AGENDA AND NOTICE OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD MEETING

Tuesday, April 15, 2008
8:30 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

Documents for this meeting are available on-line at:
http://etf.wi.gov/boards/board_gib.htm
To request a printed copy of the agenda items, please contact
Sharon Walk, at (608) 267-2417.

Times shown are estimates only.
Denotes action item.

8:30 a.m. **1.** **Consideration of Minutes of February 12, 2008, Meeting**

8:35 a.m. **2.** **Health Insurance Program**
- Establish Dual-Choice Enrollment Dates
- 2009 Guidelines and Uniform Benefits
- Health Risk Assessment Tools

10:30 a.m. **3.** **Miscellaneous**
- Legislative Update
- Correspondence/Complaint Summary
- 2009 Meeting Dates
- Pending Appeals Status Report
- University of Wisconsin-River Falls Update
- Future Agenda Items

10:35 a.m. ***4.** **Consideration of Responses to Request for Proposals for Income Continuation Insurance and Long-Term Disability Insurance Programs**

11:00 a.m. ***5.** **Consideration of Life Insurance Contract Extension**

11:10 a.m. **6.** **Announcement of Action Taken on Business Deliberated During Closed Session**

11:15 a.m. **7.** **Adjournment**

*** The Board may be required to meet in closed session pursuant to the exemptions contained in Wis. Stats. § 19.85(1)(e) to discuss the use of public employee trust funds. If a closed session is held, the Board will reconvene into open session for further actions on these and subsequent agenda items.**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Sharon Walk, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931. Telephone number: (608) 267-2417. Wisconsin Relay Service 7-1-1. e-mail: sharon.walk@etf.state.wi.us.

MINUTES OF MEETING

DRAFT

STATE OF WISCONSIN
GROUP INSURANCE BOARD

Tuesday, February 12, 2008

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

BOARD PRESENT:
Cindy O'Donnell, Vice-Chair
Esther Olson, Secretary
Martin Beil
Eileen Mallow
Paul Ostrowski (representing Jennifer Donnelly)
Gary Sherman

BOARD NOT PRESENT:
Stephen Frankel, Chair
Robert Baird
Jeannette Bell
Janis Doleschal
David Schmiedicke

PARTICIPATING ETF STAFF:
Dave Stella, Secretary
Bob Conlin, Deputy Secretary
Tom Korpady, Administrator, Division of Insurance Services
Bill Kox, Director, Health Benefits and Insurance Plans Bureau
Matt Stohr, Director of Legislation, Communications, and Planning
Sharon Walk, Group Insurance Board Liaison

OTHERS PRESENT:
Barb Belling, Office of the Commissioner of Insurance
Jeff Bogardus, Division of Insurance Services
Phil Dougherty, Wisconsin Association of Health Plans
Liz Doss-Anderson, Division of Management Services
Rhonda Dunn, Office of the Secretary
Elizabeth Dye, Group Health Cooperative
Kjirsten Eisner, Minnesota Life Insurance Company
Colleen Evans-Carter, Compcare Blue
‘
Caitlin Frederick, Department of Administration
David Grunke, Wisconsin Physicians Service Insurance Corporation
Emily Halter, Group Health Cooperative South Central
Ross Hampton, Wisconsin Education Association Trust
Roni Harper, Division of Insurance Services
Sandy Hayes, Dean Health Plan
Pamela Henning, Division of Management Services
Steve Hurley, Division of Management Services
Kathy Ikeman, Unity Health Insurance
Christina Keeley, Division of Management Services
Sari King, Division of Retirement Services

Jon Kranz, Office of Internal Audit and Budget
Arlene Larson, Division of Insurance Services
Ann McCarthy, Division of Management Services
Byron Mickle, Navitus
Peg Narloch, Division of Insurance Services
Greg Nelson, Wisconsin Physicians Service Insurance Corporation
Diane Poole, Division of Insurance Services
Beth Ritchie, University of Wisconsin System Administration
Deb Roemer, Division of Insurance Services
Chris Schmelzer, Minnesota Life Insurance Company
Ron Sebranek, Physicians Plus Insurance Corporation
Mel Sensenbrenner, State Engineers Association
Sonya Sidky, Division of Insurance Services
Joan Steele, Division of Insurance Services
John Verberkmoes, American Federation of Teachers-Wisconsin
John Vincent, Division of Trust Finance and Employer Services
Al Wearing, Blue Cross Blue Shield of Wisconsin

Cindy O'Donnell, Vice-Chair, Group Insurance Board (Board), called the meeting to order at 9:08 a.m.

ANNOUNCEMENTS

Mr. Korpady introduced Matt Stohr, the new Director of Legislation, Communications, and Planning. He also mentioned that Lisa Ellinger has been appointed as the Deputy Administrator in the Division of Insurance Services.

Ms. O'Donnell announced that Paul Ostrowski had been designated by Jennifer Donnelly to represent her at this meeting.

CONSIDERATION OF MINUTES OF NOVEMBER 6, 2007, MEETING

MOTION: Ms. Mallow moved approval of the minutes of the November 6, 2007, meeting as submitted by the Board Liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

ELECTION OF OFFICERS

MOTION: Ms. Mallow moved to nominate the current slate of officers (Stephen Frankel, Chair; Cindy O'Donnell, Vice-Chair; and Esther Olson, Secretary) for another term. Mr. Beil seconded the motion, which passed without objection on a voice vote.

HEALTH INSURANCE PROGRAM

Guidelines/Uniform Benefits Timeline. Mr. Kox discussed the timeline for development of changes to the Guidelines and Uniform Benefits for contract year 2009. The staff discussion group will begin meeting next week. Board members and their staff are invited to participate in the discussions. Final recommendations for changes will be presented to the Board at the

April 15, 2007, meeting. Ms. Mallow stated that Barb Belling from the Office of the Commissioner of Insurance would participate in the discussion group meetings.

Mr. Beil stressed that the discussion group needs to explore and take proactive steps in addressing the issues that arose last year in the northwest part of the state when one of the health plans made significant changes in its provider network. He noted that it was unfair to ask employees to make life decisions about their families' health care based on incomplete network information from the plans. He said we need to do better. He acknowledged the recent expansion of the Humana network but noted that much of it occurred after people had already selected their plans for 2008.

2008 Dual-Choice Enrollment Results. Mr. Kox provided the Board with information on the 2008 Dual-Choice enrollment results. The most significant change was the migration of contracts from Humana-Western. This was a result of the change in Humana-Western from its Preferred One Network to a Wisconsin-based network that uses the Marshfield Clinic. For the local program, there was a large migration from Physicians Plus to Unity-Community.

Report on Health Plan Employer Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (CAHPS®). Mr. Kox noted that the HEDIS® and CAHPS® documents form the basis of the report cards that are published each year in the dual-choice booklets. On average, Wisconsin Health Maintenance Organizations are above the national average in terms of performance. The information provided in HEDIS® and CAHPS® provides a tool for members to use when making decisions regarding health care coverage.

Pharmacy Benefit Manager Audit. Mr. Kox reported on the third party audit of Navitus Health Solutions (Navitus). A cover memo along with the complete audit was provided to the Board. Navitus has been the Pharmacy Benefit Manager (PBM) since 2004. The audit was performed by CGI Technologies & Solutions, Inc. (CGI). According to the report, the degree of accuracy for Navitus is between 99.92% and 99.93%, which CGI indicated was at the top for all of the PBMs that they have audited.

PROPOSED SCOPE STATEMENT CONCERNING AMENDMENTS TO WISCONSIN ADMINISTRATIVE CODE ETF 11.11.

Mr. Conlin discussed the proposed scope statement relating to Wis. Admin. Code ETF 11.11. This scope statement deals with appointment of counsel to represent the Board. The intent of the proposed scope statement is to provide the Board and the Department with more flexibility in managing the legal caseload. Mr. Conlin noted that when this scope statement was presented to the Board in November 2007, there were some concerns raised about the role of the Department of Justice in representing the Board and the Department worked to address those concerns. Ms. O'Donnell indicated that the Department of Justice has had all of its concerns met regarding this scope statement.

MOTION: Mr. Beil moved to adopt the scope statement. Ms. Olson seconded the motion, which passed without objection on a voice vote.

LEGISLATIVE UPDATE

Mr. Stohr introduced himself to the Board and provided background on his experience prior to joining the staff at Employee Trust Funds. He discussed the current legislative session and noted that the general session is scheduled to conclude on March 13, 2008. He referred the Board to the legislative report that was distributed prior to the meeting and invited Board members to contact him with any questions or concerns they might have.

MISCELLANEOUS

Ms. O'Donnell referred the Board members to the various miscellaneous items included in the Board packets. Ms. Olson commented on the *Pending Appeal Report.* Specifically, she remarked on the fact that there are currently only 27 appeals. Mr. Stella noted that at one time there were over 300 pending appeals and indicated that the Department continues to work on strategies for resolving appeals.

ITEMS FOR FUTURE DISCUSSION

Mr. Ostrowski, on behalf of Ms. Donnelly, asked that the following questions regarding Health Risk Assessment Tools (HRAs) be reviewed by the Department and that a report be presented to the Board at a future meeting:

- Which health plans have HRAs?
- Are the HRAs "home-grown" or purchased?
- If purchased, from whom?
- Do the plans offer these tools to state employees?
- What do the plans do with the data?

Ms. Mallow added the following question:

- If HRAs are offered to state employees, how many people are taking advantage of them?

MOTION TO CONVENE IN CLOSED SESSION

Ms. O'Donnell announced that the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85(1)(e) for the purpose of discussing the use of public employee trust funds. Staff from the Department of Employee Trust Funds, the Department of Administration, and the Office of the Commissioner of Insurance were invited to remain during the closed session.

MOTION: Mr. Beil moved to convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1)(e) for the purpose of discussing the use of public employee trust funds. Mr. Ostrowski seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Beil, Mallow, O'Donnell, Olson, Ostrowski, and Sherman.

Members Voting Nay: None

The Board convened in closed session at 9:36 a.m. and reconvened in open session at 9:48 a.m.

Mr. Korpady announced that the Board took the following action during the closed session:

INCOME CONTINUATION INSURANCE (ICI) AND LONG TERM DISABILITY INSURANCE (LTDI) PROGRAMS

The Board approved the Request for Proposals (RFP) for the ICI and LTDI programs. The RFP will be released on February 12, 2008.

ADMINISTRATIVE SERVICES CONTRACT EXTENSION FOR THE STANDARD PLANS

The Board approved a two-year extension of the administrative services contract with the self-insured health plans currently held by Wisconsin Physicians Service. This extension will go into effect at the end of 2008.

ADJOURNMENT

MOTION: Mr. Beil moved adjournment. Mr. Sherman seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 9:50 a.m.

Dated Approved: _____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: March 17, 2008

TO: Group Insurance Board

FROM: Arlene Larson, Manager
Self-Insured Health Plans

SUBJECT: Establishment of Dual-Choice Enrollment Period

The Board establishes the annual dates for the Dual-Choice Enrollment period.

Staff recommends setting October 6-24, 2008, as the Dual-Choice Enrollment period for coverage effective on January 1, 2009.

Setting this date allows sufficient time to complete the printing, distributing and mailing of the *It's Your Choice* books prior to the start of Dual-Choice. It also provides time for plans to print the provider directories needed by participants making their Dual-Choice Enrollment decisions. It also offers payroll representatives adequate time to enter application data in light of their payroll calendar timelines.

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

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	4/15/2008	2

STATE OF WISCONSIN
Department of Employee Trust Funds
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CORRESPONDENCE MEMORANDUM

DATE: March 26, 2008

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 2009 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 19 and March 6 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 meetings were attended by Barbara Belling, Office of Commissioner of Insurance (OCI); Caitlin Morgan Frederick, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Beth Ritchie, University of Wisconsin (UW); and the following Department of Employee Trust Funds (Department) staff: Tom Korpady, Lisa Ellinger, Bill Kox, Joan Steele, Arlene Larson, Jeff Bogardus, Matt Stohr, Steve Hurley, Liz Doss-Anderson, Christina Keeley, and Brian Schroeder.

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 contract to reflect changes due to the implementation of electronic eligibility data transfer with health plans. 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 #
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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 2009. 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 2009.

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 health plans, some minor revisions were considered and/or made when developing the recommendations contained in this memo. Comments on these recommendations from specific health plans 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 shading 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) **State Maintenance Plan:** The group discussed and recommended giving the Board the flexibility to make the State Maintenance Plan available at Tier 2 in any county, whether or not a qualified Tier 1 plan is available. This may be used to supplement provider availability in areas where the Standard Plan is the only other alternative.

2) **Incorporation of Pharmacy Data:** The group discussed and recommended expanding the requirement for health plans to incorporate the Department's pharmacy claims data into all aspects of disease management. Currently, health plans are only required by contract to incorporate the pharmacy claims data into the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

3) **Annual Utilization Report:** The group discussed and recommended requiring health plans to submit an annual utilization report describing utilization trends identified for our group and how they compare to trends for the health plan's commercial business.

RECOMMENDED CHANGES TO THE LOCAL CONTRACT:

1) **Underwriting:** Currently, the Board has an underwriting process for large employers with 51 or more eligible employees. The group recommends expanding the underwriting process to small employers with 50 or fewer eligible employees. The process would be similar to that used currently for large employer groups, except that surcharges for higher risk groups would likely be higher. We expect that surcharges could range up to 85%. This is similar to small group underwriting in the commercial market. Employers would be assessed a fee to

cover the cost of the underwriting process. 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 that smaller employers are even more price sensitive, which leads to greater adverse selection. Staff continues to investigate how to put this in practice, and with Board approval will implement this change if it can be efficiently administered. We will report back to the Board at that time.

2) **Opt-Out Surcharge:** 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 adding language to the contract whereby the Board reserves the right to assess a surcharge, as determined by the Board's actuary, when a local employer does not remove the opt-out provision from its labor agreements within three years.

RECOMMENDED CHANGE TO UNIFORM BENEFITS

Cost-neutral recommendation. As described below, the group recommends the following benefit change that is cost-neutral.

1) **Pharmacy Annual Out-of-Pocket (OOP) Maximum:** The annual OOP maximum is currently $350 per individual/$700 per family. Periodically, the Board revises the OOP maximum in accordance with the change in relative value of the original Uniform Benefits maintenance drug list. It was not increased from 2004 through 2006. For 2008, it was increased in relative value for 1½ years to make up for some of the lag. According to the Board's actuary, if the OOP maximum is increased according to the change in its relative value for the 2½ years during which it was not adjusted, it would be $440/$880 in 2009. 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 $375/$750. The group recommends increasing the OOP maximum for 1½ years to catch up for those years for which it was not adjusted. Thus, the group recommends increasing the OOP maximum to $385/$770 for 2009.

Other potential changes affecting costs. As described below, the group discussed the following benefit changes with a cost impact but did not reach consensus on recommending their inclusion. They decided to bring the issue to the Board. If the Board decides to add coverage for the food substance in enteral feedings, the cost can be offset by increasing the emergency room copayment.

2) **Enteral (Tube) Feedings:** Uniform Benefits currently covers all apparatus for enteral feedings. There was interest by some members of the study group to ask the Board to consider enhancing this benefit by covering the food substance (enteral nutrition). Food, including enteral nutrition, is currently excluded unless it is administered during a covered outpatient or inpatient confinement. According to the Board's actuary, the cost to cover the food substance when it is the sole source of nutrition is $0.15 to $0.20 per member per month (PMPM).

3) **Emergency Room Copayment:** The group considered increasing the emergency room visit copayment to generate savings to offset benefit additions. The savings to increase the emergency room copayment from $60 to $70 is $0.16 PMPM. 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 or be punitive in rural areas where there are limited choices due to fewer urgent care facilities or limited urgent care hours.

Summary of Cost Impact of Potential Changes

Benefit Increase	PMPM
Enteral Feedings Food Substance	$0.15 -.20
Total	**$0.15 - .20**

Benefit Reduction	PMPM
Emergency Room Copayment	$0.16
Total	**$0.16**

DISCUSSION OF OTHER ISSUES

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

1) **Review of Provider Qualification Criteria:** The group discussed changes to the qualification criteria as suggested by some employers in Western Wisconsin. The group considered expanding the qualification criteria to require health plans to have at least one mental health provider, pediatrician and obstetrician/gynecologist (OB/GYN) in a county. However, many health plans expressed concerns with adopting these changes. Nine health plans indicated that if the proposed qualification criteria were adopted, they would qualify in significantly fewer counties in large part because these specialists are unavailable in rural counties. As a result, we would likely have to put the State Maintenance Plan in those counties. Yet the State Maintenance Plan would also be unable to offer those services resulting in no improvement in the available provider panels. Therefore, the group does not recommend revising the provider qualification criteria.

2) **Minimum Dental Benefit Level:** The group discussed an employer's request to specify a minimum benefit level for the optional dental benefit in order to avoid a potential gap in coverage when services are not covered by the dental benefit or the DentalBlue supplemental dental plan. The group did not recommend pursuing this change as the dental benefit is optional and the Board traditionally has not put limits on the benefit level.

3) **Medicare as Primary Payer for Local Employers:** The group discussed requiring Medicare to be the primary payer for active employees and dependents on active employee contracts who are enrolled in Medicare when the employer has fewer than 20 employees. Health plans indicated support of this change but expect the Department to track the affected members. Staff recommended pursuing this after the Department has completed implementation of the electronic eligibility data transfer (EEDT) project with health plans, which will allow the Department to efficiently track and report this information to the health plans. The EEDT project is expected to be completed in 2009.

4) **High-Deductible Option for Local Employers:** The group discussed an employer's request to offer a high-deductible option of $1,100 per individual/$2,200 per family for which employers could administer a health savings account (HSA). In addition to various risk and administrative issues, it is believed there is very little interest from other local employers in a high-deductible option. This is based on results from a telephone survey conducted last year with local employers enrolled in the deductible option.

5) Non-Payment for Medical Errors: Under new regulations adopted by the Centers for Medicare and Medicaid Services (CMS) that go into effect October 2008, payment will be withheld from hospitals for care associated with treating certain medical errors and infections. The group does not recommend adding a similar requirement in our contract for 2009 but to consider pursuing in future years. This is based on health plan feedback to delay the requirement to gain knowledge from CMS' experience and to allow time to incorporate this change into provider contracts.

6) **Maintenance Therapy:** The group considered removing the exclusion for maintenance therapy, which would then allow for therapy and other related benefits to prevent a member's condition from backsliding when the member's condition is not expected to improve. The PMPM cost to remove the exclusion is $0.90 to $1.20. The Board's actuary indicates that it is highly unusual to provide this coverage. Therefore, the group does not recommend pursuing this benefit change. Barbara Belling compared the Uniform Benefit's definition of "Maintenance Therapy" to that used by several health plans in their commercial policies to determine if it is similar. Barbara states the Uniform Benefit's definition is very similar to the other health plans that she reviewed. Based on that comparison, only a minor clarification has been made to the Uniform Benefit's definition.

7) **Hearing Aid Benefit:** The group discussed a participant's request to increase the benefit limit for hearing aids. Currently, the benefit is payable at 80%, up to a maximum payment of $1,000 per hearing aid no more than once every three years. To increase the benefit to a maximum payment of $1,500, the PMPM cost would be approximately $0.50 to $0.60. The Board's actuary indicates annuitants utilize this benefit at a rate that is three times greater than the rate for employees. The group does not recommend pursuing this benefit change because it may promote employees subsidizing benefits for retirees due to the significant difference in utilization.

8) **Biofeedback:** The group discussed a participant's request to expand the benefit for biofeedback to include services provided by a physician. Currently, biofeedback may be covered when it is provided by a physical therapist for treatment of headaches and spastic torticollis. The PMPM estimated cost to expand the benefit to allow services to be provided by a physician would be $0.02. The group does not recommend pursuing this change because the contract currently has a provision for alternate treatment that would allow a health plan to extend coverage to services provided by a physician in those limited situations when it is determined to be medically appropriate.

9) **Contact Lens Fittings:** The group discussed a participant's request to add coverage for contact lens fittings, which are currently excluded. The PMPM estimated cost to add this benefit is $0.75 to $1.00. The group does not recommend pursuing this benefit due to its high cost.

10) **Imaging Copayment:** Another benefit change to generate cost savings that the group discussed was adding a copayment for imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans. This is recommended by the Board's actuary based on trends of increased utilization and costs. The PMPM savings to implement a $20 copayment per visit is $0.16 for MRIs and $0.23 for CT scans. If the annual maximum out-of-pocket costs for the copayments are capped at $40 (that is, the member would pay up to two copayments per year), the PMPM savings is $0.14 to implement a $20 copayment for MRIs and $0.17 to implement a $20 copayment for CT scans. Rather than imposing the copay, the group felt the health plans should be encouraged to work with their providers to manage this benefit.

11) **Pharmacy Copayments:** The group discussed increasing pharmacy copayments as another possible way to generate cost savings to offset benefit additions. If the pharmacy copayments were increased from $5/$15/$35 to $5/$18/$40, and the pharmacy OOPM was increased to $385/$770, the PMPM savings is $0.51. As the group did not recommend any additional benefit increases, and if the Board decides there are no other benefit increases to offset, there is no need for this change.

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 2009 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. Page 1			Added language to allow the Board the right to make a Tier 2 plan available in any county.	Refer to discussion item #1 on page 2 of the memo.
Guidelines II., D., 7. Page 2			Added language requiring health plans to incorporate pharmacy data into all aspects of disease management.	Refer to discussion item #2 on page 2 of the memo.
Guidelines II., D., 8. Page 2			Added language requiring health plans to submit an annual utilization report for our group.	Refer to discussion item #3 on page 2 of the memo.
Guidelines II., G., 3., l. Page 4			Added language prohibiting health plans from using members' social security numbers on identification cards and other mailings.	To protect our members' confidential information.
Guidelines II., H. Page 5			a) Added language applicable to the deductible option for the local program. b) Added language specifying the range for the Medicare and Graduate Assistant rates must be justified by data.	a) To clarify current practice. b) To clarify current practice.
Guidelines II., J. Pages 6 - 8			Updated the time table for annual submissions.	To include the annual utilization report and to clarify current practice.
Addendum 2 Page 9			a) Added language indicating statutory continuity of care provisions apply to our program, which include continuity of care for a participant in her second or third trimester of pregnancy. b) Added language in the qualification criteria specifying there must be a hospital under contract and/or routinely utilized by plan providers in the county or major city.	a) To clarify current practice. b) To clarify expectations with health plans to ensure appropriate access for members.
	Article 1.7 Pages 10 - 11	Same	a) Updated the definition to be consistent with Uniform Benefits. b) Deleted language that indicated a different termination date for legal wards. c) Added language allowing coverage to continue for full-time students on a medical leave of absence. d) Revised language to allow for over-aged disabled dependent children to be eligible on a new employee's contract.	a) To clarify current practice. b) Recommended by staff for consistent adminis-tration of eligibility for over-aged dependents. c) To comply with 2007 Wisconsin Act 36. d) Recommended by staff. It is viewed as an equity issue and is not expected to materially affect costs.

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
	Article 2.3 (4) Page 12	Same	Added language specifying the handling of premium in fraudulent situations.	Recommended by staff to clarify current practice.
	N/A	Article 3.1 (4) Page 13	Added language specifying that employers with an opt-out provision may be assessed a surcharge.	Refer to discussion item #2 on page 3 of the memo.
	Article 3.3 (2)(a) Page 14	Same	Added language clarifying that an application is void when the employee terminates employment prior to the effective date of coverage.	Recommended by an employer to clarify current practice.
	Article 3.3 (8) Page 14	Same	Revised language to reflect changes to the process and utilize terminology applicable to all health plans.	To reflect changes due to electronic eligibility data transfer with health plans.
	Article 3.4 (5) & (7) Page 15	Same	Added language extending to annuitants the enrollment rights under Health Insurance Portability and Accountability Act (HIPAA) regulations.	To give annuitants the same enrollment rights as provided for employees and continuants.
	Article 3.4 (7) Page 15	Same	Added language specifying the process for switching health plans as provided by HIPAA regulations.	Recommended by staff to clarify current practice.
	Article 3.11 Page 16	Same	Added language allowing spouses to specify a future date to transfer coverage from one to the other.	Recommended by an employer.
	N/A	Article 3.11 Page 16	Added language allowing a local employer to request a special enrollment opportunity for spouses due to spousal coverage policy changes.	Requested by an employer.
	Article 3.12 (2) Page 16	N/A	Added language clarifying the eligibility for employer contribution.	Recommended by staff to clarify current practice.
	Article 3.13 (3) Page 17	Same	Added language clarifying the premium includes pharmacy and administrative fees.	Recommended by staff to clarify current practice.
	Article 3.16 (3) Page 19	Same	Added language clarifying the process for members who do not enroll in Medicare B or subsequently drop it.	Recommended by staff.
	Article 3.18 (1) (b) Page 20	Same	Added language requiring health plans to report terminations of direct pay contracts and specifying premium refund limitations.	Recommended by staff due to non-compliance from several health plans and to minimize pharmacy liability.
	Article 3.18 (1) (d) Page 20	Same	Added language specifying process for health plans to follow when a direct pay member cancels coverage.	Recommended by staff due to health plans' mishandling of cancellation requests.

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. 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 and/or a Tier 2 plan available in any county. 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.

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.

7. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, information requested on the disease management survey and catastrophic claims data. Where appropriate, such as for the catastrophic claims data report, plans are expected to separate out pharmacy claims from the Department's pharmacy benefit manager from any pharmacy claims that are paid by the plan.

8. 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 and disease management capabilities and effectiveness, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.). Plans shall also include a report detailing the State of Wisconsin group experience by disease categories, place of services along with comparisons to aggregate benchmarks and any other measures the plan believes will be useful to Department staff and the Board in understanding the source of cost and utilization trends. The format may be determined by each plan.

   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.~~

9. 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.

10. 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)

11. 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 succeeding plan 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. The new plan shall assume liability for any subsequent services as provided for in 3.18 (3) of the Contract. Employees who enroll during prescribed enrollment periods shall not be subject to any waiting periods or evidence of insurability requirements.

    The dual-choice enrollment process is limited to those individuals who are currently insured under the state health program. Employees may only opt for alternate health plans at the time of initial hire, upon becoming eligible for employer contribution toward premium ~~(completion of six months under the state retirement system)~~, or - if a late enrollee - by entry into the Standard health plan before being permitted to enroll in an alternate health plan during a "dual-choice" enrollment period.

    However, if a plan becomes insolvent, experiences a significant loss of primary physicians and/or hospitals or no longer meets the minimum criteria for qualification in that county, or if the Board so directs due to an unapproved change of ownership, merger or acquisition, the department may close the plan to new enrollments, authorize a special enrollment period so that subscribers in that service area may change to another plan without waiting periods for pre-existing conditions, or both. The special enrollment period authorized by the Board may either require all employees insured by the plan to elect coverage under another plan or allow all employees insured by the plan the option to continue to be insured by the plan or to elect coverage under another plan.

l. Agree to ~~assign~~ utilize ~~ID~~ identification numbers (~~G~~group and subscriber) according to the system established by the Department of Employee Trust Funds. ~~It is preferable but not mandatory to assign ID~~ Identification numbers ~~that are~~ must not correlate~~d~~ to social security numbers. ~~However, upon member request, such an ID number must be assigned.~~ Social Security numbers may be incorporated into the subscriber's data file and may be used for identification purposes only and not disclosed or used for any other purpose. Plans must always keep record of social security numbers for providing data and other reports to the Department and track the 8-digit unique member ~~ID~~ identification number that is assigned by the Department.

m. Upon request of the Department or the participant, the plan must provide the total dollar amount of claims paid by the plan that has been applied towards the participant's lifetime benefit maximum.

n. The plan's provider network must comply with the access standards set forth in WI Adm. Code § INS 9.32.

o. Provide coverage for eligible children as required under the National Medical Support Notice, a State and Federal law providing for a special enrollment opportunity for eligible children in certain cases when ordered by a court.

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[1]:
  - Individual
  - Family

- Deductible Option for Local Program

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 the calculated rate in Table 7 of Addendum 1A without written justification. ~~and~~ It may not exceed 50% of the single rate for regular coverage; 2 eligible rate shall be 2 times the 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. It may not exceed the calculated rate in Table 7 of Addendum 1A without written justification.

4. Deductible Option for Local Program: The ratio is to be determined annually by the Board's actuary based on the relative value of the deductible plan to the traditional plan.

~~4~~5. 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~~6. 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~~7. Include completed Table contained in Addendum #1A.

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[1] 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.

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 15~~6~~, 2008~~7~~	• New plans only. Proposal to participate in the program (Section II., I, page 1-18). Contract to be executed by plan/Board. (Section 3)	
~~April 30~~May 2, 2008~~7~~	• Estimated premium rate proposal for next calendar year.	
May 16~~5~~, 2008~~7~~	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June ~~1~~2, 2008~~7~~	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • 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. • Addendum 1C – Utilization Review Worksheet. • 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. • 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. • Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to: Julie Maendel Deloitte Consulting 400 One Financial Plaza 120 South Sixth St Minneapolis, MN 55402-1844 • Addendum 1B and Tables 8A and 8B describing catastrophic data.	
June 16~~5~~, 2008~~7~~	• HEDIS information is required for the prior calendar year in the format as determined by the Department.	
July 1~~3~~, 2008~~7~~	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit.	
July 21, 2008	• Report on utilization and disease management capabilities and effectiveness. [Section II., D., 8.]	
July 2~~0~~, 2008~~7~~	• Premium rate quotations for next calendar year. (Annually, about July 10, each plan will be provided with a rate quotation form.)	

Due Date (Receipt by Dept)	Information Due	Date Submitted
July 25, 2008~~7~~	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1 data submission was unacceptable.) • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	
July ~~27~~31, 2008~~7~~	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August ~~10~~8, 2008~~7~~	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 15, 2008~~7~~	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period.	
August 2~~6~~8, 2008~~7~~	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals.	
August ~~31~~29, 2008~~7~~	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period. • Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
September 15~~4~~, 2008~~7~~	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September 21, is required. • For plans not participating in the group health insurance program in 2007, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 2007. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 26**. • Draft of letter the plan will mail to current subscribers summarizing dental benefit and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September 21, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 26, WITH FORWARDING REQUESTED.**	
September 15~~4~~, 2008~~7~~	• In order to lessen participant confusion during the Dual-Choice Enrollment period, the plan, its representatives and informational materials shall advise participants that only those providers listed in its current provider directory should be considered when making their health plan choice.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
~~September 26, 2007~~ TBD	• Dual-Choice kick off meeting in Madison	
September ~~28~~30, 2008~~7~~	• Completed contract, signed and dated. This must include two (2) copies of the contract and all applicable attachments. • Provide five (5) copies of all informational materials in final form to the Department. • Final dental benefit exclusion description which will be provided to members if the plan offers dental coverage.	
October ~~3~~5, 2008~~7~~	• Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
~~October 8 – 26, 2007~~ TBD	• Dual-Choice Enrollment Period.	
October 30 – ~~Nov~~December ~~8~~30, 2008~~7~~	• Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of student and disabled dependent status. • ~~On or before December 1, report complying with HIPAA to the Department and to the employing agency any subscribers whose level of coverage has changed (e.g., family to single) as a result of the annual student status questionnaire.~~Report the student status and disabled dependent status in the file format and frequency as determined by the Department.	
January 2, 2009~~8~~	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of referral and grievance procedures must be included.	
January 15, 2009~~8~~	• Issuance of new ~~ID~~ identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March ~~2~~3, 2009~~8~~	• Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights.	
April 1, 2009~~8~~	• A Quality Improvement plan in the format set forth by the Department. • ~~Report on utilization capabilities and effectiveness of chronic care/disease management and wellness/prevention activities. [Section II., D., 7.]~~	
~~18th of Each Month~~	• ~~Report identifying direct pay terminations and reinstatements or, if none, statement indicating no data to report.~~	
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • Report direct pay terminations and reinstatements in the format as determined by the Department.	
Monthly	• Research and report proposed resolution to the Full File Compare discrepancies identified by the Department.	

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:
In addition to the continuity of care provisions under Wis. Stat. §609.24, the following provider guarantee provision applies. 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 country 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 under contract and/or routinely utilized by plan providers 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).

1.7 "DEPENDENT" means the ~~spouse of the~~ SUBSCRIBER'S:

- Spouse
- ~~and his or her u~~Unmarried child~~ren~~
- ~~(including l~~Legal ward~~s~~ who become~~s a~~ legal ward~~s~~ of the SUBSCRIBER prior to age 19 but not a temporary ward~~s,~~
- ~~a~~Adopted child~~ren~~ ~~or children~~ when placed in the custody of the parent ~~for adoption~~ as provided ~~for in~~ by Wis. Stat. § 632.896~~, and~~
- ~~s~~Stepchild~~ren),~~
- Grandchild 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.

A DEPENDENT child must be ~~who are~~ dependent on the SUBSCRIBER (or the other parent) for at least 50% of the~~ir~~ child's support and maintenance ~~and meet~~ as demonstrated on 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 in 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.~~

A ~~C~~child~~ren~~ born outside of marriage become~~s a~~ DEPENDENT~~S~~ 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 or a court order is filed within 60 days of the birth.

A spouse and a stepchild~~ren~~ cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. ~~Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards.~~ Other ~~C~~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) A ~~C~~child~~ren~~ age 19 or over who ~~are~~ is a full-time student~~s~~, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be a DEPENDENT~~S:~~

- ~~(a)~~ At the end of the calendar year in which the~~y~~ child cease~~s~~ to be a full-time student~~s~~ or in which the~~y~~ child turn~~s~~ age 25, whichever occurs first.

- ~~(b)~~ At the end of the month in which the~~y~~ child ~~cease to be dependent for support or maintenance or~~ marrie~~s~~y, 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, thi~~s e 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), ~~and~~ night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the DEPENDENT ceases to be a full-time student due to a medically necessary leave of absence.

(~~3~~2) ~~If otherwise eligible~~ A dependent child~~ren~~ who is ~~are, or become,~~ incapable of self-support ~~on account~~ because of a physical or mental disability ~~which~~ that 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~~ is an eligible DEPENDENT~~S~~, regardless of age ~~or student status~~, so long as they~~y~~ child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a DEPENDENT for federal income tax purposes and is not married). ~~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.

(~~3~~4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(~~4~~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 and/or pharmacy benefit manager.

1.8 "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.

1.9 "EMPLOYEE" means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., 2m., or 8.

1.10 “EMPLOYER” means an eligible State of Wisconsin agency as defined in Wis. Stat. § 40.02 (54).

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

1.12 “HEALTH PLAN” means the alternate health care plan signatory to this agreement.

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

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

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

1.16 "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.

1.17 "PREMIUM" means the rates shown on ATTACHMENT C plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, 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.

2.3 CLERICAL AND ADMINISTRATIVE ERROR.

(1) Except for the constructive waiver provision of section 3.6, no clerical error made by the EMPLOYER, the DEPARTMENT or the HEALTH PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of section 3.6, if an EMPLOYEE or ANNUITANT has made written application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the EMPLOYER or the DEPARTMENT, due to clerical error, to give proper notice to the HEALTH PLAN of such EMPLOYEE'S application.

(3) In the event that an EMPLOYER erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid.

(4) Except in cases of fraud, unreported death, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall not be made prior to January 1 of the previous calendar year. No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

2.4 REPORTING.

(1) EMPLOYEES, 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 and unique DEPARTMENT identifier) 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.

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 or on behalf of EMPLOYEES in lieu of coverage under this program. EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical. The BOARD reserves the right to assess a surcharge as determined by the BOARD's actuary if this not done within three years. EMPOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision.

3.3 SELECTION OF COVERAGE.

(1) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on, or after the date the application is received by the EMPLOYER. No application for coverage may be rescinded on or after the EFFECTIVE DATE of coverage.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for EMPLOYER contributions to be effective upon becoming eligible for EMPLOYER contribution. In accordance with Wis. Stat. § 40.51 (2), an EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements. However, when the EMPLOYEE terminates employment prior to the EFFECTIVE DATE of coverage, the application is void and any premiums paid or deducted will be refunded.

(b) Notwithstanding paragraph (2) a. above, an EMPLOYEE who is not insured but who is eligible for an EMPLOYER contribution under Wis. Stat. § 40.05 (4) (ag)1 may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Stat. § 40.05 (4) (ag)2 to be effective upon the date of the increase in the EMPLOYER contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.

(8) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that ~~who~~ is not available in the plan selected, the HEALTH PLAN shall immediately ~~reject the application and return it to~~ notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected to one, which has that physician, clinic or care system available, upon notice to the EMPLOYER that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application. The HEALTH PLAN may not simply reassign a primary physician, clinic or care system.

3.4 DUAL-CHOICE ENROLLMENT PERIODS.

(1) The BOARD shall establish enrollment periods which shall permit eligible and currently covered EMPLOYEES, ANNUITANTS and CONTINUANTS to transfer coverage to any plan offered by the BOARD pursuant to Wis. Stat. § 40.51.

Unless otherwise provided by the BOARD, the dual-choice enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a dual-choice enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous dual-choice enrollment period will be allowed a Dual-Choice enrollment provided an application is filed during the 30-day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. A move from a medical facility to another facility by the SUBSCRIBER is not considered a residential move. An application must be filed during the 30 day period, which begins on the date the SUBSCRIBER moves.

(5) As required by Federal law, an EMPLOYEE, ANNUITANT or CONTINUANT may change HEALTH PLANS if a claim is incurred by an individual covered under the policy that would meet or exceed the lifetime maximum BENEFITS. An application must be filed during the 30-day period after a claim is denied due to the operation of a lifetime limit on all BENEFITS with coverage effective on the first day of the month on or following receipt of the application.

(6) A SUBSCRIBER under (3), (4) and (5) above who does not file an application to change plans within this 30 day enrollment period, may change only to the STANDARD PLAN, and shall be subject to the pre-existing condition clause contained in the STANDARD PLAN contract. Coverage shall be effective the first day of the calendar month, which begins on or after the date the application is received by the EMPLOYER.

(7) As required by Federal law, an insured EMPLOYEE, ANNUITANT or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

(8) The HEALTH PLAN shall accept any individual who transfers from one plan to another or from individual to family coverage without requiring evidence of insurability, waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3).

3.11 COVERAGE OF SPOUSE.

If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other 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, or a later date as specified on 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, 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. ***Added to Local Contract only:*** Upon an EMPLOYER'S request, the DEPARTMENT may approve at its discretion a special enrollment opportunity for affected employees due to a change in policy for coverage of spouses.

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) ***Added to State Contract only:*** The EMPLOYER contribution toward PREMIUM continues for ~~After~~ the first three months of the LAYOFF or leave of absence for which PREMIUMS have not already been deducted, after which the insured EMPLOYEE is responsible for payment of the full PREMIUM ~~which~~ that must be paid in advance., ~~and~~ ~~e~~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 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.

(4) For the purpose of this provision and in accordance with Wis. Stat. §40.05 (4g), an eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving state contributions for health insurance on the date he or she is activated for duty. The thirty-six month limitation for continuing coverage, described in (1) above, does not

apply.

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 previously paid.

(2) If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

(3) The PREMIUMS referred to in this section shall be the gross amount paid to the HEALTH PLAN for the particular coverage, including the pharmacy and administrative fees. ~~and~~ tThe EMPLOYEE shall be required to pay any amounts normally considered the EMPLOYER contribution. If the right of the EMPLOYEE to the position is sustained, the EMPLOYER shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE contribution.

3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS.

(1) As required by Wis. Adm. Code § ETF 40.01, ~~T~~the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall continue coverage, either individual or family, if the DEPARTMENT receives an application for coverage from the surviving DEPENDENT within 90 days after the death of the insured EMPLOYEE or ANNUITANT or 30 days of the date the DEPARTMENT notifies the DEPENDENT of the right to continue, whichever is later. A DEPENDENT that regains eligibility and was previously insured under a contract of a deceased EMPLOYEE or ANNUITANT will be eligible for coverage until such time that they are no longer eligible.

(2) Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

(3) PREMIUMS shall be paid:

(a) From accumulated leave credits until exhausted; then

(b) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then

(c) Directly to the HEALTH PLAN.

3.15 COVERAGE OF EMPLOYEES AFTER RETIREMENT.

(1) Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

(a) Retires on an immediate annuity as defined under Wis. Stat. § 40.02 (38),

(b) EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health insurance purposes. If the disability annuity terminates and the PARTICPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

(c) Terminates employment after attaining 20 years of creditable service. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment if the terminated EMPLOYEE is not eligible for an immediate annuity.

(d) Receives a long-term disability benefit as provided for under Wis. Adm. Code § ETF 50.40.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance ~~approval notice~~. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period proceeding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance ~~approval notice~~. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by the DEPARTMENT shall cause the health care coverage to be cancelled.

3.16 COVERAGE OF ANNUITANTS, 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 enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary ~~carrier~~ payor or who subsequently cancels Medicare coverage 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.

In the event that a PARTICIPANT is enrolled in regular coverage, ~~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. In such cases, the HEALTH 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 state. 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, CONTIUANT 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.

3.18 INDIVIDUAL TERMINATION OF COVERAGE.

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another HEALTH PLAN through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the HEALTH PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period. HEALTH PLANS must notify the DEPARTMENT within one month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the HEALTH PLAN are limited to one month following the termination date.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF expires, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT or a later date as specified on the cancellation of coverage notice. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph (4) as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under 3.18 (4) of this section.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows the EMPLOYEE to maintain coverage for 36 months instead of 18.

(2) No refund of any PREMIUM under sub. (e) may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

(3) Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT 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.

Notable Changes Under Consideration for the 2009 Uniform Benefits

Section Page Number (in Attachment D)	Description	Reason for Change
Schedule of Benefits I. Pages 1 - 3	a) Clarified the additional therapy visits are available only when prior authorized by the health plan. b) Clarified that contact lens fittings are not covered. c) Clarified that only specifically listed dental services are covered.	a) Change requested by a health plan to clarify existing practice. b) Change requested by a member to clarify existing practice. c) Change requested by a health plan to clarify contract language.
Definitions II. Pages 4 – 12	a) Updated the definition of DEPENDENT as described in Attachment A, Contract Article 1.7. b) Clarified the definitions of EMERGENCY and URGENT CARE to state that charges may be subject to usual and customary charges. c) Clarified the definition of MAINTENANCE THERAPY.	a) Refer to Attachment A, Contract Article 1.7. b) Change requested by a health plan to clarify existing practice. c) Refer to discussion item #6 on page 5 of the memo.
Benefits and Services III., A., 1., b. Page 13	Added language explaining that prior authorizations are at the discretion of the health plan.	Change requested by a health plan to clarify existing practice.
Benefits and Services III., A., 2., b. Page 14	Added language explaining that prior authorizations are at the discretion of the health plan.	Change requested by a health plan to clarify existing practice.
Benefits and Services III., A., 12., c. Page 17	Clarified that respiratory therapy does not apply to the therapy maximum.	Change requested by a health plan to clarify existing practice and to ensure uniform administration by health plans.
Benefits and Services III., C., 2. Page 23	Revised the section heading to more accurately describe the benefits covered under that section.	Change requested by a health plan to clarify contract language.
Benefits and Services III., C., 3. Page 24	a) Clarified the initial lens that is directly related to cataract surgery is covered. b) Clarified that other services related to the hearing aid are applied to the maximum benefit. c) Clarified that repairs and maintenance are subject to the coinsurance and do not apply to the annual out-of-pocket maximum on certain benefits.	a) Change recommended by staff to clarify existing practice. b) Change requested by a health plan to clarify existing practice and to ensure uniform administration by health plans. c) Change requested by a health plan to clarify existing practice and to ensure uniform administration by health plans.
Benefits and Services III., C., 5. Page 25	Revised the section heading to more accurately describe the benefits covered under the section.	Change recommended by staff to clarify existing practice.

Section Page Number (in Attachment D)	Description	Reason for Change
Exclusions and Limitations IV., A., 8., a. Page 31	Clarified that take home drugs and supplies dispensed at the time of discharge from any setting are excluded.	Change requested by a health plan to clarify existing practice.
Exclusions and Limitations IV., A., 10., a. Page 32	Updated language to indicate that health plans determine when a prior authorization is required.	Language had previously been revised to remove the requirement for health plans to prior authorize any services exceeding $500.
Exclusions and Limitations IV., A., 10., c. Page 32	Clarified the meaning of alternative communication devices.	Change requested by a health plan to clarify existing practice.
Exclusions and Limitations IV., A., 10., e. Page 32	Added language specifying that upgrades or replacements are not covered when existing equipment is working properly, there is no change in condition, and the equipment does not need to be repaired or replaced.	Change requested by a health plan and recommended by staff due to a member complaint.

UNIFORM BENEFITS

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 Patient~~s~~ 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 available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per calendar year.

- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related 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. (Contact lens fittings are not part of the routine exam and are not covered.)

- 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 ~~C~~coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. 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):

$385~~0~~ per individual or $7700~~0~~ 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: Payable at 80%~~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 Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, 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:
  - ~~s~~Spouse
  - ~~u~~Unmarried child~~ren~~
  - ~~l~~Legal ward~~s~~ who become~~s~~ a legal ward~~s~~ of the Subscriber prior to age 19, but not a temporary ward~~s~~
  - ~~a~~Adopted child~~ren and children~~ when placed in the custody of the parent ~~for adoption~~ as provided ~~for in~~ by Wis. Stat. § 632.896~~. Adoptive children become Dependents when placed in the custody of the parent~~
  - ~~s~~Stepchild~~ren~~
  - ~~g~~Grandchild~~ren~~ 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.

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

A ~~C~~child~~ren~~ born outside of marriage become~~s~~ a Dependent~~s~~ 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 or a court order is filed within 60 days of the birth.

A spouse and a stepchild~~ren~~ cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. 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. A ~~C~~child~~ren~~ age 19 or over who ~~are~~ is a full-time student~~s~~, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be a Dependent~~s~~:
   - At the end of the calendar year in which the~~y~~ child cease~~s~~ to be a full-time student~~s~~ or in which the~~y~~ child turn~~s~~ age 25, whichever occurs first.
   - At the end of the month in which the~~y~~ child ~~cease to be dependent for support or maintenance, or~~ marrie~~s~~~~y, 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. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the DEPENDENT ceases to be a full-time student due to a medically necessary leave of absence.

2. ~~If otherwise eligible,~~A dependent child~~ren~~ who is ~~are, or become,~~ incapable of self-support because of a physical or mental disability ~~which~~ that 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,~~ is an

eligible Dependents, regardless of age or student status, so long as they child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a Dependent for federal income tax purposes and is not married). 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 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.

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. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges while holding the member harmless.

- **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.
- **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~~ Provider.

- **MEDICALLY NECESSARY**: A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; (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 Health 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.
- **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 Health 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. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges while holding the member harmless.

- **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 charges) prior to receiving services. 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 Health 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. Prior Authorizations are at the discretion of the Health Plan. 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. Prior Authorizations are at the discretion of the Health Plan.

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),

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.)

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

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:

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 Confined in a Hospital.

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.

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.

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

- 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 Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. 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 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, medical supplies and Durable Medical Equipment will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. All purchases or monthly rentals 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.

- An initial lens per surgical eye ~~following~~ directly related to 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 maximum payment applies to all services directly related to the hearing aid, for example, an ear mold. 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, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, 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). Services will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids, the out-of-pocket costs will apply to the annual out-of-pocket maximum for Durable Medical Equipment.

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 the Health Plan. 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 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. Coverage of Newborn Infants with 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 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, 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., 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. 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.

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 do not apply solely to the category in which they are listed 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.

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: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this 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.

e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f. Implantable birth control devices (for example, Norplant).

g. Surrogate mother services.

h. 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).

i. 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.

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 unless Prior ~~a~~Authorized as required by the Health Plan.

b. Repairs and replacement of Durable Medical Equipment/supplies unless 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 (for example, electronic keyboard for an hearing impairment); and self-help devices not Medically Necessary, as determined by the Health Plan, 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. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the Participant's condition nor is the existing equipment, models or devices in need of repair or replacement.

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 for weight loss (for example, appetite suppressants, Xenical).

e. Anorexic agents.

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

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

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

i. Charges for injectable medications, except for Self-Administered Injectable medications.

j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.

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

l. 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.

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 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 Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan’s network. In this instance, the liability will remain with the previous 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 a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

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

ad. 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.

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

af. 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.

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CORRESPONDENCE MEMORANDUM

DATE: March 18, 2008

TO: Group Insurance Board

FROM: Joan Steele, Manager, Alternate Health Plans

SUBJECT: Availability of Health Risk Assessments

This memo is for the Board's information only. No action is required.

The term Health Risk Assessment (HRA) covers a fairly broad range of tools that are designed to identify participants with certain characteristics that can develop into diseases within a given time span. In the more simple form, HRAs provide an on-line survey assessing a participant's health history and lifestyle choices. In their more in-depth form, HRAs include biometrics screenings including blood tests, and further the assessment through the use of a health coach. The goal of HRAs is to identify members at risk of disease and educate them on prevention and behavior change in order to improve a participant's quality of life as well as reduce future health care costs.

At the February 12, 2008 Group Insurance Board (Board) meeting, members of the Board asked that the following questions regarding HRAs be reviewed by the Department and that a report be presented to the Board at a future meeting. From the nature of the questions, we concentrated on survey-type HRAs.

1. Which health plans offer HRAs?

The following health plans indicate they offer HRAs:

- Anthem Blue Cross Blue Shield
- Arise Health Plan
- Dean Health Plan
- GHC Eau Claire
- GHC-SCW
- Gundersen Lutheran Health Plan
- Health Tradition
- Humana
- Medical Associates Health Plan
- MercyCare Health Plan
- Physicians Plus
- Security Health Plan
- UnitedHealthcare
- Unity
- WPS Patient Choice

Network Health Plan indicates it does not have an HRA tool available. However, its members can complete an HRA through its pharmacy benefits manager.

2. Is the HRA 'home-grown' or purchased from a vendor?

Anthem Blue Cross Blue Shield and Humana offer an HRA that is 'home-grown.' The remaining thirteen plans have purchased their HRA from a vendor.

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

Signature _____ Date _____

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3. If the HRA is purchased, from whom?

CPM Marketing Group
Health Solutions
HealthMedia
Mayo Clinic
Stay Well Health Solutions
Tri-State Occupational Health
Univ. of Michigan (used by two health plans)
Wellsource (used by five health plans)

4. Do health plans offer these HRA tools to state employees?

The following health plans offer their HRAs to state employees:

Health Plan	Offer Online Version	Offer Paper Version	Offer Telephonic Version
Anthem Blue Cross Blue Shield	X		
GHC Eau Claire	X	X	
GHC-SCW	X		
Humana	X	X	X
MercyCare Health Plan	X	X	
Physicians Plus	X		
Security Health Plan	X		
UnitedHealthcare	X		
WPS Patient Choice		X	

The following health plans do not offer their HRAs to state employees:

Arise Health Plan
Dean Health Plan
Gundersen Lutheran Health Plan
Health Tradition
Medical Associates Health Plan
Unity

5. What do health plans do with the data collected from HRAs?

In general, most health plans compile a summary for the participant, provide an aggregate summary to the employer, and/or identify participants that may be suitable candidates for the health plan's disease management programs.

6. If HRAs are offered to state employees, how many people are taking advantage of them?

The following health plans track the number of state employees that have completed HRAs:

	# Completed		# Completed
GHC Eau Claire	39	Physicians Plus	300
Humana	74	Security Health Plan	71
MercyCare Health Plan	0	UnitedHealthcare	15

Anthem Blue Cross Blue Shield, GHC-SCW and WPS Patient Choice indicate the data is not available.

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CORRESPONDENCE MEMORANDUM

DATE: March 24, 2008

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Linda Esser, Executive Staff Assistant, Quality Assurance Services Bureau

SUBJECT: Correspondence and Complaint Summary

This summary is provided for informational purposes and contains a listing of issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following:

(1) correspondence received by the Department addressed to the Secretary or the GIB;

(2) the number of requests for information and assistance made to the ombudspersons in the Quality Assurance Services Bureau (QASB).

The information in the attached tables is from January 1, 2008, through February 29, 2008.

QASB staff will be available at the Board meeting to address any questions you have regarding this report. Thank you.

Attachments

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
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Correspondence:

	Number
Health Insurance	
• Complaint regarding WPS and the Beech Street network.	1
• Complaints regarding Medicare Plus $1 Million benefits.	2
• Complaint regarding having been automatically enrolled in the Humana Medicare Advantage Plan.	1
• Complaint regarding lack of information provided to make an informed choice when selecting an HMO.	1
Pharmacy Benefits	
• Complaint regarding lack of coverage for shingles vaccine (Zostavax)	1
• Complaint regarding prescription drug costs. Feels that costs should be the same whether purchased via mail order or local pharmacy.	1
Disability Programs	
• Participant concern regarding need for assistance in applying for duty disability benefits.	1
TOTAL	8

Contacts to Ombudspersons:

From January 1, 2008, through February 29, 2008, 337 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, including inquiries and requests for assistance regarding Medicare Part D. Some reoccurring issues identified by staff included: confusion about the Humana Medicare Advantage Private Fee for Service plan, assessment of incorrect co-payments for prescription drugs at the pharmacy, access to appropriate providers, shingles vaccine coverage criteria, enrollment and eligibility discrepancies related to the annual student and disabled dependent verification process and complaints about the DentalBlue plan.

The following tables summarize the method of contact and program areas involved (compared with 2007).

Total Contacts (by month)	2008	2007
January	162	85
February	175	89
Total	337	174

Method of Contact (year to date)	2008	2007
Telephone	259	N/A
E-mail/Contact Us Internet Page	64	N/A
US Mail	7	N/A
Walk-In	7	N/A

Number of Contacts by Program (year to date)	2008	2007
Health Insurance-HMO's	150	91
Health Insurance-Self Funded	55	43
Pharmacy Benefits	87	23
Non-WRS Programs (DentalBlue)	18	2
Disability/Income Continuation Insurance	7	3
All Other Program Types* (Life Insurance, ERA, EPIC, Spectera, WRS/ASLCC and WDC)	20	12

*It is not common to receive a large number of complaints regarding these programs. The availability of ombudsperson assistance in this area is not widely known and most of these programs are not under contract with ETF; rather, they are benefits that the Board simply approves to be offered through payroll deduction.

Key:

- *ASLCC: Accumulated Sick Leave Conversion Credit*
- *ERA: Employee Reimbursement Accounts. Optional pre-tax savings account for medical expenses and dependent care.*
- *EPIC: Optional supplemental benefit plan that provides coverage for dental, excess medical and accidental death and dismemberment.*
- *Spectera: Optional vision benefit*
- *WDC: Wisconsin Deferred Compensation*
- *WRS: Wisconsin Retirement System*

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CORRESPONDENCE MEMORANDUM

DATE: April 1, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Board Liaison

SUBJECT: 2009 Group Insurance Board Meeting Dates

The following are the 2009 meeting dates for the Group Insurance Board. Please check your schedules to determine if these dates will be convenient for you. You will receive information on specific times prior to each meeting.

Tuesday, February 17, 2009
Tuesday, April 14, 2009
Tuesday, June 9, 2009
Tuesday, August 25, 2009
Tuesday, November 10, 2009

If you have questions regarding this schedule, please feel free to contact me at (608) 267-2417.

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

_____ _____
Signature Date

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CORRESPONDENCE MEMORANDUM

DATE: April 1, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

PENDING APPEALS BY BOARD						
As of:	ETF	GIB	WR	TR	DC	TOTAL
03/01/08	**13**	**8**	**7**	**1**	**0**	**29**
New Appeals (+)	+4	0	0	0	0	+4
Final Decisions (-)	-1	0	0	0	0	-1
Appeals Withdrawn (-)	-3	-3	-2	0	0	-8
04/01/08	**13**	**5**	**5**	**1**	**0**	**24**
+/-	0	-3	-2	0	0	-5

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

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CORRESPONDENCE MEMORANDUM

DATE: March 11, 2008

TO: Group Insurance Board

FROM: Marcia Blumer, Program Manager
Wisconsin Public Employers Group Life Insurance Program

SUBJECT: Extension of Minnesota Life Insurance Company Contract

The current contract with Minnesota Life Insurance Company (MLIC) for administration of the Wisconsin Public Employers (WPE) Group Life Insurance Program runs from January 1, 2004, through December 31, 2008. The contract allows for two one-year extensions. MLIC has been the administrator of the WPE Group Life Insurance Program since its inception in 1958 and has provided excellent service to the Department and plan participants. A full report of 2007 plan experience is scheduled for the August 2008 Group Insurance Board meeting.

Recommendation

Staff recommends that the Board authorize extension of the current contract for two years, from January 1, 2009, through December 31, 2010.

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

_____ _____
Signature Date

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