

2. ADDENDUMS

ADDENDUM 1

PLAN UTILIZATION AND RATE REVIEW INFORMATION

NAME OF PLAN: _____

SERVICE AREA COVERED: _____

PREMIUM RATES BASED ON: COMMUNITY RATED EXPERIENCE
 STATE EMPLOYEE EXPERIENCE*
 LOCAL EMPLOYEE EXPERIENCE*
 OTHER (PLEASE SPECIFY BASIS)
 * USE SEPARATE ADDENDUM 1 PAGES

This Rate Review information shall be provided June 5, 2015. It must be submitted directly to the Board's Actuary in the prescribed Excel format via e-mail. The accompanying data shall also be submitted on the same date in the prescribed format via a secure file transfer.

The Department will provide written guidelines to the plan concerning the definitions, group numbers or subgroups, report period, and other information required to prepare this report. Additional data may be required on different subgroups (COBRA participants, for example) throughout the contract year.

STATE OF WISCONSIN ACTUARIAL DATA REPORT GENERAL TABLE DESCRIPTION

Based upon the membership, experience data, trend assumptions, and assumed administrative costs provided, the data and calculations provided in TABLES 1-15 of the Addendum1 utilization and experience data request calculate prospective premium rates for calendar year 2016. Any plan for which proposed calendar year 2016 premium rates differ from those developed in Addendum 1 TABLES 1-15 will be required to submit its justification and applicable renewal calculation.

TABLE 1 – MONTHLY ENROLLMENT AND PREMIUMS

TABLE 1 will calculate average contract size and contract mix figures based upon data provided. The number of member months and contracts for the period 1/1/2014-3/31/2015 should be input for single coverage in Columns B and C and for family coverage in Columns D and E.

The contractual premium rates by coverage tier should be entered on line 30. Line 31 should be the dental benefit component of the premium applicable to the prior dental benefit. Line 32 should include any other adjustments that may have been made to the contractual premium rates. The net premium is calculated on line 33 as the sum of line 30-32.

The remainder of the worksheet will auto calculate, including lines 43-44 that calculate average contract size and mix for single and family coverage.

TABLE 2 -- ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

The first section of TABLE 2 requests the member counts for the period of 4/1/2014-3/31/2015 by age group and sex (regardless of whether the member is an employee or a dependent).

The second section of TABLE 2 requests the member counts for December 2014 by age group and sex (regardless of whether the member is an employee or a dependent).

The third section of TABLE 2 requests the member counts for March 2015 by age group and sex (regardless of whether the member is an employee or a dependent).

A box at the bottom of TABLE 2 will show the automatically calculated average age and average age/sex factor.

The age calculation should be based on the employee or dependent's age on the first day of the month.

All counts should reconcile to TABLE 1.

TABLE 3 -- ACTUARIAL DATA REPORTS

TABLE 3A: APRIL 1, 2014 THROUGH MARCH 31, 2015 FEE FOR SERVICE CLAIMS

TABLE 3B: APRIL 1, 2014 THROUGH MARCH 31, 2015 CAPITATION ENCOUNTER

GENERAL DESCRIPTION

TABLE 3 requests fee for service claims and capitation encounter experience information for all health plans, whether they are experience rated or fully or partially capitated. There are separate sections for medical fee for service and capitation encounter data (TABLES 3A and 3B, respectively). Please complete those portions of the data request that are applicable to your type of plan.

- Category: One report is requested for each of the following eight categories:
- i. State of Wisconsin Employee Plan, Non-Medicare, Non Graduate Assistant
 - ii. State of Wisconsin Employee Plan, Medicare
 - iii. State of Wisconsin Employee Plan, Graduate Assistant
 - iv. State of Wisconsin Local Plan, Non-Medicare
 - v. State of Wisconsin Local Plan, Medicare
 - vi. State of Wisconsin High Deductible Plan
 - vii. Total Organization, Non-Medicare/Commercial
 - viii. Total Organization, Medicare

A title worksheet is included in the first tab of the workbook. Use the dropdown box to specify the category of each report.

For the Medicare lines of business (State & Local), the experience and membership provided should include only those members who are Medicare-eligible (no non-Medicare eligible spouses or other dependents). Please respond to the questions in TABLE 11 and indicate if this is not the case.

Please note that the Total Organization refers to all commercial group business for your organization, including the State of Wisconsin but excluding Medicaid participants. If you offer more than one plan option to either Non-Medicare or Medicare State of Wisconsin Employee or Local Plan participants, please include a separate report for each option.

➤ Report Period

The report should include all services rendered from April 1, 2014 through March 31, 2015.

➤ Benefit Description

Refer to the section immediately following for a detailed description of services to be included in each benefit category. If you are unable to follow these definitions, indicate the reason why and the actual definition used.

➤ Total Number of Admissions

For hospital inpatient services, the total number of admissions rendered for all members during the Report Period.

➤ Total Number of Days

For hospital inpatient services, the total number of hospital days rendered for all members during the Report Period.

➤ Total Billed Charges

For all services, the total billed charges. Billed charges are defined as undiscounted charges for covered services during the requested Report Period. The experience should not include any billed charges for services not covered by the plan. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

➤ Total Allowed Charges

For all services, the total allowed charges. Allowed charges are defined as discounted charges for covered services during the requested Report Period. The experience should not include any allowed charges for services not covered by the plan. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

➤ Total COB (including Medicare)

For all services, the total amount paid for covered services by another carrier or Medicare through coordination of benefits during the requested Report Period.

➤ Total Member Cost Share

For all services, the total member cost share. Member cost share is defined as any participant/member liabilities such as copayments, coinsurance or deductibles applicable for covered services during the requested Report Period.

- Total Paid Charges
For all services, the total paid claims. Paid claims are defined as discounted charges net of employee cost-sharing during the requested Report Period. In other words, the experience should not include any participant/member liabilities such as copayments, coinsurance or deductibles. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.
- Total Number of Member Months
The total number of member months is the number of months each member and dependent is eligible for benefits during the Report Period. Please note that this cell is linked to the total 4/1/2014-3/31/2015 member months from TABLE 1.
- Annual Admissions Per 1,000
For hospital inpatient services, calculated as the total Number of Admissions divided by the total Number of Member Months, times 12,000.
- Annual Days Per 1,000
For hospital inpatient services, calculated as the Total Number of Days divided by the Total Number of Member Months, times 12,000.
- Average Length of Stay
For hospital inpatient services, calculated as the Total Number of Days divided by Total Number of Admissions.
- Average Paid Charges Per Day
For hospital inpatient services, calculated as Total Paid Charges divided by the Total Number of Days.
- Average Paid Charges Per Member Per Month
Calculated as Total Paid Charges divided by the total Number of Member Months.
- Total Number of Services
For non-hospital inpatient services, the total number of services rendered for all members during the Report Period. Please note the services are defined in the Benefit Description section.
- Annual Services Per 1,000
For non-hospital inpatient services, calculated as Total Number of Services divided by the total Number of Member Months, times 12,000.
- Average Paid Charges Per Service
For non-hospital inpatient services, calculated as the Total Paid Charges divided by the Total Number of Services.
- Fee For Service Incurred Claim Factor
This factor is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges.

➤ Runout Months

This is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of 4/1/2014-3/31/2015. For example, if a plan includes experience for claims that were incurred from 4/1/2014-3/31/2015 and paid through 5/31/2015, the Runout Months would equal two and the Incurred Claim Factor should be reflective of the Runout Months.

➤ Fee For Service Incurred Claims

Incurred claims will be calculated as (1 + Completion Factor) multiplied by the Paid Charges. This represents the total amount of claims that have been incurred in the Reporting Period.

➤ Capitation Paid

The total capitation payments paid during the Report Period. This will calculate automatically from Total Paid Capitation during the Report Period entered on Table 4.

BENEFIT DESCRIPTION FOR TABLES 3A and 3B

TABLE 3A requests medical fee for service utilization and claims experience for the period 4/1/2014-3/31/2015. TABLE 3B requests medical capitation encounter data for the period 4/1/2014-3/31/2015.

The following benefit descriptions should be used in developing the Actuarial Data Report. Where possible, Current Procedural Terminology Codes—CPT 2014 Professional Edition, (CPT-4 codes) has been included to aid in the summarization of information. The appropriate HCFA Common Procedure Coding System (HCPCS) Level II codes are also included. For services affected by the Medicare Resource Based Relative Value System (RBRVS), both the CPT code ranges used prior to RBRVS and the evaluation and management CPT code ranges introduced by RBRVS have been included.

Note: There have been no changes to the mapping this year and the required data submission utilizes identical methodology.

A. HOSPITAL INPATIENT

This benefit includes daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Services are counted as the number of admissions and the number of days confined. Ancillary charges should not include professional charges for hospital-based physicians.

1. Non-Maternity

- a. Medical: A medical admission includes a confinement without a major surgery and without a diagnosis indicating a substance abuse or psychiatric condition.
- b. Surgical: A surgical admission includes a confinement primarily resulting from a surgery or multiple surgeries.
- c. Mental Health: A psychiatric admission includes a confinement with a primary diagnosis involving a psychiatric condition.

- d. Substance Abuse: A substance abuse admission includes a confinement with a primary diagnosis involving an alcohol and/or drug abuse condition.

2. Maternity

- a. Maternity Deliveries: This benefit includes hospital inpatient room and board and ancillary services for normal and cesarean deliveries for the mother. Charges for the well newborn baby should be included but newborn admissions and days should be excluded.
- b. Maternity - Non-Deliveries: This benefit includes hospital inpatient room and board and ancillary services for complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.
- c. Neonatal ICU: This benefit includes hospital inpatient room and board and ancillary services for premature infants or other neonatal care.

3. Extended Care Facility

This benefit includes daily room and board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

B. HOSPITAL OUTPATIENT

1. Emergency Room

This benefit includes services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Services are counted as the number of visits to the emergency room. Charges should include facility charges only and not professional charges.

2. Outpatient Surgery

This benefit includes hospital outpatient services for surgery, including surgery performed in a hospital outpatient facility or a freestanding surgical facility. Services are counted as the number of surgical procedures and not the number of outpatient surgical encounters. Charges should include facility charges only and do not include professional charges.

3. Radiology

This benefit includes the technical component of radiology services performed by a hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

4. Pathology

This benefit includes the technical component of pathology services performed by the hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

5. Outpatient Mental Health

This benefit includes mental health outpatient services. Services are counted as the number of visits to the outpatient mental health facility. Charges should include facility charges only and not professional charges.

6. Outpatient Substance Abuse

This benefit includes substance abuse outpatient services. Services are counted as the number of visits to the outpatient substance abuse facility. Charges should include facility charges only and not professional charges.

7. Other

This benefit includes hospital outpatient services other than emergency room, surgery, radiology and pathology, such as physical therapy, maternity non-delivery, and supplies. Services are counted as the number of procedures. Charges should include facility charges only and not professional charges.

8. Other Facility

- a. Hospice -This benefit includes all facility charges and services provided in a hospice for a terminally ill patient and family. Charges incurred in the hospice ward of a hospital are included as well as in a stand-alone hospice facility.
- b. Transitional Care -This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be provided in a hospital outpatient or day care setting and charges would include professional and facility charges.

C. PHYSICIAN

1. Surgical Services

a. Inpatient Surgery:

- (1) Professional Surgeon (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgeries performed by a surgeon on an inpatient basis. Services are counted as the number of inpatient surgical procedures and not the number of surgical admissions. Charges should include normal pre-surgical and post-surgical encounters with the surgeon and would include both primary and assistant surgeon charges.

b. Anesthesia:

- (1) Inpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140 or 10040-69990 with anesthesia modifier)

This benefit includes services by an anesthesiologist or anesthesiologist for non-maternity and maternity surgeries performed in an inpatient setting. Services are counted as the number of inpatient surgical procedures requiring anesthesia. Charges should include inpatient pre-surgical and post-surgical encounters, and the usual monitoring procedures.

- (2) Outpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140, or 10040-69990 with anesthesia modifier)

Same as above except in an outpatient setting, including a hospital outpatient department, freestanding surgical facility or physician's office.

c. Maternity:

- (1) Normal Deliveries (CPT-4 Codes 59400-59430, 59610-59614)

This benefit includes physician obstetrical care for normal deliveries and complications of pregnancy that result in a normal delivery. Services are counted as the number of maternity cases that result in a normal delivery. Charges should include delivery care and standard pre- and post-natal visits.

- (2) Cesarean Deliveries (CPT-4 Codes 59510-59515, 59618-59622)

This benefit includes physician obstetrical care for cesarean deliveries and complications of pregnancy that result in a cesarean delivery. Services are counted as the number of maternity cases that result in a cesarean delivery. Charges should include delivery care and standard pre-natal and post-natal visits.

- (3) Other OB Services (CPT-4 Codes 59000-59350, 59812-59899)

This benefit includes physician obstetrical care for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion as well as other obstetrical services that are not related to a delivery (e.g. amniocentesis, fetal monitoring, etc.). Services are counted as the number of procedures. Charges should include surgical care and standard pre-natal visits.

d. Outpatient Surgery:

- (1) Outpatient Surgical Center (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit provides for surgery by a physician in a hospital outpatient department or a freestanding surgical facility. Services are counted as the number of outpatient procedures and not the number of outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with a surgeon.

- (2) Office (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgery by a physician in the physician's office. Services are counted as the number of office outpatient surgical procedures and not the number of office outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with the physician.

2. Physician — Inpatient Visits

- a. Hospital Visits (CPT-4 Codes 99217-99239, 99289-99300, 99460, 99462-99465, HCPCS Codes M0064-M0100)

This benefit includes visits to hospitals by a physician. Services are counted as the number of visits. Physician visits by the surgeon in the case of a surgery should be included in the surgery benefit.

- b. Critical Care Visits (CPT-4 Codes 99170-99199, 99289-99292, 99466-99480)

This benefit includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician (e.g. cardiac arrest, shock, bleeding, respiratory failure, etc.). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Services are counted as the number of procedures.

- c. Mental Health Visits (CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999, M0064-M0100)

This benefit includes visits to hospitals for a psychiatric patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

- d. Substance Abuse Visits (CPT-4 Codes 90791-90792, 90832-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes visits to hospitals for a substance abuse patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

- e. Extended Care Visits (CPT-4 Codes 99304-99318, HCPCS Codes M0064-M0100)

This benefit includes physician visits to approved extended care facilities. Services are counted as the number of procedures.

- f. Home Health Visits (CPT-4 Codes 99324-99350, 99500-99602, HCPCS Codes M0064-M0100)

This benefit includes physician visits in the insured's home or a custodial facility. It does not include visits by a nurse. Services are counted as the number of visits.

3. Office Services

- a. Office Visits (CPT-4 Codes 99143-99150, 99201-99215, HCPCS Codes M0064-M0100)

This benefit includes visits to a physician's office. Physical exams, well baby exams and any pre-surgical or post-surgical visits are included elsewhere. Services are counted as the number of visits. Charges should include professional fees of the primary physician or the referral physician. Charge levels should include only the physician's time; the charges for lab or x-ray procedures performed in the physician's

office and medications are included elsewhere.

- b. Therapeutic Injections (J Codes) (CPT-4 Codes 96360-96379; HCPCS Codes J0120-J8999, J9019, J9042)

This benefit includes professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included. Services are counted as the number of procedures.

- c. Allergy Testing/Allergy Immunotherapy (CPT-4 Codes 95004-95079, 95115-95199, HCPCS Codes G0008-G0010, J0171-J8999)

This benefit includes professional services and materials associated with allergy tests when administered by the staff of the attending physician. This benefit also includes professional services and materials associated with allergy immunotherapy (serum, syringes, etc.) when administered by the staff of the attending physician. Services are counted as the number of procedures.

- d. Chemotherapy Drugs (HCPCS Codes J9000-J9999, excluding codes J9019 and J9042.)

This benefit includes professional services and materials associated with chemotherapy drugs when administered by the staff of the attending physician. Services are counted as the number of procedures.

- e. Diagnostic Testing

This benefit provides for the following professional services:

<u>Service</u>	<u>CPT-4 or HCPCS Codes</u>
Biofeedback	90901-90911
Gastroenterology	91000-91299
Otorhinolaryngology Services	92502-92505, 92511-92526, 92700
Vestibular Function Tests	92531-92548
Non-Invasive Peripheral Vascular Diagnostic Studies	93875-93998
Pulmonary	94002-94799
Neurology	95782, 95783, 95800-96020
Chemotherapy	96401-96549, HCPCS Codes Q0083-Q0085
Dermatology	96900-96999
Miscellaneous	96101-96125, 96150-96155, 99000-99091, 99175-99199, 99354-99360, 99477-99499, HCPCS Code G9143

Not all of the above procedures are necessarily diagnostic testing. They were included in this benefit because they are related to diagnostic testing. Services are counted as the number of procedures.

f. Urgent Care

This benefit includes services for medical care performed in an urgent care facility. Services are counted as the number of visits to the urgent care center. Charges should include both facility and professional charges.

g. Other (HCPCS Codes A4206-A4608, A4641-A4652, A5051-A9999, B4000-B5200, M0075-M0100)

This benefit includes physician office services not included elsewhere. Services are counted as the number of procedures.

4. Other Physician Services

a. Emergency Room Visits (CPT-4 Codes 99281-99288)

This benefit includes visits to the emergency area of a hospital outpatient facility by either a primary care physician or a hospital staff physician. Services are counted as the number of visits.

b. Consults (CPT-4 Codes 99241-99255, 97802-97804, HCPCS G0270-G0271)

This benefit includes a consulting specialist and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate source for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. Consultations can be provided for both inpatient and outpatient care. Services are counted as the number of consultations.

c. Cardiovascular (CPT-4 Codes 92950-93799; HCPCS Codes M0300-M0301, Q0035)

This benefit includes therapeutic services (e.g. CPR), cardiography (e.g. EKGs), cardiac catheterization and other cardiovascular services performed by a physician. Services are counted as the number of procedures.

d. Dialysis (CPT-4 Codes 90935-90999; HCPCS Codes A4650-A4932, E1500-E1699, M0064-M0100)

This benefit includes services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures. Services are counted as the number of procedures.

e. Other Physician Services (CPT-4 Codes 96567-96571, 99143-99150, 99363-99380; Miscellaneous HCPCS Codes)

This benefit includes physician services not allocated to other line items. Services are counted as the number of procedures.

f. Radiology:

(1) Inpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by a physician when the x-ray is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of radiology services should be included in the hospital inpatient benefit.

(2) Outpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by the physician when the x-ray is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of radiology services should be included in the Hospital Outpatient - Radiology benefit or in the Physician - Radiology - Office (Combined Professional and Technical) benefit.

(3) Office - (Combined Professional and Technical) (CPT-4 Codes 70010-77032, 77071-79999; HCPCS Codes Q0092, R0000-R5999)

This benefit includes both the professional and technical component of radiology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the x-ray is performed in an office or clinic setting.

g. Surgical Pathology:

(1) Inpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional services by a physician when the surgical pathology procedure is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of pathology services should be included in the hospital inpatient benefit.

(2) Outpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional service by the physician when the surgical pathology procedure is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of pathology services should be included in the Hospital Outpatient - Pathology benefit or in the Physician - Pathology - Office (Combined Professional and Technical) benefit.

(3) Office (Combined Professional and Technical) (CPT-4 Codes 88300-88399; HCPCS Code Q0091)

This benefit includes both the professional and technical component of surgical pathology services when these services are billed together. Services are counted

as the number of procedures. Charges should only be included here when the lab work is performed in an office or clinic setting.

D. OTHER SERVICES

1. Physical Therapy

(CPT-4 Codes 97001-97002, 97005-97799)

This benefit includes physical therapy when ordered by the attending physician. Services are counted as the number of procedures.

2. Occupational/Speech Therapy

(CPT-4 Codes 92506-92508, 97003-97004, HCPCS Codes V5362-V5364)

This benefit includes occupational therapy when ordered by the attending physician. Services are counted as the number of procedures.

3. Chiropractic

(CPT-4 Codes 98940-98943)

This benefit includes visits to a licensed chiropractor's office including those visits involving manipulations. This benefit includes x-rays taken in the chiropractor's office. Services are counted as the number of procedures.

4. Private Duty Nursing/Home Health

(CPT-4 Codes 99500-99602)

This benefit includes private nursing and home health visits if required by the attending physician and not representing custodial care. Services are counted as the number of procedures.

5. Ambulance

(HCPCS Codes A0000-A0999)

This benefit includes professional ambulance service. Services are counted as the number of procedures.

6. Durable Medical Equipment/Prosthetics

(HCPCS Codes A4611-A4640, B9000-B9999, E0100-E1406, E1700-E8002, K0001-K0900, L0100-L9999, Q0081, V5030-V5299, V5336)

This benefit includes appliances, equipment, and prosthetic devices. Appliances and equipment include braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. Prosthetics includes artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, and medically necessary reconstruction). Services are counted as the number of items.

7. Laboratory

(CPT Codes 36415, 80047-88299, 89049-89240; HCPCS Codes G0027, P0000-P9999)

This benefit includes both the professional and technical component of non-physician laboratory services when these services are billed together. Services are counted as the number of procedures.

E. ADDITIONAL BENEFITS

1. Immunizations

(CPT-4 Codes 90281-90749)

This benefit includes the professional services and materials associated with administering immunizations. Services are counted as the number of procedures.

2. Well Baby Exams

(CPT-4 Codes 99381, 99391, 99460-99465)

This benefit includes normal periodic examinations of well children under age one. Services are counted as the number of exams.

3. Well Child Exams

(CPT Codes 99382-99384, 99392-99394, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of children ages 1 through 17. Services are counted as the number of exams.

4. Physical Exams

(CPT-4 Codes 99385-99387, 99395-99397, 99401-99429, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of adults and children over the age of 17. Services are counted as the number of exams.

5. Vision Services

(CPT-4 Codes 92002-92287, 92499)

This benefit includes eye exams and other ophthalmology services conducted by a licensed ophthalmologist or optometrist. Services are counted as the number of procedures.

6. Vision Supplies

(CPT-4 Codes 92310-92371; HCPCS Codes V2020-V2799)

This benefit includes lenses and frames and contact lenses. Services are counted as the number of services.

7. Speech Exams

(CPT-4 Codes 92506-92508; HCPCS Codes V5301-V5364 (except V5336))

This benefit includes speech exams. Services are counted as the number of procedures.

8. Hearing Exams

(CPT-4 Codes 92550-92597; HCPCS Codes V5000-V5020)

This benefit includes hearing exams. Services are counted as the number of procedures.

9. Podiatrist

This benefit includes services performed by a licensed podiatrist. There are no specifically identified CPT codes for this treatment. Services are counted as the number of visits.

10. Mammography Exams

(CPT Codes 77051-77059)

This benefit includes routine mammography examinations of female adults. Charges should include the x-ray associated with the exam. Services are counted as the number of procedures.

11. Outpatient Mental Health

(CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999)

This benefit includes psychiatric treatment by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

12. Outpatient Substance Abuse

(CPT-4 Codes 90785-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes treatment of alcohol and/or drug abuse by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

13. Other Services

This line item would include all services that have not been allocated to any of the above line items.

TABLE 4 – PAID CLAIMS AND ENCOUNTER EXPERIENCE BY MONTH

TABLE 4 requests medical fee for service claims, capitation encounter data and capitation payments by month for the period 1/1/2014-3/31/2015.

Claims and encounter data should be entered for the six main service categories consistent with TABLES 3A & 3B: Hospital Inpatient, Hospital Outpatient, Other Facility, Physician, Other Services and Additional Services. There are separate columns for fee for service and encounter data. Data entered by month should not include any incurred claim completion factors.

Additional input is required for total actual capitation payment by month for the same period.

TABLE 5 -- MEDICAL TREND ASSUMPTIONS

TABLE 5 requests information regarding the trends used in the rate development. **NOTE: The trend periods used in the calculations are listed at the top of the table.**

Step 1 shows the calculation of the weighted trend for fee-for-service costs. The weighted trend is the trend assumed by the carrier from the midpoint of the experience period to the midpoint of the rating period. Prepare separate tables for each period. Prepare one table for 2014-2015 and another table for 2015-2016 annual trends.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second and third columns represent trend factors for cost and utilization. Estimates of these factors need to be input for both trending periods.

The fourth, fifth, and sixth columns are automatically calculated fields which develop an overall trend factor for both rating periods.

Step 2 calculates the two year weighted trend for fee-for-service costs. The aggregate trend is calculated by multiplying the sum of one (1) plus the weighted trend for the first period (for only 9 months) times the sum of one (1) plus the weighted trend for the second period.

Step 3 requests the aggregate trend for capitated services.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second column requests the projected annual trend for 2014-2015.

The third and fourth columns automatically calculate an overall weighted annual trend for 2014-2015 based on the trend input and the distribution of capitated service categories.

The fifth, sixth and seventh columns are similar to columns one, two and three and four as described above. However, plans should enter projected annual trend for 2015-2016 in the fifth column.

The two year weighted trend for capitated services is then calculated. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period times the sum of one plus the weighted trend for the second period.

Step 4 is where the carrier should explain any special circumstances which may have caused the trends to be unusually high or low.

**TABLE 6 -- MEDICAL ADMINISTRATIVE EXPENSES
AND OTHER PMPM COSTS**

TABLE 6 requires a breakdown of the administrative expenses and any other miscellaneous costs included in the rate development.

Medical Administrative Expenses:

The first column lists a detailed description of the different expense categories requested.

The second column is the 2014 PMPM cost for the expense category.

The third column is the PMPM cost that was included in the 2015 rate calculation.

The fourth column is the estimated PMPM cost included in the 2016 rate calculation.

TABLE 7 -- REQUIRED PREMIUM PMPM

TABLE 7 uses the information provided on TABLES 1 - 6 to calculate the required premium per member per month for calendar year 2016. Please note that these automatically calculate and plans are not required to input data.

Line 1 - is the grand total amount of fee-for-service claims cost PMPM for the experience period as shown in TABLE 3A. This amount includes the incurred claim factor supplied to bring the claims to an incurred level.

Line 2 - is the aggregate fee-for-service trend factor as shown in TABLE 5.

Line 3 - is the claims cost trended to the rating period, which is calculated by multiplying Line 1 by Line 2.

Line 4 - is the total capitation cost PMPM from TABLES 3A and/or 3B.

Line 5 - is the aggregate capitated services trend factor from TABLE 5.

Line 6 - is the total capitation cost trended to the rating period, which is calculated by multiplying Line 4 by Line 5.

Line 7 - is the total estimated 2016 administrative cost PMPM as shown on TABLE 6.

Line 8 - is the required medical premium PMPM and is calculated by adding lines 3, 6 and 7.

TABLE 8 – 2016 CALCULATED RATES

TABLE 8 includes information from TABLES 1 through 7 to automatically calculate the single and family rates.

Step 1 details the calculation of the conversion factor used to convert the required premium per member per month to single and family rates.

Line 1, Column B - is the contract mix from TABLE 1, line 44 Column B.

Line 2, Column B - is the contract mix from TABLE 1, line 44 Column C.

Line 3, Column B - is the sum of the contract mix for single and family, which must equal 100%.

Line 1, Column C - is the average contract size for single from TABLE 1, line 43 Column B.

Line 2, Column C - is the average contract size for family from TABLE 1, line 43 Column C.

Line 3, Column C - is the average contract size in total from TABLE 1, line 43 Column D.

Line 1, Column D - is the rate ratio for single of 1.0.

Line 2, Column D - is the rate ratio for family of 2.0 for Medicare, 2.5 for non-Medicare.

Line 3, Column D - is the weighted average rate ratio in total for single and family.

Line 1, Column E - is the conversion factor for single and is derived by dividing the total average contract size by the total rate ratio.

Line 2, Column E - is the conversion factor for family and is derived by multiplying the conversion factor for single by the rate ratio for family.

Step 2 details the calculation of the 2016 medical rates using the required premium PMPM and the conversion factor.

Line 4, Column C - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column C - is conversion factor for single.

Line 6, Column C - is the calculated 2016 rate for single and is derived by multiplying the required premium PMPM by the conversion factor.

Line 4, Column D - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column D - is the conversion factor for family.

Line 6, Column D - is the calculated 2016 rate for family and is derived by multiplying the required premium PMPM by the conversion factor.

Line 7 - The last line pulls the net 2015 in force medical only rates for single and family coverage from TABLE 1 Line 33.

TABLE 9 – CALCULATED LOSS RATIOS

TABLE 9 includes information from TABLES 1 through 8 to automatically calculate the loss ratios for each of the periods.

The experience period loss ratios are calculated by first calculating the monthly revenue from TABLE 1 and pulling the monthly claims and capitation experience from TABLE 4.

The projected 2015 and 2016 loss ratios have a number of calculated fields that utilize the reported claims experience and calculated rates.

TABLE 10 – CLAIMS IN EXCESS OF \$100,000 Incurred Period: April 1, 2014 through March 31, 2015

Line 1 - is the total amount of paid claims for individuals with paid claims of \$100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of \$150,000 each, you would enter the value of $\$150,000 \times 5 = \$750,000$.

Line 2 - is the number of individuals with paid claims of \$100,000 or greater.

Line 3 – is the total amount of claims of \$100,000 or greater on an individual basis. For example, if you had five cases with paid claims of \$150,000 each, this cell would calculate as follows: $\$150,000 \times 5 - \$100,000 \times 5 = \$250,000$.

Line 4 - is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as $(1 + \text{Incurred Claim Factor})$ multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of 4/1/2014-3/31/2015. For example, if a plan includes experience for claims that were incurred from 4/1/2014-3/31/2015 and paid through 5/31/2015, the Runout Months would equal two.

Line 6 - will be calculated as $(1 + \text{Completion Factor})$ multiplied by the Paid Charges. This represents the total amount of claims of \$100,000 or greater that have been incurred in the Reporting Period.

TABLE 11 – QUESTIONS REGARDING SUBMITTED DATA

TABLE 11 requests responses to questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 11. TABLE 11 is considered a part of the required data and must be provided at the same time as all other information.

TABLE 12 – TOP PROVIDER REPORT

TABLE 12 requests plans submit a list of top facility and top professional providers based on Plan Paid dollars for the Addendum population and the time period April 1, 2014 through March

31, 2015. The provider information requested includes name, location, National Provider Identifier number and utilization counts.

Table 12 is only included in three of the eight categories:

- i. State of Wisconsin Employee Plan, Non-Medicare
- ii. State of Wisconsin Employee Plan, Medicare
- iii. State of Wisconsin Local Plan, Non-Medicare

TABLE 13 – REQUIRED DATA FORMAT

Data is to be submitted to the Board's Actuary and match the information in the service categories detailed in TABLES 3A & 3B. It is expected that the data will match both the utilization and billed amounts. In later years more financial information will be required in the detail file.

Please send data for all groups. We are requesting 12 months of incurred data covering the period April 1, 2014 Through March 31, 2015 and paid through the most recent and complete month. Both fee for service claims and capitation encounter data should be provided with an appropriate code to separate.

The file should be comma delimited and include Control totals for all groups and files sent. The Control totals should include: Total Record Count, Total Billed Amount, Total Allowed Amount (not for 2015) and Total Paid Amount (not for 2015)

TABLE 14 – SERVICE CATEGORY CODES

TABLE 14 provides a mapping of the line items in TABLES 3A & 3B. The data should be grouped as described in that section, with the mapping included in the data sets.

TABLE 15 – ACTUARIAL CERTIFICATION

There is a new requirement to have the rate development, supporting reports and detailed data be certified by an actuary who is a Member of the American Academy of Actuaries. There is a box to allow an actuary to enter their certification language.

The actuary should enter his Name, Firm, Phone and Date of the certification.

If vendors are unable to meet the actuarial certification requirement, they should provide acceptable language and justification. The rates should then be certified by their Chief Financial Officer.

**State of Wisconsin
Addendum 1**

REPORT CATEGORY

One report is requested for each of the following eight categories:

- State of Wisconsin - Employee Plan, Non-Medicare, Non Grad Assistant
- State of Wisconsin - Employee Plan, Medicare
- State of Wisconsin - Employee Plan, Grad Assistant
- State of Wisconsin - Local Plan, Non-Medicare
- State of Wisconsin - Local Plan, Medicare
- State of Wisconsin - High Deductible Plan
- Total Organization - Non-Medicare/Commercial
- Total Organization - Medicare

Please specify the category of this report by choosing one option from the dropdown box below:

State of Wisconsin - Employee Plan, Non-Medicare, Non Grad Assistant

TABLE 1
MONTHLY ENROLLMENT AND PREMIUMS
 January 1, 2014 Through March 31, 2015

Enrollment	SINGLE		FAMILY	
	Members	Contracts	Members	Contracts
Jan-14	0	0	0	0
Feb-14	0	0	0	0
Mar-14	0	0	0	0
Apr-14	0	0	0	0
May-14	0	0	0	0
Jun-14	0	0	0	0
Jul-14	0	0	0	0
Aug-14	0	0	0	0
Sep-14	0	0	0	0
Oct-14	0	0	0	0
Nov-14	0	0	0	0
Dec-14	0	0	0	0
Total 2014	0	0	0	0
Jan-15	0	0	0	0
Feb-15	0	0	0	0
Mar-15	0	0	0	0
Total 2015 Q1	0	0	0	0

Premiums	2014		2015	
	Single	Family	Single	Family
Contract Rate	\$0.00	\$0.00	\$0.00	\$0.00
Dental Component	\$0.00	\$0.00	\$0.00	\$0.00
Other Adjustments	\$0.00	\$0.00	\$0.00	\$0.00
Net Premium Rate	\$0.00	\$0.00	\$0.00	\$0.00

CALCULATION OF CONTRACT MIX AND CONTRACT SIZE
 April 1, 2014 Through March 31, 2015

	Single	Family	Total
Member Months	0	0	0
Contract Months	0	0	0
Contract Size	0.0	0.0	0.0
Contract Mix	0%	0%	0%

TABLE 2
ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

Age Category	Member Months 4/1/14 - 3/31/15		
	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

Age Category	December 2014 Member Counts		
	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

Age Category	March 2015 Member Counts		
	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

Age Category	Age/Sex Factors (using member months)		
	Male	Female	Total
Under 1	3.66	3.05	0.00
1-4	0.59	0.50	0.00
5-14	0.37	0.33	0.00
15-17	0.52	0.57	0.00
18-24	0.46	0.74	0.00
25-34	0.54	1.25	0.00
35-44	0.78	1.26	0.00
45-54	1.34	1.61	0.00
55-64	2.36	2.26	0.00
65-74	3.07	2.79	0.00
75+	3.07	2.79	0.00
TOTAL	0.00	0.00	0.00

Average age (from 4/14-3/15 member months):	0
Average age/sex factor (using 4/14-3/15 member months):	0.00

TABLE 3A
Fee For Service Claims Experience - Actuarial Data

April 1, 2014 Through March 31, 2015														
Type of Service	Total # of Admissions	Total # of Days	Total Billed Charges	Total Allowed Charges	Total COB (Including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Admissions/1,000	Annual Days/1,000	Average Length of Stay	Average Paid Charges per Day	Average Paid Charges PMPM	Percent of Total
Hospital Inpatient														
Medical/Surgical	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Mental Health (MH)	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Substance Abuse (SA)	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Subtotal Non-Maternity														
Maternity/Deliveries	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Maternity/Non-Deliveries	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Neonatal ICU	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
Subtotal Maternity														
Extended Care Facility	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%
1. Total Hospital Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0	0	\$0.00	\$0.00	0.0%

Type of Service	Total # of Services	Total Billed Charges	Total Allowed Charges	Total COB (Including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Services/1,000	Average Paid Charges PMPM	Average Length of Stay	Percent of Total		
Hospital Outpatient													
Emergency Room	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Surgery	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Radiology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Pathology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Mental Health (MH)	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Substance Abuse (SA)	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Other (Specify)	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
2. Total Hospital Outpatient	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
3. TOTAL HOSPITAL													
Other Facility													
Hospice	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Transitional Care	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
4. Total Other Facility	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Physician Services													
Inpatient Surgery	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Anesthesia	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Anesthesia	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
IP Maternity - Normal Deliveries	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
IP Maternity-Cesarean Deliveries	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
IP Other OB Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Hosp/Surgical Center	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Office Surgery	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Hospital Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Critical Care Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Mental Health Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Substance Abuse Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Extended Care Facility Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Home Health Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Office Visits	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Therapeutic Injections (I/Codes)	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Allergy Testing/Immunotherapy	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Chemotherapy/Immunology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Diagnostic Testing	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Urgent Care	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Emergency Room	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Consult	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Cardiovascular	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Diagnosis	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Radiology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Radiology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Office Radiology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Inpatient Pathology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Pathology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Office Pathology	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Other (Specify)	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
5. Total Physician Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Other Services													
Physical Therapy	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Occupational/Speech Therapy	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Chiropractic Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Practical Duty Nurse/Home Health/Care Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Acupuncture	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
DME/Prosthetics	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Laboratory	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
6. Total Other Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Additional Services													
Immunizations	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
DVA/E-aby Exams	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Well Child Exams	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Physical Exams	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Vision Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Vision Supplies	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Speech Exams	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Hearing Exams	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Podiatry Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Mammography	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Mental Health	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Outpatient Substance Abuse	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
Other	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
7. Total Additional Services	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
8. Total Fee For Service	0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	0.0%		
9. Total FFS Incurred Claim Factor	0.0000%												
10. Number of Renewal Months	0												
11. Incurred Fee For Service Total							\$0	0				\$0.00	0.0%
12. Total Capitation Paid (From Table 3B Line 9)							\$0	0				\$0.00	0.0%
13. Incurred Claim Grant Total							\$0	0				\$0.00	0.0%

Valid

Valid

TABLE 3B
Capitation Encounter Experience - Actuarial Data

April 1, 2014 Through March 31, 2015														
Type of Service	Total # of Admissions	Total # of Days	Total Billed Charges	Total Allowed Charges	Total COB (Including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Admissions/ 1,000	Annual Days/1,000	Average Length of Stay	Average Paid Charges per Day	Average Paid Charges PMPM	Percent of Total
Hospital Inpatient														
Mental Hospital	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Mental Hospital (MH)	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Substance Abuse (SA)	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Subtotal Non-Maternity														
Maternity Delivery	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Maternity Non-Delivery	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Neonatal ICU	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
Subtotal Maternity														
Extended Care Facility	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	
1. Total Hospital Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	0	0	0		\$0.00	\$0.00	0.0%
Other Facility														
Emergency Room	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Surgery	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Radiology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Pathology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Mental Health (MH)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Substance Abuse (SA)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Other (Specify)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
2. Total Hospital Outpatient	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
3. TOTAL HOSPITAL	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Other Facility														
Hospice	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Transitional Care	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
4. Total Other Facility	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Physician Services														
Inpatient Surgery	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Anesthesia	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Anesthesia	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
IP Maternity - Normal Delivery	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
IP Maternity-Cesarean Delivery	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
IP Other OB Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Hosp/Surgical Center	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Office Surgery	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Hospital Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Outpatient Care Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Mental Health Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Substance Abuse Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Extended Care Facility Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Home Health Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Office Visits	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Therapeutic Injections (Cocaine)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Allergy Testing (non-anaphylaxis)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Chemotherapy Drugs	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Diagnosis Testing	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Urgent Care	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Emergency Room	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Counselor	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Telemedicine	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Diapers	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Radiology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Radiology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Office Radiology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Inpatient Pathology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Pathology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Office Pathology	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Other (Specify)	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
5. Total Physician Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Other Services														
Physical Therapy	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Occupational/Speech Therapy	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Chiropractic Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Private Duty Nursing/Home Health Care Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Ambulance	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
DMB/Prosthetics	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Laboratory	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
6. Total Other Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
Additional Services														
Immunizations	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Well Child Exams	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Well Child Exams	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Physical Exams	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Flu Shots/Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Vision Supplies	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Speech Exams	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Hearing Exams	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Podiatry Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Mammography	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Mental Health	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Outpatient Substance Abuse	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
Other	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
7. Total Additional Services	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
8. Total Encounter Data Reported	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%
9. Total Capitation Paid	0	\$0	\$0	\$0	\$0	\$0	\$0	0	0	\$0.00	\$0.00	\$0.00	\$0.00	0.0%

Please provide any documentation necessary

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TABLE 5
MEDICAL TREND ASSUMPTIONS

Experience Period: April 1, 2014 Through March 31, 2015
 Rating Period: January 1, 2016 Through December 31, 2016
 Midpoint of Experience Period: October 1, 2014
 Midpoint of Rating Period: July 1, 2016

Step 1. Calculate Weighted Trend for Fee For Service Experience Claims Data

2014-2015 Annual Trend					
Category	Trends			% of Total See Table 3A	Weighted Trend
	Cost	Utilization	Combined		
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Total				0.0%	0.0%

2015-2016 Annual Trend					
Category	Trends			% of Total See Table 3A	Weighted Trend
	Cost	Utilization	Combined		
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Total				0.0%	0.0%

Step 2. Calculate Aggregate Trend Factor for Experience Claims Data

2014-2015 Annual Trend	1.000
2015-2016 Annual Trend	1.000
1) Aggregate Trend Factor	1.000

Step 3. Calculate Weighted Trend for Capitated Services

Category	2014-2015 Annual Trend			2015-2016 Annual Trend		
	Trends	% of Total See Table 3B	Weighted Trend	Trends	% of Total See Table 3B	Weighted Trend
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		0.0%	0.0%	Total	0.0%	0.0%

2014-2015 Annual Trend	1.000
2015-2016 Annual Trend	1.000
2) Aggregate Trend Factor	1.000

Step 4. Describe any special circumstances which may have caused aggregate trends to be unusually high or low.

**TABLE 6
MEDICAL
ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS**

Detailed Description of Administrative Expense Category	2014 PMPM Actual	2015 PMPM Per Rate Renewal	2016 PMPM Estimated
ACA Fees	\$0.00	\$0.00	\$0.00
Reinsurance	\$0.00	\$0.00	\$0.00
Risk	\$0.00	\$0.00	\$0.00
Retention	\$0.00	\$0.00	\$0.00
Profit	\$0.00	\$0.00	\$0.00
Claims Processing	\$0.00	\$0.00	\$0.00
Medical Management	\$0.00	\$0.00	\$0.00
Wellness Incentive	\$0.00	\$0.00	\$0.00
Premium Tax	\$0.00	\$0.00	\$0.00
Marketing	\$0.00	\$0.00	\$0.00
Other*	\$0.00	\$0.00	\$0.00
1) TOTAL	\$0.00	\$0.00	\$0.00

*Please list and describe in detail amounts included in Other

**TABLE 7
REQUIRED PREMIUM PMPM**

DESCRIPTION	COST PMPM
1. Incurred claims cost PMPM for experience period (Table 3A Line 11)	\$0.00
2. Aggregate fee for service trend factor (Table 5 Line 1)	1.000
3. Claims cost trended to rating period (1. x 2.)	\$0.00
4. Total capitation PMPM (Table 3A Line 12)	\$0.00
5. Aggregate capitated services trend factor (Table 5 Line 2)	1.000
6. Capitation cost trended to rating period (Line 4 x Line 5)	\$0.00
7. 2016 Administrative cost PMPM (Table 6 Line 1)	\$0.00
8 REQUIRED MEDICAL PREMIUM PMPM (3 + 6 + 7)	\$0.00

**TABLE 8
2016 CALCULATED RATES**

Step 1

Conversion Factor Calculation				
	Contract Mix	Average Contract Size	Rate Ratio	Conversion Factor
1. Employee	0.0%	-	1.0	0.000
2. Family	0.0%	-	2.5	0.000
3. Total	0.0%	-	-	

Step 2

2016 Medical Rate Calculation		
	Single	Family
4. Required Premium PMPM	\$0.00	\$0.00
5. Conversion Factor	0.000	0.000
6. 2016 Calculated Rates	\$0.00	\$0.00
7. 2015 Inforce Rates	\$0.00	\$0.00

0.0% Single Rate Increase

**TABLE 9
CALCULATED LOSS RATIOS**

January 1, 2014 Through March 31, 2015			
	REVENUE	EXPENSE	MEDICAL LOSS RATIO
Jan-14	\$0	\$0	0.0%
Feb-14	\$0	\$0	0.0%
Mar-14	\$0	\$0	0.0%
Apr-14	\$0	\$0	0.0%
May-14	\$0	\$0	0.0%
Jun-14	\$0	\$0	0.0%
Jul-14	\$0	\$0	0.0%
Aug-14	\$0	\$0	0.0%
Sep-14	\$0	\$0	0.0%
Oct-14	\$0	\$0	0.0%
Nov-14	\$0	\$0	0.0%
Dec-14	\$0	\$0	0.0%
TOTAL 2014	\$0	\$0	0.0%
Jan-15	\$0	\$0	0.0%
Feb-15	\$0	\$0	0.0%
Mar-15	\$0	\$0	0.0%
TOTAL Q1 2015	\$0	\$0	0.0%

Projected CY 2015			
	MONTHLY REVENUE	MONTHLY EXPENSE	MEDICAL LOSS RATIO
TOTAL 2015	\$0	\$0	0.0%

Projected CY 2016			
	MONTHLY REVENUE	MONTHLY EXPENSE	MEDICAL LOSS RATIO
TOTAL 2016	\$0	\$0	0.0%

TABLE 10
LARGE CLAIMANTS > \$100,000

4/1/14 - 3/31/15 Service Dates	
1. Total Paid Claims for Individuals with Paid Claims of \$100,000 or Greater	\$0
2. Number of Individuals with Paid Claims of \$100,000 or Greater	0
3. Total Paid Claims Greater than \$100,000 on an Individual Basis	\$0
4. Total Incurred Claim Factor	0.000%
5. Number of Runout Months	0
6. Incurred Claims Total	\$0

TABLE 11

please enter in the space provided below each question

1) When providing information for Medicare lines of business (State & Local), who is being included in the membership.

a) If a Medicare-eligible member with family coverage has a spouse (no other dependents) who is not eligible for Medicare, where are the spouse's membership and claims experience being reflected? In other words, are the spouse and his/her experience reflected in the Medicare (State or Local) experience or the regular employee (State or Local) experience?

b) In a situation similar to that above in (a) where there are also dependent children, how are the children's membership and claims experience being reflected? Are their membership and claims experience included in the Medicare (State or Local) or regular employee (State or Local) experience?

c) What happens when an employee not eligible for Medicare has a Medicare-eligible spouse? In other words, where are the employee and his/her experience reflected (Medicare or regular employee coverage) and where are the spouse and his/her experience reflected (Medicare or regular employee coverage)? If there are any dependent children, where are their membership and claims experience reflected?

2) Please describe the basis for the renewal (experience, community rated etc.)

TABLE 12
 TOP PROVIDER REPORT
 Based on April 1, 2014 Through March 31, 2015 Incurrals

FACILITY

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

PROFESSIONAL

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

State of Wisconsin - Employee Plan, Non-Medicare, Non Grad Assistant

TABLE 13
REQUIRED DATA FORMAT
Based on April 1, 2014 Through March 31, 2015 Incurrals

	Field Name	Field Description	Examples/Notes
1	HealthPlanCode	Two-digit plan code	
2	HealthPlanName	Health Plan Name	
3	Group	State or Local	State (S) or Local (L)
4	Plan	Plan Design	Uniform Benefits (U) or HDHP (H)
5	EligibilityStatus	Active Employee, Non-Medicare Retiree, Medicare Retiree, Grad Assistant	Active Employee (1); Non-Medicare Retiree (2); Medicare Retiree (3); Grad Assistant (4)
6	ServiceCategory	Service Category Code	See Service Category Codes in Table 14 for complete listing
7	Capitated	Yes or No	Y, N; Specifies whether a claim is capitated (Y) or not (N)
8	ClaimNumber	Medical claim number	ClaimNumber is an assigned number that identifies a claim
9	ClaimLineNumber	Line number of the claim	ClaimLineNumber identifies the line item detail for each service provided
10	SubscriberID	Subscriber identification number	Navitus Subscriber ID
11	MemberID	Member identification number	Navitus Member ID
12	Relationship	Self, Spouse or Child	Self (1); Spouse (2); Child (3)
13	ProviderID	Provider identification number	National Provider Identification number (NPI); if unable to provide then populate this field with Provider TIN
14	ProviderName	Name of provider	
15	ProviderAddress	Address of provider	
16	ProviderCity	City of Provider	
17	ProviderState	State of Provider	
18	ProviderZipCode	Zip code of Provider	
19	ProviderSpecialty	Specialty description	Use CMS Standard Coding
20	NetworkFlag	In or out of network	Y, N; Specifies whether a claim is in (Y) or out (N) of network.
21	OutOfAreaFlag	Claim is out of area	(1) if out of area
22	PlaceOfServCode	Place of service code	Use CMS Standard Coding
23	ProcTypeFlag	Procedure code type	Code which indicates what types of codes are in the procCode field CPT4 (C), HCPCS (H), revenue codes (R), and DRG, ICD9Proc codes (D)
24	ProcCode	Procedure code	Code for the medical procedure performed. Types of codes include CPT4, HCPCS, revenue codes, etc. If non-standard codes are used, code descriptions are required.
25	ModifierCode	Modifier code for procedure	Used to further define the medical procedure code
26	PrimaryDiagCode	ICD-9 code or ICD10 if applicable	
27	Diag2Code	Additional ICD-9 code or ICD10 if applicable	
28	Diag3Code	Additional ICD-9 code or ICD10 if applicable	
29	Diag4Code	Additional ICD-9 code or ICD10 if applicable	
30	DRG	DRG Code	
31	ServiceFromDate	Date of service start	
32	ServiceToDate	Date of service end	
33	Service Units	Number of units	
34	Discharge Status		Use CMS Standard Coding
35	ClaimPaidDate	Date claim paid	
36	SubmittedAmount	Amount Submitted	Not required for 2015
37	NotCoveredAmount	Amount not covered	Not required for 2015
38	BilledAmount	Amount billed	Totals must tie to Addendum 1
39	SavingsAmount	Amount of savings as generated by network	Not required for 2015
40	AllowedAmount	Amount allowed under contract	Not required for 2015
41	DeductibleAmount	Amount of deductible	Not required for 2015
42	CoinsuranceAmount	Amount of coinsurance	Not required for 2015
43	CoPayAmount	Amount of copay	Not required for 2015
44	MedicarePaid	Amount paid by Medicare	Not required for 2015
45	COBAmount	Coordination of Benefits amount other than Medicare	Not required for 2015
46	PaidAmount	Amount paid	Not required for 2015

TABLE 14
SERVICE CATEGORY CODES

Major Service Category	Detailed Service Category	Code
Hospital Inpatient	Medical	1
Hospital Inpatient	Surgical	2
Hospital Inpatient	Mental Health (MH)	3
Hospital Inpatient	Substance Abuse (SA)	4
Hospital Inpatient	Maternity Deliveries	5
Hospital Inpatient	Maternity Non-Deliveries	6
Hospital Inp+B13atient	Neonatal ICU	7
Hospital Inpatient	Extended Care Facility	8
Hospital Outpatient	Emergency Room	9
Hospital Outpatient	Surgery	10
Hospital Outpatient	Radiology	11
Hospital Outpatient	Pathology	12
Hospital Outpatient	Mental Health (MH)	13
Hospital Outpatient	Substance Abuse (SA)	14
Hospital Outpatient	Other (Specify)	15
Other Facility	Hospice	16
Other Facility	Transitional Care	17
Physician Services	Inpatient Surgery	18
Physician Services	Inpatient Anesthesia	19
Physician Services	Outpatient Anesthesia	20
Physician Services	IP Maternity - Normal Deliveries	21
Physician Services	IP Maternity-Cesarean Deliveries	22
Physician Services	IP Other OB Services	23
Physician Services	Outpatient Hosp/Surgical Center	24
Physician Services	Office Surgery	25
Physician Services	Inpatient Hospital Visits	26
Physician Services	Inpatient Critical Care Visits	27
Physician Services	Inpatient Mental Health Visits	28
Physician Services	Inpatient Substance Abuse Visits	29
Physician Services	Extended Care Facility Visits	30
Physician Services	Home Health Visits	31
Physician Services	Office Visits	32
Physician Services	Therapeutic Injections (J Codes)	33
Physician Services	Allergy Testing/Immunotherapy	34
Physician Services	Chemotherapy Drugs	35
Physician Services	Diagnostic Testing	36
Physician Services	Urgent Care	37
Physician Services	Emergency Room	38
Physician Services	Consults	39
Physician Services	Cardiovascular	40
Physician Services	Dialysis	41
Physician Services	Inpatient Radiology	42
Physician Services	Outpatient Radiology	43
Physician Services	Office Radiology	44
Physician Services	Inpatient Pathology	45
Physician Services	Outpatient Pathology	46
Physician Services	Office Pathology	47
Physician Services	Other (Specify)	48
Other Services	Physical Therapy	49
Other Services	Occupational/Speech Therapy	50
Other Services	Chiropractic Services	51
Other Services	Private Duty Nursing/Home Health Care Services	52
Other Services	Ambulance	53
Other Services	DME/Prosthetics	54
Other Services	Laboratory	55
Additional Services	Immunizations	56
Additional Services	Well Baby Exams	57
Additional Services	Well Child Exams	58
Additional Services	Physical Exams	59
Additional Services	Vision Services	60
Additional Services	Vision Supplies	61
Additional Services	Speech Exams	62
Additional Services	Hearing Exams	63
Additional Services	Podiatry Services	64
Additional Services	Mammography	65
Additional Services	Outpatient Mental Health	66
Additional Services	Outpatient Substance Abuse	67
Additional Services	Other	68

TABLE 15
ACTUARIAL CERTIFICATION

Insert Actuarial Certification Language. The certification should cover the development of the rates, all reporting and that the detailed data matches the submission.

Actuary:	<input type="text"/>
Firm:	<input type="text"/>
Phone:	<input type="text"/>
Date:	<input type="text"/>

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. 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 2; the final copy is due on July 24. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Upon request, the Department may review the qualification status of a plan on a county by county basis and make recommendations to the Board. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a county or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.

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

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

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

Plans that remove providers from their network for the following calendar year for the group health insurance program are prevented from adding those providers back to the network without approval from the Department until the next benefit year for which they submit a final bid based on inclusion of those providers. This provision does not apply to normal attrition.

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

SAMPLE FORMAT

Date: _____
 Plan: We-Care
 (Name of Plan)

 La Crosse
 (Location/Service Area)

Counties and Major Cities in Service Area	No. Dentists	No. Chiropractors	No. General Hospital Routinely Utilized	No. FTE Primary Care Providers*	Total Members
Crawford	17	3	0	4	560
Juneau	10	3	0	3	90

La Crosse (City)	7	2	2	29	340
La Crosse (County)	18	4	3	102	680

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