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CORRESPONDENCE MEMORANDUM

DATE: May 3, 2012

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Emily Loman, Manager Alternate Health Plans

SUBJECT: Guidelines and Uniform Benefits for the 2013 Benefit Year

Staff recommends the Group Insurance Board (GIB) adopt the Guidelines and Uniform Benefits (UB) changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.

BACKGROUND

Annually, the GIB reviews its *Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program.* These guidelines establish participation requirements for health plans for the upcoming benefit year (2013) as well as establish employer and employee eligibility and certificates of coverage for insured health plans.

On February 29 and March 16, 2012, an advisory study group, composed of twelve Department of Employee Trust Funds (ETF) staff and five other state agency representatives, met to review and offer comments on a list of potential benefit adjustments and guideline changes compiled by ETF. The study group did not vote on recommendations; its purpose was to offer feedback on issues for ETF's consideration. Study group member feedback and ETF's final recommendations are contained in this memo for the GIB's consideration. The attached tables also include other relevant clarifications that are not specifically discussed in this memo.

The study group meetings included: Jennifer Stegall, Office of Commissioner of Insurance (OCI); Jennifer Kraus, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Beth Ritchie, University of Wisconsin (UW) System; Nicole Zimm, UW System; and the following ETF staff: Lisa Ellinger, Bill Kox, Emily Loman, Arlene Larson, Jeff Bogardus, Roni Harper, Betty Wittmann, Brian Shah, Brian Schroeder, Dan Hayes, Liz Doss-Anderson, and Vickie Baker.

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

Lisa Ellinger — Signature
5/8/12 — Date

Board	Mtg Date	Item #
GIB	5.22.12	5A

Attached are the following:

- **Attachment A**: Explains the basis for any notable changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B1:** Excerpts from the Guidelines and Addendum with recommended cost-neutral modifications for 2013.
- **Attachment B2:** Excerpts from the State and Local Contracts with recommended cost-neutral modifications for 2013.
- **Attachment C**: Explains the basis for notable changes to UB.
- **Attachment D:** Excerpts from UB, with recommended modifications for contract year 2013.

Staff previously advised the GIB at its February meeting to expect few benefit changes for 2013, as we continue to assess the impact of relatively significant changes incorporated in 2012. For the 2013 benefit year, ETF recommends only those benefit changes that, when considered as a whole, are cost neutral to the overall benefit level of the Group Health Insurance Program.

The impetus for these proposals comes from the GIB, participants, health plans, and staff. Health plans were informed of proposed changes via e-mail on February 16, 2012. 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 in Attachments B (Guidelines/Addendums/Contracts) and D (UB) that are not described on the table or discussed below. We consider these to be minor modifications or clarifications of current practice.

Please note that as staff continues to refine UB, further contract changes may be necessary. Staff will bring any notable changes before the GIB but also requests authority to proceed with any needed technical clarifications or changes related to compliance with federal requirements.

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

SECTION 1: RECOMMENDED CHANGES TO BENEFITS

1. **Retainers and/or Prep Work Associated with Orthodontia Due to Injury:** The study group discussed a participant's request to add coverage for mouth guards/retainers, when medically necessary, as part of prep work provided prior to tooth repair related to accidents. The GIB's actuary indicates this change would cost $0.04 per member per month (PMPM).

   Due to the estimated low cost and relatively low utilization, ETF recommends adding this benefit.

2. **Smoking Cessation:** The current smoking cessation benefit covers only smoking cessation medications that require a written prescription and that are listed on the formulary, as well as only one office visit per year for counseling and to obtain a prescription. The study group discussed expanding the benefit as follows with corresponding cost estimates from the GIB's actuary:

   A. Two quit attempts per year, $0.52 PMPM;
   B. Four telephonic counseling sessions per year, $0.02 PMPM;
   C. Include on the formulary all Food and Drug Administration (FDA)-approved over-the-counter (OTC) nicotine replacement therapy, $0.13 PMPM;
   D. Include on the formulary all FDA-approved prescription tobacco cessation medications, $0.32 PMPM;
   E. Eliminating or minimizing the out-of-pocket (OOP) costs (e.g. co-pays), $0.11 PMPM;
   F. Eliminating the maximum limits on quantity, $0.31 PMPM;
   G. Requiring pre-authorization for the extension of a first quit attempt, $0.03 PMPM.

   Most plans are already equipped to provide telephonic counseling and many provide multiple sessions.

   Due to the estimated low cost, ETF recommends only expanding the smoking cessation benefit to include four telephonic counseling sessions. ETF also recommends requiring prior authorization for any limited extension of smoking cessation pharmacological products. ETF considers any such cost-effective increase to the smoking cessation benefit as a part of our long-term commitment toward enhancing our wellness program.

3. **Hospice Benefits:** Hospice is a multi-disciplinary area of healthcare that uses palliative care to improve the quality of life for patients at or near the end of life. Under current UB, hospice care must be provided through a licensed hospice care provider approved by the health plan and is only available to a participant whose life expectancy is six months or less and who is confined. Supplies and services currently include counseling and bereavement counseling for one year after the

participant's death. A one-time in-home palliative consult is also currently covered after the participant receives a terminal diagnosis, regardless of whether life expectancy is six months or less.

This year, the study group considered adding in-patient stays of up to 30 days at an approved hospice facility or skilled nursing facility. The GIB's actuary estimated this cost at $0.27 PMPM.

Due to the estimated low cost, ETF recommends adding 30 days at an approved hospice facility to the uniform hospice benefit. ETF also considers any such cost-effective increase to the hospice benefit as a part of our long-term commitment toward enhancing our wellness program.

4. **Level 4 – Specialty and Lifestyle Prescription Drugs:** The study group considered adding Level 4 cost-sharing for typically high-cost specialty and certain lifestyle prescription medications to the prescription drug benefit administered by the pharmacy benefit manager (PBM). Specialty medications are currently defined as medications that require special storage and handling. The study group also considered a minor revision to the definition of specialty medication to also include medications that require special administration and/or monitoring, which can significantly increase administrative costs. The study group considered defining lifestyle medications as those which are not medically necessary to treat an illness or injury.

   The study group discussed designing Level 4 to require a $50 copayment and a separate annual out-of-pocket maximum (OOPM) of $1,000 per individual and $2,000 per family. The current annual prescription drug OOPM is $410 per individual and $820 per family and applies only to Level 1 and Level 2 formulary prescription drugs. Level 3 copayments for non-formulary drugs do not apply to the annual OOPM and would continue to be required to be paid after the annual OOPM has been met. The study group realized that higher copays for specialty medications could negatively affect the sickest members of the program. Therefore, it also considered allowing members to opt out of Level 4 requirements when they obtain specialty medications from the PBM's specialty mail order vendor. Specialty vendors have been shown to control specialty drug costs better than other retail or mail-order pharmacies by dispensing medications and adjudicating costs more effectively. The study group considered combining the less expensive Level 1/Level 2 copay (currently $15) to specialty medications obtained from the specialty vendor as an incentive for members to use the specialty vendor.

   ETF recommends designing Level 4 to require a $50 copay and allowing the Level 4 OOPM to "wrap" the Level 1/Level 2 OOPM for members who use the specialty vendor for specialty medications.

Regarding lifestyle medications: Currently, only one medication (Viagra) is covered, due to being "grandfathered" by other plans prior to Navitus or may be covered in individual cases pursuant to a decision from an Independent Review Organization (IRO).

Graph 1: Summary of Cost Impact of 2013 Recommended Benefit Changes

	BENEFIT	SAVINGS	COST	TOTAL
1.	Retainer for accidental injury		$0.04 PMPM	
2.	Pre-Authorization for Extension of First Quit Attempt		$0.03 PMPM	
3.	30-day hospice facility in-patient stay		$0.27 PMPM	
4.	Level 4 specialty and lifestyle drugs	-$0.33 PMPM		
	TOTAL	**-$0.33 PMPM**	**$0.34 PMPM**	**+$0.01 PMPM**

SECTION 2: RECOMMENDED CHANGES TO GUIDELINES HAVING A DIRECT IMPACT ON ADMINISTRATION COSTS

5. **Health Risk Assessment (HRA) and Biometric Screenings:** HRAs and biometric screenings are widely-used screening tools in wellness and health promotion programs that can help provide participants with an evaluation of their health risks and lifestyle choices. Providers can use HRAs and biometrics to identify participants who may be at risk for certain diseases or chronic conditions. ETF regards HRAs and biometric screenings as best practices for offering an effective wellness program.

   HRAs and biometrics can help prompt early intervention with those whose behavior can be changed, potentially improving members' health and reducing the incidence of costly treatment of adverse health events. The four most basic and useful biometric measures are: blood pressure, body mass index (BMI), cholesterol, and glucose levels. Despite the apparent benefits, most participants choose not to complete an HRA or biometrics screening unless a health plan or employer provides some type of an incentive. The most common incentives are gift cards or reductions to monthly premiums or deductibles. Without incentives, the GIB's actuary estimates that less than 15% of participants are likely to complete an HRA and biometric screening.

   The study group discussed a broad range of approaches on this concept and sought price estimates from the GIB's actuary for ETF's consideration in determining the

best approach. The GIB's actuary estimates that requiring a health plan to provide an HRA and biometric screening without incentives would cost the state approximately $1.01 PMPM ($1.9 million annually). The cost of offering a voluntary HRA/biometric screening with a cash-equivalent incentive of $150, which could achieve approximately a 45% participation rate, depends largely on the individual program design of the health plan. Claims cost estimates for savings from HRAs and biometrics are not quantifiable at this time.

ETF recommends a requirement that plans design a wellness program with the expectation that plans administer an annual health risk assessment (HRA) and biometric screening to 30% to 50% participation of their adult members. In addition, plans may provide cash equivalent incentives up to $150.00 in value to encourage broad participation. ETF also recommends the requirement that plans provide biometric screenings that shall at a minimum test: glucose level, BMI, cholesterol level, and blood pressure. Subscribers may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes results from the four tests listed above and the results were obtained within six months from the date on which the HRA is submitted.

In order to encourage the health plans to administer HRAS and biometric screenings to more than 50% of their participants, as described above, we will issue a credit to the plan during annual negotiations.

6. **Prior Authorization for High-Tech Radiology and Low Back Surgery:** Consistent with the recommendations of Dr. Tom Hirsch, ETF's medical consultant, the study group considered requiring health plans to implement prior authorization requirements for referrals to specialists for participants seeking high-tech radiology services (e.g., MRI, PET, CT scans) or lower back surgery procedures. Prior authorizations would not be required for participants presenting "red flag" concerns (i.e., clinical presentations requiring immediate or expedited orthopedic, neurosurgical, or other specialty referral). The study group initially considered requiring prior authorizations only for those plans routinely demonstrating over-utilization of these services. The study group discussed the administrative challenges associated with monitoring plans' utilization rates on an annual basis and decided this type of system would be too burdensome on both ETF and the health plans.

   The GIB's actuary estimates savings on prior authorizations for lower back surgeries including office visits at $0.21 PMPM. Estimated savings on prior authorizations for high-tech radiology is $0.75 PMPM. The GIB's actuary estimates that a prior authorization requirement will result in a 7.5% reduction in utilization of both services.

ETF recommends requiring prior authorizations for all health plans regardless of whether the plan demonstrated consistent over-utilization. ETF also recommends requiring prior authorizations for participants seeking high-tech radiology services.

7. **Primary Care Physician (PCP) Requirement:** The study group discussed whether to require plans to implement a policy that would require participants to select and use a PCP to coordinate care with specialists. The measure, which has been historically used in managed care settings, has been shown to reduce costs and improve quality of care in certain settings. The GIB's actuary estimates that the savings, which it projects at less than 1% on a paid claims basis or less than 0.9% on a premium basis, could justify the extra administrative burden placed on plans. Currently, 11 out of the 18 participating health plans require a PCP or primary care clinic.

   The study group also discussed whether a PCP requirement could be overly burdensome on participants who have frequent or routine appointments with specialists. However, this may be mitigated by learning the administration details of each health plan. ETF recommends implementing contract language that creates an incentive for health plans to require members to use a PCP by crediting a participating plan during annual negotiations.

Graph 2: Summary of Impact to Administration Costs Based on 2013 Recommended Guideline Changes

	SERVICE	SAVINGS	COST	TOTAL
1.	HRA/Biometric Screenings with Incentives		Low Estimate: $1.01 PMPM High Estimate: Depends on plan design	
2.	Prior Authorization for Low Back Surgery	-$0.21 PMPM		
3.	Prior Authorization High-Tech Radiology	-$0.75 PMPM		
4.	PCP Requirement	< -1%		
	TOTAL	**-$0.96 PMPM + < 1%**	**Low: $1.01 PMPM** **High: Depends on plan design**	

SECTION 3: RECOMMENDED CHANGES HAVING NO DIRECT EFFECT ON BENEFIT OR ADMINISTRATION COSTS

8. **2011 Wisconsin Act 133:** Prior to the enactment of 2011 WI Act 133 on April 4, 2012, under Wis. Stat. §40.51 (7), only those local employers participating in the Wisconsin Retirement System (WRS) were authorized to offer health insurance coverage to their employees through the Wisconsin Group Health Insurance Program. Act 133 changed §40.51 (7) to allow local employers not participating in the WRS to offer such insurance to employees who are eligible.

   Due to contractual provisions that prohibit impairment to the existing contract, ETF recommends that this statutory mandate take effect in the Group Health Insurance contract on January 1, 2013. ETF also recommends revising all relevant contractual provisions to allow non-WRS-participating employers to offer Wisconsin Group Health Insurance to employees who are eligible. In addition, ETF requests authority to make any necessary technical changes to the contract in order to facilitate implementation.

9. **Health Plan Grievance Letter Language:** In 2011, ETF received a moderate number of complaints from members who had received, from their health plans, grievance letters that relied on terms not recognized or defined under UB as the basis for their adverse decisions. A grievance letter is part of the health plan's internal process for resolving member complaints. Adverse grievance decisions can be appealed to ETF and subsequently the GIB. Department determinations are written findings by ETF applying law or contract terms to actual facts to determine a benefit. The study group considered that health plans must use terms defined under UB so that ETF can properly examine and issue findings on relevant contract provisions. The study group also considered that members are more likely to be confused by letters using terms not defined under UB and therefore may be more likely to appeal adverse decisions.

   ETF recommends requiring that health plans cite specific UB provision(s) to support its decisions. Plans, however, may use non-contract terms to explain a particular provision or term in the contract. ETF considers this recommendation as part of our continued efforts at reducing the number of appeals to the Board.

10. **Premium refunds for Retroactive Medicare Enrollment:** Retired participants who are Medicare eligible are required to enroll in Medicare Parts A and B when initially eligible. Enrollment in Medicare Parts A and B automatically changes the eligible participant's group health insurance coverage to a Medicare-coordinated contract with a lower monthly premium. Despite multiple notices from ETF instructing eligible participants to enroll timely in Medicare, some participants fail to enroll or fail to

notify ETF of enrollment. When this happens, ETF may be required to retroactively enroll the participant in a Medicare-coordinated contract.

Currently, our contract allows retrospective adjustments to premium to extend back as far as six months. However, Medicare's retroactive limits on retroactive enrollment, which are typically 60 to 90 days depending on the individual agreement between the individual health plan and Medicare, controls. Therefore Medicare's retroactive enrollment rules limit how far back ETF can retroactively enroll an eligible participant in a Medicare-coordinated contract.

ETF recommends clarifying retroactive enrollment into Medicare-coordinated contracts to align with the retroactive claims adjudication limits set by Medicare. Aligning retroactive enrollment in Medicare-coordinated contracts with Medicare's rules on retroactive claims submissions would allow those claims paid under a Medicare-reduced contract to be paid by Medicare.

11. **Methadone Maintenance Exclusion:** The study group considered recommendations from two health plans to clarify the extent to which methadone treatment is covered under UB. Currently, UB provides only a general exclusion for maintenance therapy that is not medically necessary. These plans want a specific exclusion for methadone maintenance therapy in order to more effectively communicate to participants the limitation imposed on methadone treatment when plans have determined that treatment has crossed the line from rehabilitative to maintenance therapy, which is a non-covered benefit. The study group considered that some plans report covering methadone treatment for greatly extended periods of time, while others are far less generous.

    Based on this feedback, ETF recommends including a specific exclusion for methadone maintenance therapy when treatment is no longer medically necessary, as this would help plans to more consistently administer this portion of Alcohol and Drug Abuse (AODA) benefits.

12. **Women's Health and Cancer Act of 1998:** The study group discussed a recommendation from a health plan to clarify reference in UB to the Women's Health and Cancer Act of 1988. Currently, UB provides coverage under the Act only for the treatment of breast cancer. The health plan wants the contract to reflect the intent of the Act, which it considers as providing coverage not only to cancer patients, but for all valid medical and surgical benefits with respect to mastectomies that are medically necessary. After researching the issue, ETF determined that the legislative intent of the Act is, in fact, to provide broader benefits for medically necessary mastectomies.

ETF recommends that contract language be revised to include coverage of medical and surgical benefits with respect to mastectomies for all valid medically necessary reasons.

13. **Prosthetic Durable Medical Equipment (DME):** Two recent cases involving coverage of replacement artificial limbs warrant clarification of the relevant contractual provision under UB. *This issue was not considered by the study group because these two particular cases only recently came to light.* The cases involve participants who acquired artificial limbs under the contract, but due to negative growth and development of the affected area, sought coverage of medically necessary replacement prostheses. ETF believes current UB language regarding DME should be clarified to adequately address the above-mentioned situations and believes the relevant contractual provision under the Standard Plan adequately addresses these conditions.

    ETF recommends adopting language regarding DME from the Standard Plan to replace existing language under UB. This change is a clarification of existing practice.

14. **Continuity of Care Monitoring After Hospital Discharge:** The study group considered a recommendation by ETF's medical consultant to revise language in the guidelines to require health plans to demonstrate their efforts to monitor the coordination of care of participants who are at the highest risk of re-admission to the hospital. The medical consultant also recommended requiring health plans to incorporate a re-admissions reduction program and a community-based transition program similar to Medicare's transition program into their hospital and provider agreements.

    ETF believes that by requiring health plans to incorporate coordination of care and transition-to-home programs into their provider agreements, health plans will be able to more effectively manage care and potentially prevent avoidable and costly hospital readmissions. Accordingly, ETF recommends this change.

15. **Clarification of Adjudication of Immunizations and Vaccinations Under Medicare:** Level M drugs are a distinct class of drugs, which can include vaccinations and immunizations and are specifically classified under Medicare Parts B and D. Level M drugs are adjudicated by the PBM, not the health plan. In cases where the vaccination or immunization is not conducted at a network pharmacy, the PBM may require the participant to manually submit the claim to adjudicate the claim.

    The Schedule of Benefits is part of the master contract between the health plan, the PBM, and the GIB and is included at the beginning of the UB section. The Schedule

of Benefits describes certain dollar or visit limits and certain rules concerning a participant's medical and pharmacy coverage.

ETF recommends clarifying the claims adjudication process in the Schedule of Benefits for Level M prescription drugs, when the Medicare Prescription Drug Plan is the primary payer. ETF also recommends making Level M Drug and Medicare Prescription Drug Plan defined terms under the definitions section to correspond with this clarification. This change is a clarification of existing practice only and would not impact prescription drug benefit levels.

16. **Clarification of Out-of-Network Benefits:** The study group considered a recommendation from ETF staff to clarify language in the Schedule of Benefits regarding how cost-sharing for out-of-network services works in relation to the in-network OOPM. Staff also recommended revising language in the Schedule of Benefits grid outlining cost-sharing for various services. ETF staff cited some member and health plan confusion as the basis of their recommendation. Current benefit levels provide that out-of-network coinsurance amounts do not accumulate to the in-network OOPM.

    ETF recommends inserting the clarification mentioned above in the note section of the Schedule of Benefits as well as revising language in the grid.

17. **Clarification of Residential Treatment for Alcohol and Drug Abuse (AODA):** The study group considered a health plan recommendation to include residential care for AODA as an explicit exception to the exclusion for residential care. Current language was ambiguous as to whether the provision excluded residential treatment for mental health and AODA.

    ETF recommends adopting language that clearly states that AODA is a valid exception to the residential care exclusion and citing relevant administrative code.

18. Uniform Glossary: The Patient Protection and Affordable Care Act (PPACA) requires insurers to provide enrollees with a Summary of Benefits and Coverage, effective on the first day of the first plan year beginning on or after September 23, 2012.

    Based on the federal mandate to provide a uniform glossary as part of the Summary of Benefits and Coverage, ETF recommends changing the definitions of common health insurance terms included in the *It' Your Choice: Decision Guide* to align with federal definitions. ETF also recommends including diagrams included in the federal glossary, which are designed to illustrate the often complex relationships between multiple parties in health insurance situations.

SECTION 4: PROPOSED CHANGES NOT RECOMMENDED

ETF presented to the study group other issues, which did not result in recommended changes. The most notable issues are summarized below. Staff will provide additional information upon request.

19. **Low Cost Option:** The study group discussed whether to recommend offering a low-cost health insurance option side-by-side with the traditional offerings. This topic generated considerable discussion during the study group meetings. Reasons presented for offering a low-cost option included making employees better consumers of healthcare expenses, facilitating savings to the state, and offering more affordable plans for low-wage employees. Reasons presented for recommending that a full actuarial study be completed before offering any recommendation include concerns that high deductible health plans (HDHP) offered as the lower cost option in a choice environment tend to adversely affect the traditional plan, through adverse selection. The study group agreed that offering a low-cost option warrants further discussion and in-depth actuarial analysis before ETF can provide any recommendation. The study group also acknowledged timing difficulties that would arise with offering a low cost option by 2013 if this concept is to be adequately studied.

20. **Nurse-Midwife Feasibility Study:** 2011 Wisconsin Act 32 requires the GIB to study the feasibility of including in UB the costs of certified nurse-midwife services to assist in births at home or at stand-alone birth centers, but the provision does not include a deadline for completing the study. ETF recommends that this be considered as part of future discussions on potential changes to the health insurance program.

21. **Emergency Room Copay:** The study group considered increasing the emergency room (ER) copay from $75 to $100. Several health plans have indicated that $100 is the industry standard for ER copays. The GIB's actuary estimates the savings from increasing the copay to be approximately $0.21 PMPM. This change would be needed only if other benefits were added. Since the benefit level proposed by ETF is cost-neutral, ETF does not recommend increasing the ER copay at this time.

22. **Weight Loss Surgery (Gastric Bypass) Benefits:** The study group considered coverage for the surgical treatment of obesity (i.e. gastric bypass), which has been requested by participants and a few health plans over the years. The GIB's actuary estimates that for 100% coverage, the PMPM cost to add the benefit is $5.25 PMPM initially, due to pent-up demand, and $3.50 PMPM thereafter; 80% coverage is approximately $4.20 PMPM, initially, and $2.80 PMPM thereafter. The GIB's actuary indicates that, although costs of this benefit have not changed significantly, utilization continues to trend downward. ETF again agreed that adding gastric bypass for the surgical treatment of obesity remains costly and would benefit only a relatively small number of participants. Because gastric bypass may be covered

under the Standard Plan if it meets WPS medically necessary criteria, ETF does not recommend adding this benefit for 2013.

23. **Mandatory Wellness and Disease Management Participation:** The study group discussed a recommendation to require member participation in a health plan's wellness and disease management programs if that member is determined to be at moderate or high risk for disease or chronic illness based on health risk assessment results. ETF does not recommend implementing this type of requirement at this time, due to the potential for discrimination against certain groups and to the extent the Affordable Care Act constrains this type of requirement. However, ETF recommends that this be considered as part of any larger, future study of the health insurance program.

24. **Independent Review Organization (IRO):** The study group discussed a recommendation to align contract language with federal law. OCI indicated that it is awaiting further state specific guidance from the federal Department of Health and Human Services (HHS), and it is premature to delete cross reference to state law. Based on OCI's guidance, ETF decided not to remove the existing references to state statute and administrative code, so that all potentially applicable laws could inform the independent review process.

25. Silver Sneakers: The study group discussed a recommendation from a member to offer the commercially-branded "Silver Sneakers" wellness program for senior members. ETF does not recommend offering a senior-specific program because the wellness benefit that is currently offered to active employees is also available to retirees and is comparable to Silver Sneakers in the level of benefit. However, the Standard Plan and Medicare Plan do not offer this benefit. The cost would be $5.00 per contract per month.

26. **Premium Differentials for Obesity and Tobacco Use:** The study group discussed recommending to OSER that members who use any tobacco products or who have a history of a high level BMI to pay a higher premium unless they participate in an approved wellness program or get their doctor to verify they have a health condition that precludes participation. ETF does not recommend a requirement of this nature at this time, due to numerous administrative complexities associated with implementation, potential statutory constraints, and the potential for discrimination complaints from certain groups of members. However, ETF recommends that this be considered as part of any larger, future study of the health insurance program.

27. **Medicare Due to End Stage Renal Disease (ESRD):** The study group discussed a health plan recommendation to include active state employees who have Medicare prime due to ESRD in the same benefit package as retirees with Medicare prime. ETF does not recommend this suggestion because those who are eligible for and/or have Medicare coverage due to ESRD are not eligible for Medicare-reduced

contracts in our programs. Placing ESRD Medicare participants in the same benefit package as standard Medicare participants is not feasible because there is no mechanism in the current structure to provide premium differentials within an employer/retiree group.

28. **Preventive Services List:** The study group considered a health plan recommendation to include a list of preventive services based on the federal list of mandated preventive services not subject to a deductible or coinsurance requirement. At this time, ETF does not recommend incorporating such a list into the contract. However, we will consider working with the health plans to develop a list that may ultimately be incorporated into the contract as more information about federally mandated preventive services becomes available.

29. **Surgery to Correct Functional Impairment:** As currently written, the exclusion of treatment, services, and supplies for cosmetic purposes applies, except when associated with covered services to correct congenital body disorders or reconstructive surgery due to illness or injury. A health plan recommended that language be inserted to more narrowly define the exception to functional impairments related to congenital body disorders. ETF does not recommend the suggestion to modify language relating to the exclusion of treatment, services, and supplies for cosmetic purposes.

30. **Revision of Medically Necessary Definition:** The study group discussed a health plan suggestion that the GIB revise the contract's definition of medically necessary to exclude as medically necessary cosmetic surgeries associated with certain behavioral conditions. ETF does not recommend this change because ETF believes that the current definition of medically necessary, combined with the specific provisions excluding certain types of surgeries, is sufficient.

31. **Surcharge on Large Local Groups:** The study group considered inserting additional language that would specifically assess a separate surcharge for new and existing local groups**.** ETF believes that current language is sufficient to protect the program from excessive adverse risk.

32. **OTC Drug Exclusion:** The study group considered a health plan recommendation to exclude all OTC drug items, even those OTC drugs that the PBM designates as covered. ETF believes the PBM is best situated to determine whether coverage of certain drugs, even if they are OTC, can best control costs, and therefore, does not recommend the suggested change.

33. **Acupuncture Exclusion:** The study group considered a health plan recommendation to make acupuncture treatment a specific, stand-alone exclusion under UB. The plan wants a specific, stand-alone exclusion for acupuncture in order to more efficiently communicate the exclusion of this treatment to participants.

Currently, acupuncture is included as part of a comprehensive list of exclusions under experimental services and treatment. ETF thinks that it is unnecessary to revise current language to make acupuncture a stand-alone exclusion because it is currently listed as a specific exclusion under experimental services and treatment.

34. **Remove Health Plans as a Signatory to Personal Health Information (PHI) Disclosure Certificate:** The study group considered a health plan recommendation to remove health plans as signatories to the Certification to Health Insurance Issuer for Disclosure of PHI to ETF. The form was created to facilitate the transfer of PHI between ETF's Ombudsperson Services staff and the health plans when a member contacts ETF for assistance. ETF does not recommend this change because having the health plan sign the form still serves as a useful acknowledgment of the transfer of PHI.

35. **Remove References to Full-Time Student Status:** The study group considered removing contractual references to full-time student status because state and federal laws no longer require this criteria for dependent eligibility. However, under state law, an adult child is eligible for coverage if the child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the child was attending, on a full-time basis, an institution of higher education. ETF does not recommend this change because full-time student status pertains to active military status as explained above.

36. **Wellness Documentation Component:** The study group considered creating a wellness documentation component as part of the annual utilization review submitted by health plans in November. ETF does not recommend this change because current contractual requirements are sufficient.

37. **PHI Breach Notification:** The study group considered a health plan recommendation to remove the contract's reference to federal law in its provision regarding notification requirements in the event of a breach of PHI. ETF does not recommend this change because it is unaware of any law change that would make current, relevant federal law inapplicable.

We again thank the study group for their participation in this process. Staff will be available at the Board meeting to answer any questions you may have.

Attachments:
Attachment A – Notable changes to the Guidelines, Addendum, and Contracts
Attachment B1 – Excerpts from the Guidelines, Addendum
Attachment B2 – Excerpts from the State and Local Contracts
Attachment C – Notable changes to Uniform Benefits
Attachment D – Excerpts from Uniform Benefits

NOTABLE CHANGES UNDER CONSIDERATION FOR THE 2013 GUIDELINES AND STATE AND LOCALCONTRACTS

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B1)	**Contract (Attachment B2)**		
Guidelines, I., Objectives *Page 1*		Added language giving the Board authority to offer multiple benefit structures that mirror the State program to local governments.	Recommended by employers to give them flexibility to accommodate various collective bargaining agreements with employees.
Guidelines II., D., 4. *Page 2*		Added language to encourage health plans to adopt a primary care provider.	Refer to discussion item #7 on pages 6-7 of the memo.
Guidelines II., D., 5. *Page 2*		a) Added language requiring health plans to design a wellness program with the expectation that a health risk assessment (HRA) and biometric screening be provided to 30-50% of its adult members, b) Added language to require health plans to provide an incentive to encourage participation in the HRA and biometric screening.	Refer to discussion item #5 on page 5-6 of the memo.
Guidelines II., D., 9. *Pages 3-4*		a) Added language requiring health plans to utilize prior authorizations for low back surgery. b) Added language requiring health plans to utilize prior authorizations for high-tech radiology.	a) Recommended by the Board's Medical Consultant. Refer to discussion item #6 on page 6 of the memo. b) Recommended by the Board's Medical Consultant. Refer to discussion item #6 on page 6 of the memo.
Guidelines II., D., 10. *Page 4*		Added language requiring plans to timely contact high-risk participants after discharge from hospital.	Supports the Department's emphasis on managing care of high-risk participants through appropriate monitoring programs. Refer to discussion item #14 on page 9 of the memo.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B1)	**Contract (Attachment B2)**		
Guidelines II., D., 19. *Page 5*		Added language requiring health plans that offer optional dental coverage to independently review all adverse grievance decisions issued by a dental administrator.	Preserves the Group Insurance Board's authority under the contract to hear issues on appeal before the Board. Refer to discussion item #9 on page 8 of the memo.
Guidelines II., E., 7 *Page 5*		Added language requiring health plans to incorporate transition to home and hospital readmission reduction programs into their hospital and provider agreements.	Supports the Department's emphasis on managing care of high-risk participants through appropriate monitoring programs. Refer to discussion item #14 on page 9 of the memo.
Guidelines II., G., 3., d., 1. *Page 6*	Article 2.10 (6) *Page 4*	Added language requiring health plans to cite specific contract provisions upon which they base grievance decisions.	Preserves the Group Insurance Board's authority under the contract to hear issues on appeal before the Board; potentially reduces member confusion regarding the basis of adverse grievance decisions. Refer to discussion item # 9 on page 8 of the memo.
Guidelines II., J.		Updated dates in Time Table and Due Dates for Annual Information Submittals to the Department.	Reflects current and subsequent calendar year dates.
	Local Contract Preamble *Page 1*,	***Local Contract Only*** Removed reference to employers participating in the Wisconsin Retirement System (WRS) and replaced it with employers or as provided by Wis. Stat. §40.51(7)	Conforms with 2011 WI Act 133, which allows non-WRS participating local employers to offer Group Health Insurance to employees who are eligible. Refer to discussion item # 8 on page 7 of the memo.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B1)	**Contract (Attachment B2)**		
	Article 1.7 *Page 1*	Clarified definition of eligible legal ward.	Technical change.
	Article 2.2 (7) *Page 2*	Added language reserving the Department's right to require health plans to assist with drafting and mailing the federally mandated Summary of Benefits and Coverage (SBC).	A mailing of this scope and magnitude could be unduly burdensome for the Department to accomplish unassisted. Since this is the first year that SBCs have been required, the Department thinks it is prudent to reserve the right to require assistance from health plans if necessary.
	Article 2.3 (4) *Page 3*	Added language aligning the retroactive limits and requirements established by Medicare for medical and/or prescription drug coverage.	Refer to discussion item #10 on page 8 of the memo.
	Article 2.8 (1) *Page 4*	Changed the due date for reports and remittances from employers to the Department from the 20th of each month to the 24th.	Recommended by employers to provide extra time in the payment cycle needed to timely furnish reports and remittances.
	Local Contract Article 3.1 (2) *Page 5*	***Local Contract Only*** Removed provision's reference to deductible option coverage and replaced it with other option coverage.	Reflects recommendation by employers to give them flexibility to accommodate various collective bargaining agreements with employees.
	Local Contract Article 3.1 (4), (5) *Page 5*	***Local Contract Only*** Removed reference to employees of an employer participating in the Wisconsin Retirement System (WRS) and replaced it with employe who are eligible under Wis. Stat. §40.51(7)	Conforms with 2011 WI Act 133, which allows non-WRS participating local employers to offer Group Health Insurance to employees who are eligible. Refer to discussion item # 8 on page 7 of the memo.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B1)	**Contract (Attachment B2)**		
	Article 3.3 (7) (a), (b) *Page 6*	a) Corrected typo. b) Added language that if permitted by state or federal law, an employee could dis-enroll from coverage if covered under Medicaid, CHIP or Tri-Care. c) Clarified that these changes are subject to IRS section 125.	a) Technical change. b) To reflect current practice. c) To prevent improper mid-year coverage-level changes.
	Article 3.3 (11) *Page 7*	Removed language that dependents remain eligible until the adult dependent child enrolls in other health insurance coverage during an enrollment opportunity.	Removal of this provision aligns with the provision immediately preceding and our interpretation that an adult dependent does not lose eligibility upon enrollment in another plan.
	Article 3.16 (3) *Page 8*	Added language that premium refunds for retroactive enrollment on a Medicare-reduced contract will correspond with the retroactive enrollment limits and requirements set by Medicare and that this may limit the amount of premium refund to the subscriber	Refer to discussion item #10 on page 8 of the memo.
	Article 3.18 (1) (i) *Page 9*	Added language to indicate that a participant's coverage terminates at the end of the month in which the employee terminates employment.	To reflect current practice.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B1)	**Contract (Attachment B2)**		
	Article 3.18 (7) *Page 10*	Added language specifically prohibiting rescission of health insurance coverage under federal law. Explained that no rescission exists in cases of administrative delay in record-keeping.	Clarification of existing policy.

GUIDELINES EXCERPTS – ATTACHMENT "B"(1)

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Effective January 1, 2009, local governments seeking to participate in the health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the health plan and prescription drug plan. Administration of the underwriting process is done by the Standard Plan administrator and actual assessment of the surcharge is determined by the Board's actuary.

Local governments must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. The Board also may offer an optional deductible benefit and/or coinsurance benefit structure that mirrors the State program for local governments.

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Local employers must pay at least 50% but not more than 105% of the lowest cost / 88% of the average cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest / average cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

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

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D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

GUIDELINES EXCERPTS – ATTACHMENT "B"(1)

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

a. Point of service HMOs (POS-HMO).

b. Preferred Provider Plan (PPP).

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

3. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4.

4.
~~3.~~ The Board strongly encourages HEALTH PLANS to adopt a system by which upon enrollment in the GROUP HEALTH INSURANCE PROGRAM, SUBSCRIBERS and DEPENDENTS shall be required to select a PRIMARY CARE PHYSICIAN (PCP). Under such a system, the PCP furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week. Primary care includes ongoing responsibility for preventive health care, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services. The PCP shall either furnish or arrange for most of the PARTICIPANT'S health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services. The Board will reward Health Plans that establish a well-documented and efficient PCP process that effectively leads to better care and lower cost by crediting a plan's composite score during annual negotiation.

~~4.~~5. Plans must ~~have a~~ administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult members. Plans may provide cash equivalent incentives up to $150.00 in value to encourage participation. Biometric screenings shall at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Subscribers may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes results from the four tests listed above and the results were obtained within six months from the date on which the HRA is submitted. The Board will reward health plans that administer HRAs and biometric screening to more than 50% of the Participants described above by crediting the plan's composite score during annual negotiation. ~~available and~~ Plans must demonstrate, upon request by the Department, their efforts in utilizing the results to improve the health of members of the group health insurance program.

~~5.~~6. 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 quality standards and initiatives, including those as identified by the Department.

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GUIDELINES EXCERPTS – ATTACHMENT "B"(1)

~~6.~~7. 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.~~8. 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.~~9. 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, prior authorizations for high-tech radiology and low back surgery, 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.

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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.

GUIDELINES EXCERPTS – ATTACHMENT "B"(1)

- 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.

- Prior authorization procedures for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the plan for members with a history of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

- Prior authorization procedures for high-tech radiology tests, including MRI, CT scan, and PET scans. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

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.

10. Plans must demonstrate, upon request by the Department, their efforts at contacting PARTICIPANTS who are at high risk for readmission to the hospital within 30 days. Plans must contact high risk PARTICIPANTS within 3-5 business days after the PARTICIPANT is initially discharged from the hospital.

~~9.~~11. Plans must cover emergency and urgent care and related catastrophic medical care received from plan or non-plan providers at the in-plan level of benefits. The emergency room copayment is applicable if the participant is not admitted to the hospital. This out-of-service area care may be subject to usual and customary charges while holding the participant harmless as described in Section II., E., 5. unless the participant accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. Plans shall make every effort to settle claim disputes in a reasonable time frame. Plans affiliated with larger nationwide networks may offer coverage through affiliated plan networks as long as there is no additional cost to the plan or participants for doing so.

~~10.~~12. Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the state group health benefit program as a result of such termination of employment. (See Wis. Stat. § 632.897)

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GUIDELINES EXCERPTS – ATTACHMENT "B"(1)

18. Plans shall not recoup any payments it has made for prescriptions filled by participants on and after January 1, 2004.

19. Optional Dental Coverage. Plans may offer optional dental coverage if the Department receives a description of benefit level prior to the annual premium bid on a date specified by the Department. The eligibility and enrollment provisions will be the same as the medical coverage provisions as specified by the Guidelines. If a plan offers dental coverage, it will be offered to all participants who enroll for medical coverage with the plan. However, a plan may offer dental coverage under the state employee's plan only, the local employer's plan only or both plans. If a plan offers dental coverage, the plan must independently review all adverse grievance decisions issued by a third-party dental administrator and provide to affected members notification of such a review and appeal rights to the Department in accordance with the contract.

    A participant's level of benefit, after commencing a treatment for orthodontia, will not be adversely impacted by a subsequent change in benefit level made by the plan. If a participant is in a course of orthodontic treatment and changes plans while covered under this program, and both the prior and succeeding plans provide orthodontic coverage, the succeeding plan must continue to cover the course of orthodontic treatment. The participant must use plan providers of the succeeding plan. Benefit accumulations from the prior plan will carry over and will be applied to the new benefit level.

20. PPPs and POSs may have different co-pay and deductible schedules for out-of-plan providers, except in the case of emergency, urgent care or when the service is not reasonably available from a plan provider. If the participant resides in a plan's qualified county, the PPP and POS must consider the participant's physical capability to travel the necessary distance to see a specialty plan provider when determining if that plan provider is reasonably available.

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

6. ~~7.~~ Plans are expected to incorporate into hospital and provider agreements the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

7. Plans are expected to incorporate into hospital and provider agreements the hospital readmissions reduction program and the community-based care transitions program as described by Medicare and that are conducted under the authority of Sections 3025 and 3026.

A. Capital Equipment and Expenditures

Each applicant must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically

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providing services but rather, functioning as a sponsor, include within your proposal the following statement:

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c. Effective methods for containing costs for medical services, hospital confinements or any other benefit to be provided. Particular emphasis should be placed on the presence of an effective peer review mechanism and utilization review mechanism for monitoring health care costs. The Board is also particularly interested in COB (Coordination of Benefit) provisions such as third party requests, dual-coverage under different plans, etc.

d. An effective mechanism for handling complaints and grievances made by enrollees.

1) This includes a formal grievance procedure, which at a minimum complies with Wis. Adm. Code § INS 18.03, whereby the individual is provided the opportunity to present a complaint to the organization and the organization will consider the complaint and advise the enrollee of its final decision. Enrollees must be advised of the grievance process when a claim or referral is denied or if the enrollee expresses, in writing, dissatisfaction with the administration or claims practices or provision of services by the plan. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefit contractual priovision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision.

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2) When necessary, the Board intends to take a proactive approach in resolving complaints. The plan will be expected to cooperate fully with the efforts of the Department in resolving complaints. Adverse decisions are subject to review by the Board for contractual compliance if the employee is not satisfied with the plan's action on the matter.

3) The plan must retain records of grievances and file an annual summary (see schedule in Section II., J.) with the Board of the number, types of grievances received and the resolution or outcome. The annual summary report will contain data and be in a format established by the Department of Employee Trust Funds.

a. Statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically the state/local employees and dependents covered thereunder if experience rated. If the plan premium is community-rated then the plan should give some indication of the percentage the state and local employee groups represent of the total covered community. The Board will require each plan to provide an explanation of rate methodology and the rate calculation developed by the Plan's actuary or consultant. Along with supporting documentation deemed necessary by the Board's actuary. The Board will also require enrollment information on state enrollees by age, sex, single or family coverage of members. Such information will be required once each year (per Section II., C.) and shall be treated as confidential by the Board in accordance with Wisconsin and federal law.

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STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

LOCAL CONTRACT CHANGE ONLY

This CONTRACT sets forth the terms and conditions for the HEALTH PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered to EMPLOYERS ~~participating under the Wisconsin Retirement System by the Group Health Insurance Board~~ as provided by Wis. Stat. § 40.51 (7).

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ARTICLE 1 DEFINITIONS

The following terms, when used and capitalized in this CONTRACT are defined and limited to that meaning only:

1.1 "ANNUITANT" means any currently insured retired EMPLOYEE of a participating EMPLOYER: receiving an immediate annuity under the Wisconsin Retirement System, or a long-term disability benefit under Wis. Adm. Code § ETF 50.40, or a disability benefit under Wis. Stat § 40.65, or a person with 20 years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a).

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

1.3 "BOARD" means the Group Insurance Board.

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

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

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

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

- Spouse.
- DOMESTIC PARTNER, if elected.
- Child.
- Legal ward who becomes a permanent 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.

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STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

(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.

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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 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.

(7) The DEPARTMENT reserves the right to require HEALTH PLANS to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to members in a manner similar to the annual informational mailing process.

2.3 CLERICAL AND ADMINISTRATIVE ERROR

STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

(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, 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, and will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER. 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 payments for all Medicare data match inquiries.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (7) 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.

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STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

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 24th ~~20th~~-day of the calendar month for the following month's coverage.

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(2) The EMPLOYER shall immediately validate and enter into the DEPARTMENT'S myETF Benefits system 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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(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of DEPARTMENT Administrative Review Rights

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

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LOCAL CONTRACT CHANGE ONLY

ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE

(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.

STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

(2) The governing body of an EMPLOYER shall adopt a resolution for regular or ~~deductible~~ other option coverage in a form prescribed by the DEPARTMENT. An employer may elect to provide both regular and ~~deductible~~ other options separately to collective bargaining units as approved 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 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.

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LOCAL CONTRACT CHANGE ONLY

(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 who are eligible under Wis. Stat. § 40.51 (7), 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.

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(5) A Large EMPLOYER (more than 50 employees ~~who are eligible under Wis. Stat. § 40.51 (7) 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

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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.

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(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~~ is a member of the US Armed Forces, or ~~as~~ is 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 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) If permitted ~~As required~~ by state or Federal law, an eligible EMPLOYEE may defer or dis-enroll from coverage if he/she is covered under medical assistance (Medicaid), ~~or~~ the Children's Health Insurance Program (CHIP), or Tri-Care. Family status changes under this provision remain subject to Section 125 of the Internal Revenue Code. 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 described in (b) or (c) above. A full month's PREMIUM is

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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) An ANNUITANT shall be covered if a completed DEPARTMENT application form is received as specified in section 3.1 (2).

(10) If the DEPARTMENT determines it could effectively monitor it, an ANNUITANT with comparable coverage may escrow sick leave, if available, and reenroll in any HEALTH PLAN without underwriting restrictions with coverage effective on the first of the month following the DEPARTMENT'S receipt of the health insurance application.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child becomes newly eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage, increase in employee contribution share that exceeds the cost of coverage as a dependent under this program. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after 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 adult child DEPENDENT enrolls in other health insurance coverage during an 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.

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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. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such cases, the HEALTH PLAN will make claims adjustments prospectively.

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

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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 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 continuation period 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 (4) below.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason.

(i) The end of the month in which the SUBSCRIBER terminates employment.

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

(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. Except that when coverage ends by reason of termination of employment, refunds shall be made back to the end of the month in which employment terminates.

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STATE & LOCAL CONTRACT EXCERPTS– ATTACHMENT "B"(2)

(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 as required by state and federal law. 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.

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) Except in cases of fraud or where an individual makes an intentional misrepresentation of material fact, under federal law, an EMPLOYER must not retroactively cancel or rescind coverage, except to the extent attributable to a failure to pay timely premiums towards coverage. It is not considered a rescission where due to administrative delay in record-keeping the EMPLOYER retroactively cancels coverage back to the date of termination of employment.

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NOTABLE CHANGES UNDER CONSIDERATION FOR THE 2013 UNIFORM BENEFITS

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
Throughout	Changed Out-of-Pocket-Maximum (OOPM) to Out-of-Pocket-Maximum (OOPL)	Recommended by staff. Aligns UB with the federal glossary of common health insurance terminology.
Decision Guide Glossary	Will change the definitions of common insurance terms to align with federal definitions.	Recommended by staff. Refer to item #18-19 on page 10 of the memo.
Schedule of Benefits *Page 1*	Added out-of-network coinsurance amounts do not accumulate to the in-network out-of-pocket limit.	Recommended by staff. Refer to item #16 on page 10 of the memo.
Schedule of Benefits *Pages 1-3*	a) Added Annual Medical Coinsurance cost sharing explanation. b) Clarified annual Medical Out-of-Pocket Limit (OOPL). c) Clarified Illness/Injury related services. d) Clarified Emergency Room Copay. e) Clarified Medical Supplies and Durable Medical Supplies. f) Clarified Cochlear Implants for participants 18 and older. g) Clarified Cochlear Implants for participants under 18. h) Hearing Aids for participants 18 and older. i) Hearing Aids for participants under 18.	a) Recommended by staff. Clarified 90/10 coinsurance cost-sharing. b) Recommended by staff. c) Recommended by staff. d) Recommended by staff. e) Recommended by staff. f) Recommended by staff. g) Recommended by staff. h) Recommended by staff. i) Recommended by staff.
Schedule of Benefits *Pages 4-5*	Added Level 4 cost-sharing structure for specialty and limited lifestyle medications to Pharmacy Benefits.	Recommended by staff. Refer to item #4 on page 4 of the memo.
Definitions *Page 5*	Added definition of “Level M” drug to clarify adjudication of immunizations and vaccinations under Medicare.	Recommended by staff. Refer to item #15 on pages 9-10 of the memo.
Definitions *Page 6*	Added definition of Medicare Prescription Drug Plan as part of clarification of adjudication of immunizations and vaccinations under Medicare.	Recommended by staff. Refer to item #15 on pages 9-10 of the memo.

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
Benefits and Services A.,8. *Page 7*	Specifically clarified that Methadone Treatment is covered under Detoxification services only when medically necessary.	Refer to discussion item #11 on page 8-9 of the memo.
Benefits and Services A., 10. *Page 7*	a) Added prior authorization requirement for referrals to orthopedists and neurosurgeons for low back surgeries. b) Added prior authorization requirement for high tech radiology services.	a) Refer to discussion item #6 on page 6 of the memo. b) Refer to discussion item #6 on page 6 of the memo.
Benefits and Services A., 13. *Page 9*	Added coverage of in-patient stays of up to 30 days at an approved hospice facility to hospice benefit.	Refer to discussion item #3 on pages 3-4 of the memo.
Benefits and Services A., 15. *Page 9*	Added coverage of one retainer/mouth guard in preparation of accidental tooth repair.	Refer to discussion item #1 on page 3 of the memo.
Benefits and Services A., 21. *Page 9*	Revised reference to Women's Health and Cancer Act of 1988 to provide coverage for not only the treatment of breast cancer, but also for medical and surgical benefits with respect to mastectomies.	Refer to discussion item #12 on page 9 of the memo.
Benefits and Services A., 22. *Page 9*	a) Added four telephonic counseling sessions per calendar year to Smoking Cessation benefit. b) Added prior authorization requirement to obtain any limited extension of Smoking Cessation pharmacological products	a) Refer to discussion item #2 on page 3 of the memo. b) Refer to discussion item #2 on page 3 of the memo.
Benefits and Services C., 3. *Page 10*	Clarified circumstances under which replacement prostheses may be covered to align with language in the Standard Plan.	Refer to discussion item #13 on page 9 of the memo.

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
Benefits and Services D., 1., e. *Page 13*	Added that unless a participant obtains a prior authorization, coverage for Smoking Cessation pharmacological products is limited to current benefit level of one consecutive 30-day course of treatment per calendar year.	Refer to discussion item #2 on page 3 of the memo.
Exclusions and Limitations A.,9.,c. *Page 14*	a) Added residential care for Alcohol and Drug Abuse (AODA) as an exception to the exclusion of residential care under the Mental Health Services/AODA benefit. b) Included relevant administrative code citation in this exception.	a) Recommended by a health plan. Refer to discussion item #17 on page 10. b) Refer to discussion item #17 on page 10.

UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

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~~ limit. 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. Out-of-network coinsurance amounts do not accumulate to the in-network out-of-pocket limit.

- *For Participants enrolled in a Preferred Provider Plan (WEA Trust PPPs 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."

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

- Policy Coinsurance and medical Copayments: described below

Benefit	State of Wisconsin eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor	Medicare prime State of Wisconsin Participants and all participating Wisconsin Public Employer's eligible Participants
Annual Medical Coinsurance	90%/10% except as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL)	100% except as describedbelow for: durable medical equipment, cochlear implants and hearing aids.

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UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

	except as described below.	Then, 80% to OOPL.
Annual Medical Out-of-Pocket ~~Maximum~~ Limit (OOP~~M~~L)	$500 Participant/$1,000 aggregate family except as described below.	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Routine, preventive services as required by federal law	100%	100%
Illness/injury related services	90% ~~to the annual out-of-pocket of maximum (OOPM) not to exceed $500 per individual / $1,000 per family.~~ (10% member cost to OOPL)	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 does not accumulate to OOPL, after copay 90%. ~~coinsurance thereafter to OOPM.~~ (10% member cost to OOPL)	$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% ~~to the annual out-of-pocket of maximum (OOPM) not to exceed $500 per individual / $1,000 per family.~~ (20% member cost to OOPL)	80% ~~to an annual OOPM of $500 per Participant~~ (20% member cost to OOPL)
Cochlear Implants for Participants age 18 and older	90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).
Cochlear Implants Participants under age 18	As required by Wis. Stat. §632.895 (16), 90% ~~up to the annual OOPM~~ for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% hospital, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for Participants age 18 and older. One aid per ear no more than once every 3 years.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.

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Hearing Aids for Participants under age 18	As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL) ~~up the annual OOPM~~.	As required by Wis. Stat. §632.895 (16), 100%

- Policy Deductible: NONE
- 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.
- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan; and Hospital charges. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket ~~maximum~~limit. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid.
- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket ~~maximum~~limit. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 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 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.

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UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

- 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 Implants: Following accident or injury, up to a maximum payment of $1,000 per tooth.

- 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.

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 4 Copayment for Specialty and Lifestyle Prescription Drugs: $50.00

  *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.

  Level 1/Level 2 Annual Out-of-Pocket ~~Maximum~~ Limit (The amount You pay for Your Level 1 and Level 2 prescription drugs and 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~~ Limit for Wisconsin Public Employer Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

  Level 4 Annual Out-of-Pocket Limit (The amount You pay for Your Level 4 Specialty and Lifestyle prescription drugs):
  $1,000 per individual or $2,000 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)

  Specialty medications may be obtained at the Level 1/Level 2 copayment when obtained from the specialty vendor. Specialty medications not obtained from the specialty vendor are subject the Level 4 copayment. Level 1/Level 2 and Level 4 out-of-pocket limits are combined, meaning that both Level 1/Level 2 and Level 4 copayments accumulate toward the Level

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UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

1/Level 2 OOPL . Once, the Level 1/Level 2 OOPL has been met, you pay no more out-of-pocket expenses for Level 1/Leve 2l for that year. You will continue to pay Level 4 copayments until the Level 4 OOPL is met.

Lifestyle medications may only be obtained at the Level 4 copayment and not through a specialty vendor.

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

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the prescription drug annual out-of-pocket ~~maximum~~ limit.

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

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- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.

- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses or Domestic Partners.

- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.

- **LEVEL "M" DRUG**, means a prescription medication designated by the PBM and covered by Medicare Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be listed on the MEDICARE PRESCRIPTION DRUG PLAN's Medicare Part D formulary but are not included on the commercial coverage formulary. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

- **MAINTENANCE CARE:** Means ongoing care delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Care" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a Provider.

- **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT:** Means items which are, as determined by the Health Plan:

  1. Used primarily to treat an illness or injury; and

  2. Generally not useful to a person in the absence of an illness or injury; and

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3. The most appropriate item that can be safely provided to a Participant and accomplish the desired end result in the most economical manner; and

4. Prescribed by a Provider.

- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:

  1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and

  2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and

  3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and

  4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.

- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

- **MEDICARE PRESCRIPTION DRUG PLAN:** means the prescription drug coverage provided by the PBM to COVERED INIDIVIDUALS who are enrolled in Medicare Parts A and B, and eligible for Medicare Part D; and who are covered under a Medicare coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

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- **MEDICAID:** Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.

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6. Anesthesia Services

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

7. Radiation Therapy and Chemotherapy

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

UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider. Methadone Treatment shall be covered only when Medically Necessary and provided by an approved provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when medically necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route. This includes licensed professional air ambulance when another mode of ambulance service would endanger Your health. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained.

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations. Prior authorization is required for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the plan for members with a history of low back pain and who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for Participants who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

Prior authorizations are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11. Outpatient Physical, Speech and Occupation Therapy

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

12. Home Care Benefits

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two 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.

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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 You needs or developing a plan counts as one visit. Each period of four straight hours in a 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 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 year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a six-month period if authorized by the plan.

Covers a one time in-home palliative consult after the Participant receives a terminal diagnosis regardless of whether his or her life expectancy is six months or less.

In-patient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility.

When benefits are payable under both this Hospice Care benefit and the Home Care benefit, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14. Phase II Cardiac Rehabilitation

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

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

Total extraction and/or total replacement (limited to, bridge, denture or implant) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within 18 months of the accident. As an alternative, 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. Coverage of one retainer or mouth guard shall be provided when medically necessary as part of prep work provided prior to accidental tooth repair. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

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20. Chiropractic Services

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

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies ~~the treatment of breast cancer~~ includes:

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

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling ~~may~~ and/or limited extension of pharmacological products ~~be~~require prior authorization by the Health Plan.

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UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

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 cost sharing as outlined in the Schedule of Benefits**. The Participant's Coinsurance will be applied to the annual out-of-pocket ~~maximum~~limit. Durable diabetic equipment includes:

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- 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 30 days before purchase.

All Durable Medical Equipment purchases or monthly rentals must be Prior Authorized as determined by the Health Plan.

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

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, Medical Supplies and Durable Medical Equipment will be covered **subject to cost sharing as outlined in the Schedule of Benefits**.

The following supplies and equipment will be covered only when Prior Authorized as determined by the Health Plan:

- ~~Initial acquisition of artificial limbs or eyes or as needed for growth and development.~~ Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when Medically Necessary, and refitting of any existing prosthesis is not possible.

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- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, as described in the Schedule of Benefits.

- One hearing aid, as described in the Schedule of Benefits The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

- Ostomy and catheter supplies.

- Oxygen and respiratory equipment for home use when authorized by the Health Plan.

- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.

- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to cost sharing as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual out-of-pocket ~~maximum~~limit.

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

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

a. Emergency or Urgent Care. Non-urgent follow-up care out of the Service Area must be Prior Authorized or it will not be covered; and

b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, as required by Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

5. Coverage of Newborn Infants with Congenital Defects and Birth Abnormalities

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

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

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will be applied to the annual out-of-pocket ~~maximum~~ limit 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).

Medicare eligible Participants will be covered by a Medicare Part D prescription drug plan (PDP) provided by the PBM. Participants who choose to be enrolled in another Medicare Part D PDP other than this PDP will not have benefits duplicated.

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.

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 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. ~~O~~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~~limit. Coverage is limited to a maximum of one consecutive three month course of pharmacotherapy per calendar year unless the Participant obtains prior authorization for a limited extension.

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.

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9. Mental Health Services/Alcohol and Drug Abuse

a. Hypnotherapy.

b. Marriage counseling.

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UNIFORM BENEFIT EXCERPTS – ATTACHMENT "D"

c. Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37.

d. Biofeedback.

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