for under any plan in our program. ~~The treatment of the complication must be a covered benefit of the Health Plan and PBM.~~

~~ac. Any inpatient Confinement that begins prior to the Participant's initial enrollment under the Board's program is not covered. Such inpatient Confinement will not be covered under any subsequent plan in which the Participant becomes enrolled.~~

ad. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.

ae. Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is Emergency ambulance transportation.

af. Sexual counseling services related to infertility and sexual transformation.

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

### B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.
2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental Injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.
3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.
4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.
5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other Benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.
7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.
8. Lifetime policy maximum for transplant benefits: \$1,000,000.

Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

9. Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: \$2,000,000 (includes transplant benefits) per Health Plan.

## **VI. MISCELLANEOUS PROVISIONS**

---

### **A. Right To Obtain and Provide Information**

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations.

Each 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 Department of Employee Trust Funds employees as part of conducting quality assessment and improvement activities, or reviewing the Health Plan's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations;
3. The tribunal, including an independent review organization, and parties to any appeal concerning a claim denial.

### **B. Physical Examination**

The Health Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this plan (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 he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

### **C. Case Management/Alternate Treatment**

The Health Plan may employ a professional staff to provide case management services. As part of this case management, the Health Plan reserves the right to recommend that a Participant consider receiving treatment for an Illness or Injury which differs from the 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 the Participant's health; and
- c. the charges incurred for services provided under the recommended treatment will probably be less.

If the Participant or his/her authorized representative and the attending physician agree, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback,

acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

#### **D. Disenrollment**

No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance 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 the Standard Plan with a 180-day waiting period for pre-existing conditions.

Change to an alternate Health Plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

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

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care physician, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the beginning-first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent dual-choice enrollment periods. Re-enrollment in the Health Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

#### **E. Recovery Of Excess Payments**

The Health Plan and/or PBM might pay more than the Health Plan and/or PBM owes under the policy. If so, the Health Plan and/or PBM can recover the excess from you. The Health Plan and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the Health Plan and/or PBM.

Each Participant agrees to reimburse the Health Plan and/or PBM for all payments made for benefits to which the Participant was not entitled. Reimbursement must be made immediately upon notification to the Subscriber by the Health Plan and/or PBM. At the option of the Health Plan and/or PBM, benefits for future charges may be reduced by the Health Plan and/or PBM as a set-off toward reimbursement.

#### **F. Limit On Assignability Of Benefits**

This is your personal policy. You cannot assign any benefit to other than a physician, Hospital or other Provider entitled to receive a specific benefit for you.

#### **G. Severability**

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

#### **H. Subrogation**

Each Participant agrees that the insurer under these Uniform Benefits, whether that is a Health Plan or the Public Employee Trust Fund, shall be subrogated to a Participant's rights to damages, to the

## Attachment D

Page 38

extent of the benefits the insurer 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 insurer's rights of full recovery may be from any source, including but not limited to:

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

Participant's rights to damages shall be, and they are hereby, assigned to the insurer to such extent.

The insurer subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the insurer's prior written consent shall be deemed to prejudice the insurer's rights. Each Participant shall promptly advise the insurer in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the insurer such additional information as is reasonably requested by the insurer. The Participant agrees to fully cooperate in protecting the insurer's rights against a third party. The insurer 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 insurer and the Participant over the question of whether or not the Participant has been "made whole", the insurer 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 insurer provides benefits, by initiating and processing a claim pursuant to 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 insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the insurer immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

### **I. Proof Of Claim**

As a Participant, it is your responsibility to notify your Provider of your participation in the Health Plan and PBM.

Failure to notify a Plan Provider of your membership in the Health Plan may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If you receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Health Plan, clearly indicating the Health Plan's name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of your claim.

Claims for services ~~from a Non-Plan Provider~~ must be submitted as soon as reasonably possible after the services are received. If the Health Plan and/or PBM does not receive the claim within 12 (twelve) months, or if later, as soon as reasonably possible, after the date the service was received, the Health Plan and/or PBM may deny coverage of the claim.

#### **J. Grievance Process**

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

If you exhaust the Health Plan's and/or PBM's Grievance process and remain dissatisfied with the outcome, you may, ~~under certain circumstances,~~ appeal to the Department by completing an ETF complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise you of your right to appeal to the Department.

You may also request an independent review per Wis. Adm. Code § INS 18.11. In this event, you must notify the Health Plan and/or PBM of your request ~~at the same time you notify the Office of the Commissioner of Insurance~~. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. ~~The Independent Review Organization decision is final and binding.~~ You have no further right to administrative review ~~by the Department or Board or judicial review~~ once the Independent Review Organization decision is rendered.

#### **K. Appeals To The Group Insurance Board**

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision has been rendered. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.