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CORRESPONDENCE MEMORANDUM

DATE: May 11, 2011

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans

SUBJECT: Guidelines and Uniform Benefits for the 2012 Benefit Year

The study group recommends that the Group Insurance Board (Board) adopt the Guidelines and Uniform Benefits changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.

Background

Annually, the Board reviews its *Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program*. 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 March 1 and 16, 2011, to establish the 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 also took the opportunity to discuss potential benefit changes under 2011 Wisconsin Act 10. Those changes are addressed in a separate memo.

The study group meetings included: Barbara Belling, Office of Commissioner of Insurance (OCI); Jennifer Kraus, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Jim Underhill, OSER; Beth Ritchie, University of Wisconsin (UW); Nicole Zimm, (UW); and the following Department of Employee Trust Funds (Department) staff: Lisa Ellinger, Bill Kox, Joan Steele, Arlene Larson, Jeff Bogardus, Betty Wittmann, Brian Shah, Brian Schroeder, Emily Loman, Sari King, Liz Doss-Anderson, Christina Keeley, and Vickie Baker.

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Lisa Ellinger — Signature

5/18/11 — Date

Board	Mtg Date	Item #
GIB	6.7.11	5B

Please note that as staff continues to refine Uniform Benefits, further contract changes may be necessary. Staff will bring any notable changes before the Board, but also requests authority to proceed with any needed technical clarifications.

Attached are the following:

- **Attachment A** – 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 cost-neutral modifications for 2012.
- **Attachment C** – Explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** – Excerpts from Uniform Benefits, with recommended modifications for contract year 2012.

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 14, 2011. In response to comments from health plans, some minor revisions were considered and/or made when developing these recommendations. Specific health plan comments 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 CHANGE TO ELIGIBILITY/ENROLLMENT

1. **Annual Open Enrollment Opportunity:** Currently, absent a qualifying event under the federal Health Insurance Portability and Accountability Act (HIPAA), participants who are not insured in the program can enroll at anytime but are limited to the Standard Plan and those age 19 and older have a waiting period for pre-existing conditions. After January 1, 2012, the waiting period will be eliminated under the Patient Protection and Affordable Care Act (PPACA). The study group discussed eliminating the late enrollment opportunity and revising the annual It's Your Choice enrollment period into an open enrollment period. The study group recommends adopting this change and acknowledges the need for participant education so that employees who deferred coverage understand they can enroll for coverage during the open enrollment period if they plan to

retire during the upcoming year and do not want to forfeit any accumulated sick leave credits. The open enrollment period would also be made available to State retirees under Wis. Stat. § 40.51 (16), who can currently re-enroll after fulfilling a six-month waiting period for effective dates of coverage. Department staff discussed open enrollment periods with several health plans that indicate an open enrollment period is common for large employer groups and does not impact the rate. Finally, as suggested by OSER, staff also recommends an open enrollment immediately prior to retirement for individuals who are not enrolled but want to preserve post-retirement health insurance employer contribution, for example, accumulated sick leave conversion credits for State and some local employees.

2. **Health Risk Assessments (HRA):** HRAs are a tool to identify and improve the health of participants that may be at-risk for certain diseases or chronic conditions. The study group discussed requiring subscribers to take an HRA through their health plan. However, health plans indicate response rates are extremely low if there are no incentives for taking the HRA; in addition employers typically offer the incentives because they realize an array of benefits from HRA participation, such as reduced absenteeism and increased productivity. The study group recommends requiring health plans to have HRAs available for our participants and to consider such incentives as reduced copayments and Value Based Insurance Design (discussed below), as part of any larger, future study of the health insurance program.

3. **Spouse-to-Spouse and Domestic Partner to Domestic Partner Transfers:** Currently, the contract has a provision stating that when both of the spouses or Domestic Partners (DP) are employees or annuitants of the same employer, they may do spouse-to-spouse or DP-to-DP transfers whereby they may transfer the named subscriber for the family contract to the other spouse or DP. They may also convert a family contract into two single contracts or combine two single contracts into one family contract. However, the contract does not allow for the transfers to occur between state and the local programs. The study group discussed a situation in which a local employee deferred coverage because of other coverage through a spouse employed by the State, and recommends revising this provision to allow the transfer across programs.

4. **Board's Right to Reject Bid:** The study group discussed and recommends adding a provision stating the Board reserves the right to reject any health plan's bid that is not in the best interest of the program, such as a bid that falls into Tier 3. If staff or the Board's actuary recommends the Board reject a health plan's bid, health plans will have the right to address the Board via letter to explain its rationale for its bid. Some plans have expressed concerns that this new provision is too broad.

5. **Provider Addition Limitations:** Currently, health plans can add providers to its network throughout the year but the "Provider Guarantee" provision of the contract prevents the removal of providers from a network, except in limited situations such as normal attrition, quality of care and retirement. The study group recommends a provision prohibiting a health plan from adding providers to the network during a benefit year when those providers were previously in the network, but the health plan made the business decision to exclude those providers from the network for participants in our group and submitted its bid accordingly. This will prevent a health plan from taking this action to potentially shed bad risk and then reinstate those providers in its network for our group. Some plans have expressed concerns that this provision may have unintended consequences, due to the timing of provider negotiations.

6. **Unreported Deaths:** Currently, the contract does not limit retrospective premium adjustments in situations when a participant's death is not reported to the Department in a timely manner. However, there are situations when a participant's death is not reported to the Department for some length of time, sometimes for years. This can be problematic because it potentially affects the risk rating of the group. The study group discussed and recommends applying the standard six month retrospective premium adjustment limitation to unreported death situations.

7. **Medicare Rate Calculation:** The study group discussed modifying the calculation of the Medicare-reduced rate. The Board's actuary indicates the current Medicare rate ratio for the calculation is reasonable and will closely review the rates against the corresponding experience; and follow-up with the individual health plans when further justification is necessary. Thus, the study group recommends giving the actuary additional flexibility to determine the ratio at the time of the bid submission.

RECOMMENDED CHANGE TO THE LOCAL CONTRACT

1. **Underwriting:** The study group discussed the potential for requiring local municipalities to participate in the health insurance program and recommends adding language to the contract that allows for employer groups with 2,000 or more total members to be separately underwritten apart from the current process. The Board's actuary indicates groups this large are credible and can be rated accordingly. This is a measure of protection for the entire local program against adverse risk from large employers.

RECOMMENDED CHANGE TO BENEFITS

The study group discussed potential benefit changes under the current process and does not recommend any benefit changes, unless they are included as part of the potential changes under 2011 Wisconsin Act 10 as described in a separate memo.

DISCUSSION OF OTHER ISSUES

Other issues were considered by the study group but did not result in recommended changes. The most notable issues are summarized below. Staff will provide additional information upon request.

1. **Palliative Care Consult:** The study group discussed the suggestion to add benefits to provide for a one-time consult in the participant's home to discuss palliative care after the participant has received a terminal diagnosis but before the participant's life expectancy is six months or less. The Board's actuary estimates the cost to add this benefit to be $0.05 - $0.10 per member per month (PMPM). The study group recommends that this change, which is aligned with the discussions with the Department's Medical Advisor and the health plans on end of life care, be considered as part of the potential changes under 2011 Wisconsin Act 10.

2. **Dental Implants Following Accidental Injury:** The study group again considered allowing coverage for dental implants under the accidental loss of teeth provision, as dental implants are becoming the standard of care as well as a more cost-effective treatment option in some situations. If the benefit is capped at $1,000 per tooth, the cost impact is $0.24 PMPM. The study group acknowledges that DentalBlue Preferred PPO and EPIC provide limited benefits for dental implants. Because the implants are a better treatment option, the study group recommends this change be considered as part of the potential changes under 2011 Wisconsin Act 10.

3. **Inpatient Hospice:** The study group discussed a recommendation to expand the inpatient benefit for hospice care to match that of the Standard Plan, which is a lifetime maximum of 30 days of confinement in a plan-approved hospice facility. The Board's actuary estimates the cost to add this benefit is $2.20 PMPM. The study group does not recommend pursuing this change, due to its cost, but does recommend clarifying the language to specify that hospice services are available to a participant who is confined.

4. **Hearing Aids:** Currently, Uniform Benefits provides coverage at 80% per hearing aid, up to a maximum payment of $1,000 per hearing aid, no more than once every three years. The study group discussed a recommendation from a health plan to provide coverage at 100% because the current benefit may be

confusing to participants. To keep the benefit cost-neutral, the Board's actuary states the benefit is payable up to $875 per hearing aid if paid at 100%. The study group does not recommend pursuing this change as it may result in a lower benefit for many participants.

5. **Orthognathic Surgery:** The study group discussed a participant's request to add coverage for orthognathic surgery for treatment of malocclusion. Currently, Uniform Benefits excludes orthognathic surgery except when it is for treatment of Temporomandibular Joint (TMJ) disorder. The PMPM cost to add the benefit is $0.05. As the treatment may be covered under the Standard Plan if it meets WPS's medical necessity criteria, the study group does not recommend adding this benefit for 2012.

6. **Smoking Cessation:** Uniform Benefits currently covers a maximum of one consecutive three-month course of pharmacotherapy per calendar year. The study group discussed a suggestion from the pharmacy benefit manager, Navitus, to remove the three-month limitation. The Board's actuary indicates this change would cost $0.21 PMPM. The study group does not recommend pursuing this change because of its cost and the small number of participants affected.

7. **Weight Loss Surgery (Gastric Bypass) Benefits:** The study group again considered coverage for the surgical treatment of obesity (e.g., gastric bypass), which has been requested by numerous participants and a provider group. The PMPM cost to add the benefit is $5.25 initially, due to pent-up demand, and $3.50 thereafter. If benefits were added for 80% coverage, the estimated PMPM cost is $4.20 initially and $2.80 thereafter. The Board's actuary indicates that, although costs of this benefit have not changed significantly, utilization has decreased, resulting in a PMPM cost that is lower than what was provided a year ago. The study group concurred that adding gastric bypass to Uniform Benefits for the surgical treatment of obesity remains costly. As the treatment may be covered under the Standard Plan if it meets WPS's medical necessity criteria, the study group does not recommend adding this benefit for 2012.

8. **Acupuncture and Massage Therapy:** The study group discussed a request from several participants to add benefits for acupuncture and massage therapy. The study 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 acupuncture and/or massage therapy in limited situations when it is determined to be medically appropriate.

9. **Value-Based Insurance Design (V-BID):** The basic premise of V-BID is to remove barriers to essential, high-value health services to improve health outcomes, such as lowering or eliminating the copay. The concept belief is that

the regular benefits are altered with incentives or penalties to discourage use of benefits that have been determined to be of partial or little value. While the study group believes there may be value in pursuing a V-BID, it was not able to come up with a cost-neutral change that was actuarially sound. A V-BID program should be considered as part of any larger, future study on the health insurance program.

10. **Local Program – Review of the Deductible Amount:** In 2005, the $500/$1,000 deductible option was made available to local employers that wanted to offer a lower benefit level to employees and save on premium costs. At the time the deductible option was introduced, it offered a 10% premium savings compared to the traditional option. However, premium savings from the deductible option have lessened over the years, due to inflation. The study group discussed achieving the 10% premium differential by increasing the deductible amounts or creating another benefit option and recommends this be considered in any larger, future study on the health insurance program.

11. **Local Program – Funding of the Deductible:** The study group discussed a local employer's request to provide for health reimbursement accounts for use in funding the deductible when the employer has elected the deductible option coverage for its employees. Health reimbursement accounts allow for the employer to fund the deductible on behalf of the employee. Currently the contract limits employers to Section 125 plans for funding the deductible, which is comprised of contributions from the employee. Several health plans indicate the employer-funded health reimbursement account will adversely impact premiums, due to potential increases in utilization patterns, compared to those groups in which the employer does not fund the deductible. The Board's actuary states the range for premium rate savings will need to be adjusted if the employer is allowed to fund more than half of the deductible. For these reasons, the study group does not recommend allowing health reimbursement accounts for use in funding the deductible.

12. **Provider Qualification Criteria:** The study group discussed a health plan's suggestion to revise the provider qualification criteria by including "hospitalists" when there are not the minimum number of required primary care providers that have admitting privileges to the hospitals in the county. "Hospitalists" generally care for patients only when the patients are in the hospital and communicate the information back to the patient's primary care physician. Currently, if there is no qualified health plan in a county, the State Maintenance Plan will be made available, which is believed to give participants choices to have appropriate access to providers. Thus, the study group does not recommend revisions to the provider qualification criteria.

13. Enrollment Requirements: A health plan recommended the program implement residency requirements so that subscribers can only select a health plan that is a preferred provider plan (PPP) if the subscribers reside within the service area. Currently, two health plans, in addition to the Standard Plan, are preferred provider plans: WEA Trust PPP and WPS Metro Choice. The study group does not recommend this change because some subscribers may select health plans based on having providers located close to their work site instead of their residence. A health plan also recommended waiving for PPPs the requirement to contact the employer of a subscriber that lists a primary care physician or clinic on the application that is not in the provider network. The study group does not recommend this change, because it helps to ensure the subscriber selected the correct health plan.

14. Medicare Advantage (MA) Plans: Currently, retirees in the local program are required to enroll in the prescription drug plan (PDP) administered through DeanCare Rx when they become eligible for Medicare. Humana, which offers the only MA plan in the program, had indicated that changes in regulation from the Federal Centers for Medicare and Medicaid Services (CMS) would prevent the retiree on Medicare from selecting a PDP and MA plan in 2012 when they are administered by different entities. However, CMS has since extended the waiver that would have prohibited participants from being enrolled in a PDP and MA plan administered by different entities and the entities work closely together to provide coordinated care. Humana indicates the pharmacy data it currently receives on participants meets this requirement. Thus, no change is needed.

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

Attachments: Attachment A – Notable changes to the Guidelines, Addendum, and Contracts
Attachment B – Excerpts from the Guidelines, Addendum, and Contracts
Attachment C – Notable changes to Uniform Benefits
Attachment D – Excerpts from Uniform Benefits

Notable Changes Under Consideration for the 2012 Guidelines and State and Local Contracts

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines	**Contract**		
Guidelines I. *Page 1*		Added language to change the Dual-Choice enrollment period to an open enrollment opportunity.	Refer to discussion item #1 on page 2 of the memo.
Guidelines II., D., 4. & 7. *Page 2*		Added language requiring health plans to have a health risk assessment (HRA) available for participants.	Refer to discussion item #2 on page 3 of the memo.
Guidelines II., D., 5. *Page 2*		Removed names of specific quality initiatives and standards. Combined the information for requirements for hospitals and provider groups.	Recommended by staff to simplify the monitoring of participation in quality initiatives and to allow health plans some flexibility in selecting the initiatives in which they participate.
Guidelines II., D., 8. *Pages 2 - 3*		Added language clarifying reporting requirements on health plan utilization and disease management capabilities.	To support the Department's emphasis on managing care of at-risk participants through appropriate wellness and/or disease management programs.
Guidelines II., D., 11. *Pages 3 - 4*		Added language to change the Dual-Choice enrollment period to an open enrollment opportunity.	Refer to discussion item #1 on page 2 of the memo.
Guidelines II., H. *Pages 4 - 6*		a) Added language specifying the Board has the right to reject any health plan's bid that is not in the best interests of the program. b) In 2., added language giving the actuary additional flexibility in determining the ratio on the Medicare rate. c) In 9., added language specifying health plans are not to include in their rate any claims they decide to pay outside the contract.	a) Refer to discussion item #4 on page 3 of the memo. b) Refer to discussion item #7 on page 4 of the memo. c) Recommended by staff for situations such as a health plan paying a claim for a non-covered benefit due to an error by one of its staff members.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines	**Contract**		
Guidelines II., J. *Pages 7 - 10*		Updated the time table for annual submissions.	• Moved up the due date for preliminary bids, • Incorporated requirements for HRAs, • Clarified the annual eligibility verification process for disabled adult children, and • Added a quarterly submission on disease management activities.
Addendum 2 *Page 10*		Added language regarding limitations on adding providers to the network.	Refer to discussion item #5 on page 3 of the memo.
	Article 1.7 *Pages 11 - 12*	a) Updated to reflect the recently revised Wis. Adm. Code § ETF 10.01. b) Clarified information on verifying eligibility of disabled children. c) Clarified eligibility for a child born outside of marriage.	a) Technical change. b) To reflect current practice. c) To reflect current practice.
	Article 1.19 *Page 12*	Synced up language between the state and local contracts.	Technical change.
	Article 2.2 (5) *Page 13*	Added language requiring health plans to notify the Department upon discovery of a privacy breach.	Recommended by staff.
	Article 2.3 *Page 13*	a) In (4), revised limitations for retrospective premium adjustments due to unreported death. b) In (5), updated provision to comply with limitations on rescissions of coverage.	a) Refer to discussion item #6 on page 4 of the memo. b) Technical change due to the federal Patient Protection and Affordable Care Act.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines	**Contract**		
	Article 2.4 *Page 14*	a) In (2), updated language to reflect process changes due to use of electronic eligibility files. b) In (3), updated language to allow health plans to collect coordination of benefits language more frequently than annually. c) In (4) and (5), synced up language between the state and local contracts.	a) To reflect current practice. b) Recommended by a health plan. c) Technical change.
	Article 2.5 *Page 15*	a) In (1), synced up language between the state and local contracts. b) In (1), added language requiring health plans to have a health risk assessment (HRA) available for participants. c) In (2), removed language requiring health plans to reimburse vendor costs for brochures and informational material.	a) Technical change. b) Refer to discussion item #2 on page 3 of the memo. c) Recommended by staff in response to simplify the vendor reimbursement process.
	Article 2.6 *Page 15*	Added language to clarify current practice.	To reflect current practice.
	Article 2.8 (2) *Page 16*	Updated language to reflect process changes due to electronic enrollment.	To reflect current practice.
	Local Only Article 3.1 *Page 16*	a) In (1), added language to allow for separate rating of groups larger than 2,000 total members. b) In (2), revised the due date for a new employer to submit applications.	a) Refer to the local contract discussion item #1 on page 4 of the memo. b) Recommended by staff to allow for more processing time prior to the effective date.
	Local Only Article 3.2 (2) *Page 18*	Revised the deadline for an employer to submit a resolution to terminate its participation in the program.	Recommended by staff due to electronic processes that are more efficient.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines	**Contract**		
	Article 3.3 *Pages 18 - 21*	a) In (2) and (4), synced up language between the state and local contracts. b) In (11), added language to clarify the opportunities to add and terminate coverage for adult children and domestic partners.	a) Technical change. b) To reflect current practice.
	Article 3.4 *Pages 21 - 22*	a) In (1) and (5), added language to change the Dual-Choice enrollment period to an open enrollment opportunity. b) In (4), clarified the language that limits the new health plan that can be selected following a residential move. c) Throughout the provision, synced up language between the state and local contracts.	a) Refer to discussion item #1 on page 2 of the memo. b) To reflect current practice. c) Technical change.
	Article 3.6 *Page 23*	Updated provision to comply with limitations on rescissions of coverage.	Technical change due to the federal Patient Protection and Affordable Care Act.
	Article 3.7 *Page 23*	Synced up language between the state and local contracts.	Technical change.
	Article 3.10 *Pages 23 - 24*	Added language to change the Dual-Choice enrollment period to an open enrollment opportunity.	Refer to discussion item #1 on page 2 of the memo.
	Article 3.11 *Page 24*	a) Added language to allow for transfers to cross programs. b) Added language to specify that transfers must be allowable under Section 125.	a) Refer to discussion item #3 on page 3 of the memo. b) Technical change.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines	**Contract**		
	Article 3.14 (1) *Page 24*	Added language to clarify the eligibility of a child born or adopted after the death of the subscriber.	To reflect current practice.
	Article 3.15 *Page 25*	Synced up language between the state and local contracts.	Technical change.
	Article 3.16 (4) *Page 26*	Updated the defined terms to accurately reflect application of the provision.	To reflect current practice.
	Article 3.17 (1) *Page 27*	Revised language to refer to the time table in lieu of a specific date.	To simplify the annual contract update process.
	Article 3.18 *Pages 28 - 30*	a) In (5), removed language on the waiting period in the Standard Plan. b) Throughout provision, synced up language between the state and local contracts.	a) Refer to discussion item #1 on page 2 of the memo. b) Technical change.
	Article 3.20 *Page 30*	Added language to clarify the administration of the medical and pharmacy benefit accumulations.	To reflect current practice.

I. OBJECTIVES

The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objective stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board agree that these terms shall always be interpreted consistent with the objectives stated herein.

The Board's objective with alternate health care programming is: to encourage the growth of alternate health benefit plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board (Board) has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

The Board is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the Board has developed these Guidelines by which alternate health delivery plans may be evaluated for possible inclusion under the State of Wisconsin's group health benefit program on a "dual-choice" basis.

"Dual-choice" refers to a program where eligible employees and currently insured ~~(including~~ retirees and continuants~~) who are currently insured~~ have the opportunity to choose between at least two competing health benefit plans, the standard plan and one or more alternate plans. The mechanics of "dual-choice" are relatively simple. Once an alternate plan receives approval from the Board on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the Board. The Board reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health care plans to submit their premium rate quotations for the following calendar year. The Board reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

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II. GENERAL REQUIREMENTS

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D. Comprehensive Health Benefit Plans Eligible for Consideration

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4. Plans must have a health risk assessment available and demonstrate, upon request by the Department, their efforts in utilizing the results to improve the health of members of the group health insurance program ~~in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog, Checkpoint, Wisconsin Hospital Association quality accountability initiative and others as identified by the Department~~.

5. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network hospitals, providers, large multi-specialty groups, small group practices and systems of care to participate in ~~such~~ quality standards and initiatives, including ~~as the Wisconsin Collaborative for Quality Healthcare and others~~ those as identified by the Department.

6. Plans must demonstrate, upon request by the Department, 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. This may include providing actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to provider reimbursement.

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, and information received from health risk assessments. 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 in improving the health of members and encouraging healthy behaviors, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the Department. Plans shall also include a report detailing the State of Wisconsin group experience by disease and risk 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 in a format as 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.

- If members are required to select a primary care provider or primary care clinic, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.

- If members are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the plan, have a process to enroll the participants into the appropriate wellness and/or disease management programs.

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.

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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) and any eligible employee or state retiree under Wis. Stat. § 40.51 (16) who enrolls. In certain situations, for example, when the Centers for Medicare and Medicaid Services does not allow an enrollment due to an individual's residence in a given area, a plan is not required to accept the individual. 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, 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.

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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 are encouraged to 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 reserves the right to reject any plan's bid when the Board believes it is not in the best interests of the group health insurance program. 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 (all insureds under Medicare)
  - Family (at least 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 1 without written justification. It may not exceed 50% of the single rate for regular coverage unless determined by the Board's actuary to be lower; 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 1 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.

5. Local Program: Rates must be no greater than 1.5 times the rate for the state program unless the local group is sufficiently large that the rate is justified by experience, as determined by the Board's actuary.

6. 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.

[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.

7. 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.

8. Include completed Table contained in Addendum 1.

~~8.~~9. Plans shall not include in their rate any claims that they decide to pay outside the Uniform Benefits contract.

I. Submission of Proposals

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

1. Fifteen (15) copies.

2. Specific listing of the plan's pre-authorization and referral requirements.

3. A description of case management and disease management activities.

4. A list and count of providers under contract arranged by county of practice for state employees, and by zip code for local employees. An electronic version of the listing must also be made available. The Board will expect an updated listing by July 23 in order to determine what areas will constitute your service area.

5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must be in writing and address the method used for providing services and processing claims under such circumstances.

6. An organizational chart.

7. Statement of agreement to abide by all the terms and conditions set forth in the “Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits” document.

8. If a PPP, include a schedule of benefits.

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, 2011~~0~~	• New plans only. Proposal to participate in the program addressing each of the requirements in Section II of the Guidelines (Section II., I, page 1-18).	
~~April 30~~May 2, 2011~~0~~	• Estimated premium rate proposal for next calendar year.	
May 1~~3~~4, 2011~~09~~	• 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, 2011~~0~~	• 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. • Plan Utilization and Rate Review Information (Addendum 1). This information is to be mailed directly to: Julie Maendel Deloitte Consulting 50 South Sixth Street Suite 2800 Minneapolis, MN 55402-1538 • Addendum 1Tables 8A and 8B describing catastrophic data. • 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. • Report detailing the State of Wisconsin group experience with comparisons to aggregate benchmarks. [Section II., D., 8.]	
June 15, 2011~~0~~	• HEDIS information is required for the prior calendar year in the format as determined by the Department.	
July ~~8~~9, 2011~~0~~	• 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. • Information of the plan's features, including objective documentation as requested, for use in the health plan features comparison summary in the ~~"It's Your~~ Dual-Choice~~"~~ brochure.	
July 11, 2011	• Premium rate quotations for next calendar year. (Annually, about July 1, each plan will be provided with a rate quotation form.)	

Due Date (Receipt by Dept)	Information Due	Date Submitted
July 15~~6~~, 2011~~0~~	~~• Premium rate quotations for next calendar year. (Annually, about July 1, each plan will be provided with a rate quotation form.)~~ • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	
July 2~~3~~, 2011~~0~~	• 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.)	
July 29~~30~~, 2011~~0~~	• 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 ~~6~~, 2011~~0~~	• 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 1~~3~~, 2011~~0~~	• 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 19~~20~~, 2011~~0~~	• Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
August 2~~4~~, 2011~~0~~	• 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 2~~7~~, 2011~~0~~	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period.	
September 14, 2011~~0~~	• 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 201~~1~~2, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 2011. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24.** • Draft of letter the plan will mail to current subscribers summarizing dental benefit, accessing the plan's health risk assessment tool, 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	

Due Date (Receipt by Dept)	Information Due	Date Submitted
	required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24, WITH FORWARDING REQUESTED.**	
September 1920 ~~– December 31~~, 20110	• Put a PDF copy of your plan's provider directory for the upcoming benefit year on your plan's web site and provide ETF with the ~~URL of the~~ location. The PDF~~URL~~ must remain on your plan's web site ~~the same~~ through the benefit year~~the end of the calendar year~~.	
September ~~22~~21, 20110	• Dual-Choice kick off meeting in Madison.	
September 30, 20110	• Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page. • Provide four (4) copies of all informational materials in final form to the Department. • Final dental benefit description that will be provided to members if the plan offers dental coverage.	
October 31, 20110	• Report on disease management capabilities and effectiveness. [Section II., D., 8.] • Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
October ~~4~~3 – 289, 20110	• Dual-Choice Enrollment Period.	
~~October 25 – 29, 2010~~	• ~~Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of eligibility of adult children.~~	
January 1, 20121	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of accessing the plan's health risk assessment tool and referral and grievance procedures must be included.	
January 134, 20121	• Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March 1, 20121	• 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 21, 20121	• A Quality Improvement plan in the format set forth by the Department.	
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~~Generate and process the reports ~~proposed identifying resolution to~~ the Full File Compare discrepancies, contacting~~identified by~~ the Department regarding proposed resolutions for those discrepancies that you are unable to resolve.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
Annually	• Verify eligibility of adult disabled children age 27 or older, which includes checking that the: o Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year, and o Support and maintenance requirement is met, and o Child is not married.	
Quarterly	• Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	

Addendum

ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE

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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.

ARTICLE 1 DEFINITIONS

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1.7 "DEPENDENT" means, as provided herein, the SUBSCRIBER'S:

- Spouse.
- DOMESTIC PARTNER, if elected.
- Child.
- Legal ward who becomes a legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19 but not a temporary ward.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Child of the DOMESTIC PARTNER insured on the policy.
- Grandchild if the parent is a DEPENDENT child.

(1) A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.

(2) A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

(3) All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except that:

(a) An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as ~~o~~ long as the child remains so disabled ~~if~~ that he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The HEALTH PLAN will monitor ~~mental or physical disability~~ eligibility ~~at least~~ annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. ~~, and~~ The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(b) After attaining age 26,as required by Wis. Stat. § 632.885 and Wis. Adm. Code § INS 3.34, a DEPENDENT includes a child that is not married and is not eligible for coverage under a group health insurance plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a DEPENDENT under this program. The child ceases to be a Dependent at the end of the month in which he or she:

- turns 27 years of age, or
- is no longer a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

(4) A child born outside of marriage becomes a Dependent 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 Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The Effective Date of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

(6) Any DEPENDENT eligible for BENEFITS who is not listed on an application for coverage will be provided BENEFITS based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

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

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ARTICLE 2 ADMINISTRATION

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this CONTRACT, the contractor agrees not to discriminate against EMPLOYEES or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The HEALTH PLAN agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

(3) The HEALTH PLAN shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

(4) In cases where PREMIUM rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by the data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

(5) The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLANS shall notify the DEPARTMENT within two business days of discovering that the protected health information (PHI) or personal information of one or more PARTICIPANTS has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. This notification requirement shall apply only to PHI or personal information received or maintained by the HEALTH PLANS pursuant to this agreement. The HEALTH PLANS shall make good faith efforts to communicate with the DEPARMENT about breaches by major provider groups if the HEALTH PLANS know those breaches affect DEPARTMENT PARTICIPANTS.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in certain events including, but not limited to, strike and disaster, and shall submit it to the DEPARTMENT upon request.

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 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 be limited to no more than six months of PREMIUMS paid. 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.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (2) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper effective date of EMPLOYER contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled except as required by law.

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~~ electronic eligibility files 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 electronic eligibility files while ~~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. The HEALTH PLAN shall at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

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

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of ~~or~~ no more than $100 per day per occurrence, to begin on the 2nd day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed $5,000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(1) The HEALTH PLAN shall provide the SUBSCRIBER with identification cards indicating the EFFECTIVE DATE of coverage, ~~and~~ a listing of all available providers~~,~~ and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization~~s~~ and referral requirements. If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Four~~ive~~ (4~~5~~) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor~~,~~ who~~ich~~ shall provide the annual description of BENEFITS and such other information, or services it deems appropriate, including audit services. ~~The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.03 per member per month. HEALTH PLANS will be advised of amount of the charge prior to the due date for PREMIUM bids. The HEALTH PLAN will be responsible for any costs assessed to the HEALTH PLAN even if the HEALTH PLAN is withdrawing from the program.~~

(3) Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement:

> "[NAME OF HEALTH PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a HEALTH PLAN mailing to correctly inform PARTICIPANTS.

2.6 FINANCIAL ADMINISTRATION

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.

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2.8 DUE DATES

(1) Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 20th day of the calendar month for the following month's coverage.

(2) The EMPLOYER shall immediately validate and enter into the DEPARTMENT'S myETF Benefits system ~~forward to the DEPARTMENT~~ the completed applications filed by newly eligible EMPLOYEES or require EMPLOYEES to submit their request directly through myETF Benefits. For any requests submitted by a newly eligible EMPLOYEE through myETF Benefits, the EMPLOYER shall immediately validate and approve the completed application.

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ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE – *(Local Contract Only)*

(1) The group health insurance program as required by 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. The DEPARTMENT reserves the right to separately rate underwritten groups larger than 2,000 total members, as recommended by the actuary.

(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 ~~3~~40 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.

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. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

(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. Any EMPLOYER who files a resolution after December 20, 1990, and who offers a non-participating plan as required by sub. (4) shall be required to remain in the program a minimum of three years. Any EMPLOYER who is assessed a surcharge as determined by the underwriting process 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 is not done within three years. EMPLOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision. However, the DEPARTMENT may allow any EMPLOYER to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program; and (3) that the minimum number of all of the EMPLOYER'S Wisconsin Retirement System participating EMPLOYEES, including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in (2) above. The Plan Stabilization Contribution may be increased for that EMPLOYER if less than 50% of the participating EMPLOYEES elect the STANDARD PLAN coverage. The EMPLOYER cannot later have a bargaining unit drop from this health insurance program and carry other coverage.

(5) A Large EMPLOYER (more than 50 employees in the Wisconsin Retirement System) may indefinitely retain a second plan, as described in (4) above, or temporarily retain a second plan for up to four years due to timing of collective bargaining or the merger or division of municipalities by executing the appropriate Resolution to Participate provided the EMPLOYER also meets the 65% participation requirement as described in (2) above. The EMPLOYER may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the EMPLOYER'S initial enrollment period due to the EMPLOYER retaining a second plan or due to the timing of collective bargaining. The EMPLOYER must notify the DEPARTMENT, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

(6) The EMPLOYER electing the deductible option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 of the Internal Revenue Code.

(7) If participation by an EMPLOYER is approved in accordance with Sub. (2) and the subsequent participation falls under the minimum requirement, the BOARD may terminate EMPLOYER participation at the end of the calendar year by notifying the EMPLOYER prior to October 1.

(8) The EMPLOYER is responsible for notifying ANNUITANTS of the availability of coverage.

(9) The EMPLOYER is responsible for notifying any CONTINUANTS of the prior group plan of the EMPLOYER'S change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.2 EMPLOYER TERMINATION – *(Local Contract Only)*

(1) The governing body of an EMPLOYER may terminate group health insurance under Wis. Stat. § 40.51 (7), for all PARTICIPANTS for whom rights to coverage were secured by the EMPLOYER'S participation by adopting a resolution in a form prescribed by the BOARD.

(2) A certified copy of the resolution in sub. (1) must be received in the DEPARTMENT by October 15 for termination to be effective at the end of the calendar year.

(3) If the EMPLOYER fails to comply with (1) or (2) above, or if the EMPLOYER fails to maintain the required participation level in the program, the DEPARTMENT may impose enrollment restrictions on the EMPLOYER as it deems appropriate to preserve the integrity of the program. The DEPARTMENT may terminate the EMPLOYER'S participation in the program on the first of the month following notification to the EMPLOYER that it has violated the terms of the CONTRACT. The DEPARTMENT may also restrict the EMPLOYER'S re-enrollment in the program beyond the restrictions set forth in item (4) below.

(4) Any EMPLOYER who terminates participation under this section may again elect to participate with an EFFECTIVE DATE not earlier than three years after the date of termination. The EMPLOYER is responsible for notifying ANNUITANTS and CONTINUANTS of coverage termination.

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, coverage to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for ~~before the effective date of~~ the EMPLOYER contribution~~s~~ toward the PREMIUM coverage to be effective upon becoming eligible for ~~the beginning of the month on or after the effective date of the date of~~ EMPLOYER contribution ~~toward PREMIUM~~. 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.

(3) (a) An EMPLOYEE eligible and enrolled for individual coverage only may change to family coverage effective on the date of change to family status including transfer of custody of eligible DEPENDENTS if an application is received by the EMPLOYER within 30 days after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall submit the application to the DEPARTMENT.

(b) Notwithstanding paragraph ~~2~~3 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within 60 days of the birth, adoption or placement for adoption.

(4) In addition to any enrollment period required under Wis. Stat. § 40.05 (4g), an EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same EMPLOYER subject to the following:

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

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

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

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

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

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

(7) (a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the

STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, the EMPLOYEE may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the ~~an~~other plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) As required by Federal law, an eligible EMPLOYEE may defer coverage if he/she is covered under medical assistance (Medicaid) or the Children's Health Insurance Program (CHIP). If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to the DEPARTMENT.

(c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, marriage or domestic partnership, provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage or effective date of the domestic partnership.

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

(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 is not available in the plan selected, the HEALTH PLAN shall immediately 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.

(9) PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may reenroll in any HEALTH PLAN without underwriting restrictions as follows:

(a) Coverage for those who have escrowed under Wis. Stat. § 40.05 (4) (b) and (be) may enroll during the DUAL-CHOICE enrollment period and be effective the first day of the month selected by the PARTICIPANT of the following year as provided in section 3.4 (1).

(b) For the PARTICIPANTS defined in Wis. Stat. § 40.02 (25) (b) (6e) and (6g) whose sick leave has been preserved under Wis. Stat. § 40.05 (4) (bc), coverage will begin on

the first of the month following the DEPARTMENT'S receipt of the health insurance application, unless otherwise specified on the application.

(c) PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. A PARTICIPANT enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS are covered under the other plan and lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage. Coverage shall be effective on the date of termination of the prior plan or the date of the event. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(10) Eligible retired EMPLOYEES or former EMPLOYEES of the State who have reenrolled under section 3.10 (4) may select any offered plan.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child ~~DEPENDENT~~ when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the ~~Standard Plan with a waiting period for the~~ DOMESTIC PARTNER or child~~. The exception is if~~ when the DOMESTIC PARTNER or child become~~s~~ newly eligible due to loss of eligibility for other coverage or the~~,~~ loss of employer contribution for other coverage, or the child has an increase in employee contribution share that exceeds the cost of coverage as a dependent under this program~~,~~ or gets divorced. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days of the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-~~-~~CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the DEPENDENT enrolls in other health insurance coverage during an initial enrollment opportunity, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT effective the following January 1, whichever occurs first.

(12) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during the annual DUAL-CHOICE enrollment period for coverage effective the following January 1.

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 enroll for or transfer coverage to any plan offered by the BOARD as required by 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. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual DUAL-CHOICE enrollment materials. 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) A SUBSCRIBER under ~~sections 3.4~~ (3) and (4) above who does not file an application to change plans within this 30 day enrollment period~~,~~ may change plans at the next DUAL-CHOICE enrollment period~~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~~.

(6) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, domestic partnership, 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 enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. 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.

(7) 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).

(8) If the HEALTH PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make a DUAL-CHOICE election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same HEALTH PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the EMPLOYER receives the SUBSCRIBER'S request to change networks, whichever is later.

(9) Applications from ANNUITANTS and CONTINUANTS changing plans during the DUAL-~~-~~CHOICE enrollment period must be received by the DEPARTMENT postmarked no later than the last day of the DUAL-~~-~~CHOICE enrollment period, unless otherwise authorized by the DEPARTMENT.

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3.6 CONSTRUCTIVE WAIVER OF COVERAGE

Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the EMPLOYER for a period of 12 consecutive months, shall be deemed to have prospectively waived coverage upon a 30-day notice to the EMPLOYEE, unless all required PREMIUMS are paid. Coverage then may be obtained only under the deferred coverage provisions of section 3.10.

3.7 BENEFITS NON-TRANSFERABLE

No person other than a PARTICIPANT, as recorded in the office of the HEALTH PLAN, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stat. § 939.51 (3) (a). ~~Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions for PARTICIPANTS 19 years of age and older.~~

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3.10 DEFERRED COVERAGE ENROLLMENT

(1) Any EMPLOYEE actively employed with the state who does not elect coverage during the enrollment period provided under section 3.3, 3.12 (3), or who constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only by electing coverage during the DUAL-CHOICE enrollment period as provided in section 3.4 (1)~~under the STANDARD PLAN, subject to any eligibility criteria and 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~~.

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage~~, and who subsequently~~ may only elect~~s~~ family coverage ~~after the initial eligibility period specified~~ during the DUAL-CHOICE enrollment period except as allowed in section 3.3 ~~(3) shall be eligible for family coverage under the STANDARD PLAN. DEPENDENTS shall be subject to any pre-existing condition clause contained in the STANDARD PLAN contract~~.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate HEALTH PLAN during a DUAL-CHOICE enrollment period offered under section 3.4.

(4) A retired EMPLOYEE of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1); or an EMPLOYEE of the state who terminates creditable service after attaining 20 years of creditable service, remains a participant in the Wisconsin Retirement System and is not eligible for an immediate annuity may enroll for

coverage during the DUAL-CHOICE enrollment period~~become insured effective on the first day of the seventh month following receipt of the application by the DEPARTMENT~~.

(5) An eligible EMPLOYEE who is not enrolled for coverage, may enroll 30 days prior to or preceding retirement in the STANDARD PLAN for the purpose of preserving post-retirement EMPLOYER premium contribution. An application for coverage must be submitted with an EMPLOYER certification of post-retirement EMPLOYER contribution prior to the effective date of retirement.

3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin or a participating Wisconsin Public Employer 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. As permitted by Section 125 of the Internal Revenue Code, ~~T~~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 effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. 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.

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. As permitted by Section 125 of the Internal Revenue Code, ~~T~~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 DOMESTIC PARTNER 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 DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the domestic partnership terminate while carrying family coverage, the former DOMESTIC PARTNER may elect coverage without lapse if the EMPLOYER received the application within 30 days of the termination of domestic partnership.

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3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS

(1) As required by Wis. Adm. Code § ETF 40.01, the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously insured under a

contract of a deceased EMPLOYEE or ANNUITANT or a child of the EMPLOYEE or ANNUITANT who is in the process of being adopted by the deceased EMPLOYEE or ANNUITANT or born within nine months after the death of the EMPLOYEE or ANNUITANT will be eligible for coverage under the survivor's contract 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 for which PREMIUMS have not already been deducted, 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), and the EMPLOYER submits verification ~~from the EMPLOYER~~ of insured status.

(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.

(c) Terminates employment after attaining 20 years of creditable service and is eligible for an immediate annuity but defers application. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment.

(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. 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 preceeding 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. 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 irrevocably canceled.

3.16 COVERAGE OF EMPLOYEES, 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 and coverage is provided under a non-employer group number.

(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 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, 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~~ SUBSCRIBERS and ~~ANNUITANTS~~ their DEPENDENTS who are eligible for those programs is waived if the ~~EMPLOYEE~~ SUBSCRIBER 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 reduced PREMIUM ~~rates~~ for coverage under this program.

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

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

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

(8) As required by Medicare rules, Medicare is the primary payor for DOMESTIC PARTNERS age 65 and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

3.17 CONTRACT TERMINATION

(1) The CONTRACT terminates on the date specified on the signatory page. The BOARD, by September 1, or the HEALTH PLAN, by the date specified in the Guidelines, section II., J.~~August 15~~, shall provide notice of its intent not to contract for the following contract year by providing notice to the other party. The HEALTH PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the DUAL-CHOICE enrollment period.

(2) If the HEALTH PLAN terminates this CONTRACT as required by sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

(b) The attending physician determines that confinement is no longer medically necessary.

(c) The end of 12 months after the date of termination.

(d) Confinement ceases.

(3) If the HEALTH PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the HEALTH PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the HEALTH PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT as required by sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The HEALTH PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

(5) If the HEALTH PLAN terminates this CONTRACT, the HEALTH PLAN shall not again be considered for participation in the program under Wis. Stat. § 40.03 (6) (a) for a period of three CONTRACT years.

3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate at the end of the month 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. As required by 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, 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 ANNUITANT~~ for whom the EMPLOYER has no reporting responsibilities, 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, end of a domestic partnership, 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) below, 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 paragraph ~~section 3.18~~ (4) below~~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.

(i) The first day of the month following the DEPARTMENT'S written notice to a~~n EMPLOYEE~~ SUBSCRIBER who is ineligible for coverage but, due to EMPLOYER or DEPARTMENT error, was enrolled for coverage ~~as an EMPLOYEE~~. The ~~EMPLOYEE~~ SUBSCRIBER (and any eligible DEPENDENTS) will be offered a special continuation period of 36 months. The continuation period will be administered in accordance with paragraph (4) below.

(j) The effective date of the termination of EMPLOYER participation for all PARTICIPANTS for whom coverage was secured as a result of the EMPLOYERS participation.

(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.

(4) A PARTICIPANT who ceases to meet the definition of EMPLOYEE,~~/~~ ANNUITANT,~~/~~ or DEPENDENT may elect to continue group coverage for a maximum of 36 months. Application must be postmarked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for the required PREMIUM.

(5) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the

STANDARD PLAN ~~with a 180-day waiting period for pre-existing conditions for PARTICIPANTS 19 years of age and older~~.

Change to an alternate HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

(6) In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent DUAL-CHOICE enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

(7) In the situation where the EMPLOYER violates the terms of the CONTRACT, coverage for all its PARTICIPANTS, including ANNUITANTS and CONTINUANTS, terminates the first of the month following notification from the DEPARTMENT of 30 days or more.

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3.20 ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the effective date of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency, or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums will continue to accumulate for that year.

(3) The HEALTH PLAN shall provide the PARTCIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits

Notable Changes Under Consideration for the 2012 Uniform Benefits

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
Throughout	a) Removed "booklet" after the name of the It's Your Choice guide. b) Updated all number references: added commas, removed decimals, and spelled out those less than ten. c) Updated undefined terms to be lowercased.	a) Editing change recommended by ETF Publications Editor. b) Editing change recommended by ETF Publications Editor. c) Editing change recommended by ETF Publications Editor.
Schedule of Benefits *Page 2*	Removed the bullet on Autism Spectrum Disorders.	Clarified the benefit in the Benefits and Services section due to federal mental health parity.
Definitions *Pages 4 - 6*	a) Added the definition of DEPARMENT. b) Updated the definition of DEPENDENT as explained in Attachment A, page 2, contract Article 1.7. c) Updated the definition of EMERGENCY for consistency with statute. d) In the definition of PRIMARY CARE PROVIDER, removed the requirement to list one on the application.	a) To clarify use of the term throughout the contract. b) Technical changes and to reflect current practice. c) Technical change. d) To reflect current practice of encouraging, but not requiring, members to list one on the application.
Benefits and Services A., 1., b. *Page 7*	Updated the language to be in similar format as the urgent care provision that follows.	Recommended by staff.
Benefits and Services A., 4., a. *Page 8*	Clarified language for better comprehension.	Editing change recommended by ETF Publications Editor.
Benefits and Services A., 5., i. *Page 9*	Added benefits in the state program for preventive services as required by the federal Patient Protection and Affordable Care Act.	Due to the relinquishment of grandfather status of the state program.
Benefits and Services A., 13. *Page 10*	Added language to clarify that hospice care is available for a participant that is confined.	Refer to discussion item #3 on page 5 of the memo.

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
Benefits and Services C., 1. *Pages 13 - 14*	Added language referencing requirements under Wis. Adm. Code § INS 3.37.	Technical change.
Benefits and Services C., 6. *Page 14*	Added language clarifying the benefit for Autism Spectrum Disorders.	Technical change due to federal mental health parity.
Benefits and Services D., 1. & 2. *Pages 16 - 17*	Made various editing changes for ease in comprehension and consistency with rest of the contract.	Recommended by staff.
Exclusions and Limitations A., 1., b. *Page 18*	Moved the exclusion from the surgical services section to item ad. in the general section.	Recommended by a health plan.
Exclusions and Limitations A., 10., h. *Page 19*	Added an exclusion for the replacement or repair of equipment/supplies that are damaged or destroyed by the participant, lost or stolen.	Technical change recommended by a health plan as a similar exclusion is listed under the pharmacy benefit but also applies to the medical benefit.
Exclusions and Limitations A., 12., l. *Page 21*	Added language to clarify that the exclusion also applies to certain services.	Recommended by staff.
Exclusions and Limitations A., 12., ad. *Page 23*	Moved the exclusion from the surgical services section to this general section.	Recommended by a health plan.

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.

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 for all medical services except for preventive services required under Section III., A., 5., i. 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 (WEA Trust PPP and WPS Metro 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.*

Except as specifically stated for Emergency and Urgent Care (see Sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless you get a Prior Authorization from your Health Plan. Prior Authorization requirements are described in the Health Plan Descriptions section of the "It's Your Choice: Decision Guide." ~~booklet.~~

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: NONE
- 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 per Participant 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 Participant 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.

- 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. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable at 100%.

- Hearing Aids: 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. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable at 100% and the $1,000 limit does not apply.

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. ~~Fifty~~ 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.

- Hospice Care Benefits: Covered when the Participant's life expectancy is ~~6~~ six months or less, as authorized by the Health Plan.

- Transplants: Limited to transplants listed in Benefits and Services section.

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.

- Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

- ~~Autism Spectrum Disorders: Benefits payable up to $50,000 per Participant per calendar year for intensive-level and up to $25,000 per year for nonintensive-level services.~~

- Vision Services: One routine exam per Participant 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 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 or for observation for 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 ~~P~~prescription ~~D~~drugs and ~~I~~insulin):
  $410 per individual or $820 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%, which will be applied to the ~~P~~prescription ~~D~~drug ~~A~~annual ~~O~~out-of-~~P~~pocket ~~M~~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.

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- **DEPARTMENT:** Means Department of Employee Trust Funds.

- **DEPENDENT:** Means, as provided herein, the Subscriber's:
  - Spouse.
  - Domestic Partner, if elected.
  - Child.
  - Legal ward who becomes a legal ward of the Subscriber, Subscriber's spouse or insured Domestic Partner prior to age 19, but not a temporary ward.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Child of the Domestic Partner insured on the policy.
  - Grandchild if the parent is a Dependent child.

  1. A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.

  2. A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.

  3. All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:

     a. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as~~o~~ long as the child remains so disabled ~~if~~ that he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The Health Plan will monitor ~~mental or physical disability~~ eligibility ~~at least~~ annually, notifying the employer and Department when terminating coverage prospectively upon determining the Dependent is no longer so disabled and/or meets the support requirement., ~~and~~ The Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

     b. After attaining age 26, as required by Wis. Stat. § 632.885 and Wis. Adm. Code § INS 3.34, a Dependent includes a child that is not married and is not eligible for coverage under a group health insurance plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium

amount for his or her coverage as a Dependent under this program. The child ceases to be a Dependent at the end of the month in which he or she:

- turns 27 years of age, or
- is no longer a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

4. A child born outside of marriage becomes a Dependent 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 Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The Effective Date of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

5. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.

6. Any Dependent eligible for benefits who is not listed on an application for coverage will be provided benefits based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the employer, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

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- **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.

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

  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. However, the Health Plan must hold 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.

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- **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 the~~is~~ calendar year.

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- **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~~ should name Your Primary Care Provider or clinic 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 the Health Plan Descriptions section of the "It's Your Choice: Decision Guide." ~~booklet.~~ Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.

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- **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 the Health Plan Descriptions section of the "It's Your Choice: Decision Guide." ~~booklet.~~ 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.

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- **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.

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. You should use Plan Hospital emergency rooms ~~should be used~~ whenever possible. ~~Should~~ If You are not ~~be un~~able 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~~ receive~~d~~ed~~ing~~ 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 for the follow-up care are at the sole discretion of the Health Plan. In addition to the emergency room Copayment, ~~this out-of-plan~~ Emergency care from Non-Plan Providers 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:
   - o Acute allergic reactions
   - o Acute asthmatic attacks
   - o Convulsions
   - o Epileptic seizures
   - o Acute hemorrhage
   - o Acute appendicitis
   - o Coma
   - o Heart attack
   - o Attempted suicide
   - o Suffocation
   - o Stroke
   - o Drug overdoses
   - o Loss of consciousness
   - o Any condition for which You are admitted to the Hospital as an inpatient from the emergency room

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4. Reproductive Services and Contraceptives

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, ~~C~~cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a Dependent 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 old~~v~~er at the time of the 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. Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:
   - o Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
   - o IUDs and diaphragms, as described under the Durable Medical Equipment provision.
   - o 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. Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e. 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.)

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

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

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

i. Preventive services as required by the federal Patient Protection and Affordable Care Act. ~~*(Applies to Local program only)*~~

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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, 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 six~~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 is available to a Participant who is Confined. Hospice Care includes, but is not limited to, Medical Supplies and services, counseling, bereavement counseling for one~~1~~ year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a ~~6~~six-month period if authorized by the Health Plan.

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15. Extraction of Natural Teeth and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/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 18 ~~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.

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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.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease.

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:
   - o Corneal opacity
   - o 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
   - o Corneal ulcer
   - o Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - o Congestive Cardiomyopathy
   - o End-Stage Ischemic Heart Disease
   - o Hypertrophic Cardiomyopathy
   - o Terminal Valvular Disease
   - o Congenital Heart Disease, based upon individual consideration
   - o Cardiac Tumors, based upon individual consideration
   - o Myocarditis
   - o Coronary Embolization
   - o Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - o Extrahepatic Biliary Atresia
   - o Inborn Error of Metabolism
     - Alpha -1- Antitrypsin Deficiency
     - Wilson's Disease
     - Glycogen Storage Disease
     - Tyrosinemia
   - o Hemochromatosis
   - o Primary Biliary Cirrhosis
   - o Hepatic Vein Thrombosis
   - o Sclerosing Cholangitis
   - o Post-necrotic Cirrhosis, Hbe Ag Negative
   - o Chronic Active Hepatitis, Hbe Ag Negative
   - o Alcoholic Cirrhosis, abstinence for six~~6~~ or more months
   - o Epithelioid Hemangioepithelioma
   - o Poisoning
   - o 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.

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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.

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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) and as required by Wis. Adm. Code § INS 3.37.

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 and Wis. Adm. Code § INS 3.37.

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 and Wis. Adm. Code § INS 3.37. 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 as required by 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

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.

2. Durable 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.)

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6. Coverage of Treatment for Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. ~~Benefits are payable~~ Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. The therapy limit does not apply to this benefit.

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' ~~g~~Group Health Insurance Program, 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 or cost).

c. Single packaged items are limited to ~~2~~ two 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 ~~S~~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, for example, ~~(~~15 tablets for a ~~–~~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 approved products 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.~~b. 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.~~c. 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, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services 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; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by a Plan Provider to treat a metabolic or peripheral disease or a skin or tissue infection.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits and Services 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.

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10. Durable Medical or Diabetic Equipment and Supplies

a. All Durable Medical Equipment purchases or rentals unless Prior 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 a~~n~~ 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. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g. Customization of buildings for accommodation (for example, wheelchair ramps).

~~g.~~h. Replacement or repair of Durable Medical Equipment/supplies damaged or destroyed by the Participant, lost or stolen.

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 the Participant enrolled in Medicare coordinated coverage does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage.

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 ~~S~~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 (VA), except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

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. Maintenance Care.

k. Care provided to assist with activities of daily living (ADL).

l. Personal comfort or convenience items or services such as in-Hospital television, telephone, private room, housekeeping, shopping, ~~and~~ homemaker services, and meal preparation services as part of home health care.

m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o. 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 nonpayment 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.

p. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery.

q. 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.

r. Charges for any missed appointment.

s. 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).

t. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

u. 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.

v. 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.

w. Coma ~~S~~stimulation programs.

x. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.

y. Any diet control program, treatment, or supply for weight reduction.

z. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.

aa. 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 ~~a~~Act, employer's liability insurance plan or similar law or act. Entitled means You are actually insured under Worker's Compensation.

ab. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.

ac. 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.

ad. 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.

a~~c~~e~~d~~. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.

a~~f~~e~~e~~. 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.

ag~~f~~. Sexual counseling services related to infertility and sexual transformation.

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

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VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

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

Each Participant agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the Health Plan and/or PBM but also disclosures to:

1. Health care Providers as necessary and appropriate for treatment;

2. Appropriate Department ~~of Employee Trust Funds~~ employees as part of conducting quality assessment and improvement activities, or reviewing the Health Plan's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations;

3. The tribunal, including an independent review organization, and parties to any appeal concerning a claim denial.

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H. Subrogation

Each Participant agrees that the insurer under these Uniform Benefits, whether that is a Health Plan or the Department~~Public Employee Trust Fund~~, shall be subrogated to a Participant's rights to damages, to the extent of the benefits the insurer provides under the policy, for Illness or Injury a third party caused or is liable for. It is only necessary that the Illness or Injury occur through the act of a third party. The insurer's rights of full recovery may be from any source, including but not limited to:

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

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

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

In the event the Participant can recover any amounts, for an Injury or Illness for which the insurer provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the Participant shall either assert and process such claim and immediately turn over to the insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's

or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the insurer immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof Of Claim

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

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

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

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

J. Grievance Process

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

If You exhaust the Health Plan's and/or PBM's Grievance process and remain dissatisfied with the outcome, You may appeal to the Department by completing a Department ~~an ETF~~ complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department within 60 days of the date of the final grievance decision letter from the Health Plan and/or PBM.

You may also request an independent review per Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, you have no further right to administrative review once the Independent Review Organization decision is rendered.