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CORRESPONDENCE MEMORANDUM

DATE: May 23, 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 – Technical Changes

At its April 15, 2008, meeting, the Group Insurance Board (Board) reviewed and approved changes for the 2009 benefit year. In addition, the Board granted staff the authority to proceed with any needed technical clarifications. The following is a brief description of those technical clarifications and corresponding language changes. New language is shaded and underscored and language to be deleted is ~~stricken~~.

Section	Technical Clarification	Language Change
State & Local Contract *Article 1.7* *and* Uniform Benefits *Section II.*	Language explaining the support test was clarified. In addition, language was added to clarify that "student" is defined in the ETF Administrative Code.	. . . . A Dependent child must be dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated ~~on~~ by the support test~~s as a Dependent~~ for federal income tax purposes, whether or not the child is claimed. . . . Student status includes any intervening vacation period if the child continues to be a full-time student. As defined in Wis. Adm. Code § ETF 10.01 (5), s~~S~~tudent 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~~ Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools.

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

Signature _____ Date _____

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Section	Technical Clarification	Language Change
State & Local Contract *Article 2.5 (2)*	Reduced the per member per month from health plans for the costs of informational materials, such as the "It's Your Choice" booklet and "It's Your Benefit" newsletter.	. . . The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.069 per member per month.
State & Local Contract *Article 3.4 (5)*	Language was clarified to reflect that by contract, the ability to change health plans upon meeting or exceeding the benefit lifetime maximum is extended to annuitants, even though Federal law does not require it.	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. This also applies to ANNUITANTS as if Federal law required it. 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.
State & Local Contract *Article 3.4 (7)*	Language was clarified to reflect that by contract, the ability to change health plans when adding a dependent(s) following certain events is extended to annuitants, even though Federal law does not require it.	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. This also applies to ANNUITANTS as if Federal law required it. 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.
Uniform Benefits *Section II.*	In response to questions raised by a Board member at the last meeting, the intent of holding the member harmless from third party (e.g., non-plan providers) collection efforts has been clarified.	. . . services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must ~~while~~ hold~~ing~~ the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

Section	Technical Clarification	Language Change
Uniform Benefits *Section III., A., 1., b. & 2., b.*	In response to questions raised by a Board member at the last meeting, it has been clarified that prior authorizations pertain to the follow-up 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 for the follow-up care are at the sole discretion of the Health Plan.

Staff will be available at the Board meeting to respond to any questions or concerns.