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CORRESPONDENCE MEMORANDUM

DATE: April 25, 2014

TO: Group Insurance Board

FROM: Arlene Larson, Manager, Federal Health Policy & Programs
Mary Statz, Director Health Benefits and Insurance Plans Bureau

SUBJECT: Guidelines, Uniform Benefits and Uniform Dental for the 2015 Benefit year

The Department of Employee Trust Funds (ETF) staff recommends the Group Insurance Board (Board) adopt the Guidelines, Uniform Benefits and Uniform Dental changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.

Background

Annually, the Board reviews the *Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits (Guidelines).* The Guidelines establish participation requirements for health plans for the coming benefit year, employer and employee eligibility, and certificates of coverage for insured health and Uniform Dental plans.

ETF collects potential benefit and plan design changes from the Board, participants, staff and participating health plans. The Advisory Study Group (Study Group) met on March 5, March 25, and April 11 to discuss the recommendations contained in this memo. In late March, ETF also provided draft contract language based on the Study Group recommendations to the health plans for comment and feedback.

The Study Group was comprised of ETF staff, eight representatives from other state agencies, and two representatives from Wisconsin health plan professional associations. Participants included: Jenny Kraus and Mickie Waterman, Department of Administration (DOA); Jennifer Stegall, Office of Commissioner of Insurance (OCI); Paul Ostrowski, Office of State Employment Relations (OSER); Nicole Zimm, LaDonna Steinert and Beth Ritchie, University of Wisconsin System (UWS); Trina Ruppert (UW Hospital and Clinics); Phil Dougherty, Wisconsin Association of Health Plans (WAHP); Rebecca Larson, Alliance of Health Insurers (AHI); and the following ETF staff:

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance
Lisa Ellinger
Electronically Signed: 05/09/2014

Board	Mtg Date	Item #
GIB	5.21.14	4A+

Lisa Ellinger, Bill Kox, Mary Statz, Jeff Bogardus, John Bott, Sarah Bradley, Sherry Etes, Shayna Gobel, Roni Harper, Arlene Larson, Emily Loman, Tara Pray, David Nispel, Dan Hayes, Elizabeth Andrews, Allen Angel, Vickie Baker, Liz Doss-Anderson, Brian Shah, Brian Schroeder, Korbey White and Tarna Hunter.

Some recommended changes are clarifications or statements of existing practice; other revisions are more substantive. Specific changes to the contract and Uniform Benefits language are detailed in the attached reference materials, with shading of new language and ~~striking out~~ of language to be deleted.

In addition, if the same change is being made to the state and local contracts, **only the state page is included**. The attached tables and contract language include clarifications that are not specifically discussed in this memo, which are minor modifications or clarifications of current practice.

Please note:

- Additional contract changes may be necessary, due to the ongoing policy discussions related to the High Deductible Health Plan (HDHP) and Health Savings Accounts (HSAs).
- Additional changes may be required to comply with the recently-passed 2013 Wisconsin Act 186, relating to oral chemotherapy drugs.
- Changes made to the state active employee Uniform Benefits are automatically duplicated in the Wisconsin Public Employers (local) Program "Option 6" plan, per the Board's decision when that plan was established effective January 1, 2013.
- Deloitte Consulting LLP (Deloitte) is reviewing the premium bid rate ratios for the local programs, including the ratios between the regular active and Medicare rates.
- Where appropriate, the recommendations also apply to the WPS Health Insurance (WPS) contract for the Standard Plans; staff will make the necessary changes.

Staff will bring notable changes before the Board, but in the meantime staff requests the authority to proceed with any needed technical clarifications.

SECTION 1: RECOMMENDED ADMINISTRATIVE CHANGES

1A. Health Risk Assessments (HRA): ETF staff recommends that in addition to the standard screening for diet, exercise and obesity, health plans' HRAs also consistently screen for depression, substance abuse, and tobacco use. Participants who are identified as at-risk in terms of substance abuse, depression, tobacco use, diet, exercise and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services.

Health plans are currently required to offer participants an HRA, which is a required component of the $150 wellness incentive for members. Wisconsin consistently ranks in the top states on the Behavioral Risk Factor Surveillance System and National Survey on Drug Use and Health for prevalence of alcohol consumption and binge drinking. In addition, United Health Foundation's annual America's Health Ranking indicates Wisconsin adults have the highest rate of binge drinking, are above average for tobacco use, and are experiencing increased mental health issues. Provider-level "Behavioral Screening and Intervention" (BSI) treatment, has significant potential to improve the health and safety of our participants. Ensuring all HRAs screen for depression, substance abuse, and tobacco use would be an incremental step toward the full BSI model. Studies have indicated that BSI services can result in a 4:1 return on investment ratio.

Deloitte has stated that BSI implementation costs are typically not high-priced, as there are free on-line resources and state block grants available to facilitate the initiation of a BSI program. The Study Group did not express any objections to this benefit change--but it did indicate the health plans should be provided clear guidelines describing BSI as ETF moves toward provider-level intervention.

Some health plans expressed reservations about the expansion of BSI into the HRA. Their stated concern was that some of the new items are outside of the scope of an HRA and wellness and may be perceived as replacing the patient relationship with a primary care provider.

1B. Shared Decision Making (SDM): ETF staff recommends expansion of the current SDM program for participants who are considering surgery for Low Back Pain (LBP) to include the opportunity for a follow-up conversation with the primary care physician, care manager, health educator or an SDM vendor after they have reviewed the plan-provided Patient Decision Aids. Upon request by ETF, health plans will report annual patient utilization rates and program impacts. It is required that participants be provided the SDM program before they can obtain prior authorization for LBP surgery.

For 2014, ETF required health plans to implement a credible Shared Decision Making (SDM) program for participants considering surgery for Low Back Pain (LBP). The SDM process provides the participant with relevant risk and benefit information on the proposed treatment and treatment alternatives. For many medical and surgical interventions, ETF believes the SDM model represents the best available blending of physician expertise and patient choice for members and their families to guide well-informed preference and value-sensitive treatment decisions. There were no objections expressed by the Study Group regarding this benefit change. The health plans accept expanding SDM and request flexibility in implementation, whenever possible. However, some health plans anticipate difficulty in requiring providers to offer this follow-up conversation.

1C. Advance Care Planning (ACP): ETF staff recommends requiring health plans to offer a "credible" ACP program beginning January 1, 2015. In April, ETF provided health plans with the following proposal for feedback. A credible ACP program would include any <u>one</u> (or more) of the following components:

1) **the health plan is actively participating in the "Honoring Choices Wisconsin" program, an initiative of the Wisconsin Medical Society;**
2) **providers add palliative care specialists to care teams that commonly care for participants with advanced or life-threating diseases;**
3) **all participants over the age of 60 are offered the opportunity for ACP with a trained facilitator;**
4) **all participants with serious disease and likely survival rate of ≤ 2 years will be offered an ACP and/or palliative care consultation; and/or**
5) **all participants with serious disease and likely survival rate of ≤ 90 days will be offered hospice services.**

Since the 2011 Disease Management Symposium, ETF has been working to develop an ACP program as a way to address accessibility to quality end of life care. As a preliminary measurement of hospice utilization, health plans have been reporting to ETF hospice length of stay data and palliative care consultations in the quarterly and annual Disease Management surveys.

All participants and their families should have access to ACP programs that assist with care decisions. If end of life care is necessary, improved pain and symptom relief, along with the use of life-sustaining treatment that is consistent with the member's wishes, should be provided.

As stated above, draft ETF guidance of these options has been provided to health plans for review and comment. Staff will work with health plans to allow flexibility for meeting the 2015 ACP requirement. Final guidance will be provided to the Board at the August meeting. There were no objections expressed by the Study Group regarding this Disease Management initiative expansion. However, health plans expressed difficulty in requiring providers to comply with this initiative.

<u>SECTION 2: RECOMMENDED CHANGES TO THE STATE and/or LOCAL CONTRACT</u>

2A. Leaves of Absence: ETF staff recommends the enrollment opportunity offered to employees while they are on a leave of absence provide sufficient flexibility to obtain an employer contribution to health insurance premium once they complete the return from leave period.

Previously, employees who enrolled for health insurance coverage upon returning to work had coverage rescinded if they did not complete a 30-day "return from leave" period. However, federal rescission law under the Affordable Care Act prohibits

rescission in these circumstances. This change is needed to ensure the health insurance premium contribution provisions of the contract following a return from leave are being consistently applied among various State agencies and OSER.

ETF asked employers how they are administering an employee's return from a leave of absence and when the employee is being provided the employer share of the premium contribution. Staff found that employers are not uniformly applying previous ETF guidance on administering the requirements of Wis. Stat. § 40.02 (40) and Wis. Stat. § 40.05 (4) (a) (3), specifically as it relates to when the employee becomes eligible for the employer share of the premium contribution upon returning from a leave of absence.

ETF staff has been meeting with employers to discuss revised language that complies with statutory provisions, yet allows employees to have preferable options available upon return from the leave period. This recommended change allows the employee an enrollment opportunity upon their return to active performance of duty *rather than upon their leave of absence ending*. If the employee does not meet the requirements of a return from leave of absence, they continue coverage as long as the total premium is paid by the employee. The employee does not become eligible for the employer contribution until the requirement of a return from leave of absence is met.

Employers will provide the employer share of the premium beginning with the month the employee's leave of absence is deemed ended. This recommendation complies with federal law regarding rescission. It also provides clarifying direction for ETF to provide to employers regarding employee eligibility of an enrollment opportunity and the employer share of the monthly premium contribution. This will lead to consistent, uniform administration of the return from leave of absence by all employers. It should be noted that not all employers approve of the recommended change; the University of Wisconsin, specifically, expressed concerns.

2B. Wisconsin Health Information Organization (WHIO): ETF staff recommends requiring all participating health plans to submit to WHIO medical and prescription drug data for their commercial and Medicare lives residing in Wisconsin (at a minimum). This requirement excludes Medicaid data.

WHIO is a voluntary public/private organization formed in 2005 by a multi-stakeholder group of health care professionals. WHIO collects and aggregates health care data. Currently, three health plans participating in the state and local employee health insurance program do not submit data to WHIO. By increasing the insured population in WHIO, the data set can create a better representation of both insured lives and health care providers. This will improve ETF's ability to use WHIO data to measure and compare resource utilization and trends across all participating health plans. Further, ETF intends to identify and track quality performance in discrete events, time limited instances and episodes over time.

The three health plans impacted by this change are GHC Eau Claire, HealthPartners and Medical Associates, Medical Associates is reviewing how the cost of incorporating this provision will affect premium bids. Staff expects to receive this information in the estimated bids that are due on May 15, 2014. GHC Eau Claire requested that WHIO data become publicly available in order to facilitate health plan comparisons and does not see the cost to be an obstacle. HealthPartners has not specifically responded on this topic to date.

SECTION 3: RECOMMENDED UNIFORM BENEFIT CHANGES

3A. High Deductible Health Plan (HDHP): ETF staff recommends adopting the following schedule of benefits in the Uniform Benefits certificate of coverage for the state and local programs. The amounts listed for deductible and out of pocket limits (OOPLs) combine allowable medical and prescription drug services.

Medical coverage:	
Overall Deductible	**$1,500 per individual plan, $3,000 per family plan**
Coinsurance	**90%/10% for most medical services (80%/20% for Durable Medical Equipment and certain hearing aids/cochlear implants)**
OOPL	**$2,500 per individual plan, $5,000 per family plan**
Emergency Room (ER) copay	**After deductible, $75 copay followed by 90%/10% coinsurance thereafter to the OOPL. Copay is waived if the patient is admitted.**
Prescription Drug Coverage*:	
Level 1/Level 2	**After deductible, $5/$15 copay to the OOPL**
Level 3	**After deductible, $35 to the OOPL**
Level 4	**After deductible, $50 to the OOPL**
There are copay reductions available for a 90-day supply and certain Level 4 prescriptions.	

An HDHP and Health Savings Account (HSA) is required by 2013 Wisconsin Act 20. A variety of plan designs have been presented and discussed by the Board and Workgroup this spring. This is the recommended option because it most closely mirrors the structure of the fully-insured plan and has deductible and employee premium contribution levels to incent enrollment. The Study Group and Workgroup prefer this option.

A revised schedule of benefits in the Uniform Benefits certificate of coverage will delineate the deductible, coinsurance and out-of-pocket (OOPL) limits of the HDHP. This is important, because it will incorporate this benefit schedule into the foundation of Uniform Benefits. This will maintain consistent benefits coverage for all participants, but

those who select the HDHP will have benefits subject to the deductibles, coinsurance, copays, and OOPLs noted above.

Please note that this benefit structure includes no copayments and no additional Level 3 or Emergency Room (ER) out-of-pocket costs after the OOPL is met. This is a change from the existing Uniform Benefits which has Level 3 and ER copayments that continue, for example, beyond the medical $500 single/$1,000 family OOPL to the federally required Maximum Out-of-Pocket (MOOP) of $6,350 single/$12,700 in 2014.

The HDHP will be offered in conjunction with an HSA for state employees and offered within the local program as a separate, stand-alone program option that may be used in conjunction with either an HSA or a Health Reimbursement Account (HRA). If HDHP benefits change over time in the state program, the same changes will be made to the local program. Medicare eligible State and local annuitants and their Medicare eligible dependents will continue to be offered traditional Uniform Benefits.

The Study Group preferred overlaying the HDHP on Uniform Benefits for ease of comparison, explanation and understanding by our members. The health plans did not provide specific feedback regarding copays after the deductible is met.

3B. OOPLs: ETF staff recommends implementing the following inflationary increases in the medical and prescription drug OOPLs:

OOPL	2014 Single	2015 Single	Change	2014 Family	2015 Family	Change
Primary medical	**$500**	**$565**	**$65 13%**	**$1,000**	**$1,130**	**$130 13%**
Level 1 and Level 2 prescription drug	**$410**	**$485**	**$75 18.3%**	**$820**	**$970**	**$150 18.3%**

The resultant savings due to this change in the primary medical OOPL are estimated between $1.03 - $1.13 Per Member Per Month (PMPM), which is a decrease between 0.23% to 0.25% PMPM of overall premium. This change, if applied to the regular State active plan, would result in annual savings of approximately $2,000,000.

Deloitte states that for the prescription drug program, health plan data shows that our program's trend was a 3.4% increase annually and an 18.4% increase for the five-year period since the last increase to the Level 1 and Level 2 OOPL. The application of this 18.4% trend increase to current values results in a savings of approximately $.32 PMPM, which is 0.37% PMPM of drug premium change. The implementation of this change to the regular state active plan would result in annual savings of approximately $614,400.

The existing medical OOPL that applies to most services was established at $500 single / $1,000 family, effective January 1, 2012. This provision was implemented as a part of

the changes needed to comply with the 5% benefit reduction required by Act 10. The existing Level 1 and Level 2 prescription drug OOPL of $410 single / $820 family has been in place since January 1, 2010.

The Board has the authority under Wis. Stat. 40.03 (6) (c) to maintain or reduce premium costs for the state or its employees. An inflationary increase to the OOPLs is a method of maintaining the value of the program while helping to contain future premium increases.

Several members of the Study Group expressed reservations about implementing benefit reductions through increased employee cost sharing. Most state employees have experienced take-home pay reductions over the past several years due to increases in contributions toward health insurance premiums and retirement, greater out-of-pocket costs under their health insurance benefits, and minimal wage increases.

The Board should also note that this change will have a greater impact on retirees because they are more likely to reach their OOPLs.

Deloitte provided a number of inflationary increase scenarios for the Board's consideration. Based on health plan data, Deloitte states that actual medical trend cost increases in our program were 13.1% between 2012 and 2015, which is the basis for the staff recommendation above. Deloitte also presented an option of a one-year inflationary increase, which appears in the chart below.

Alternative Inflationary Increase

OOPL	2014 Single	2015 Single	Change	2014 Family	2015 Family	Change
Primary medical	**$500**	$520	$20 4%	**$1,000**	$1,040	$40 4%
Level 1 and Level 2 prescription drug	**$410**	$446	$36 8.8%	**$820**	$892	$72 8.8%

The one-year inflationary increase saves approximately $.30 - $.34 PMPM. This change, if applied to the regular state active plan, would result in annual savings of approximately $600,000. Applying approximately 50% of the five year trend for the prescription drug program results in a savings of approximately $.17 PMPM which is 0.19% of drug premium change.

Deloitte also reviewed Level 4 and the Standard Plan prescription drug OOPLs that are $1,000 single / $2,000 family respectively. Deloitte found that since these OOPLs are relatively high and used by a small population, the savings for an inflationary increase would be insignificant, for example, <$.01 PMPM.

If the Board approves the recommendations for changes to the medical and prescription drug OOPL as described above, the resultant cost savings appear in the table below:

Summary of Cost Impact of Potential Changes

Benefit Reduction	PMPM
Inflationary increase to medical OOPL	$1.03 - $1.13
Inflationary increase to prescription drug OOPL	$.32
Total	**$1.35 - $1.45**

3C. The Affordable Care Act's (ACA) MOOP requirement: ETF staff recommends revising the Schedule of Benefits language to clarify allowable plan payments.

Effective January 1, 2015, an individual or family's out-of-pocket expenses for in-network essential health benefits and out-of-network emergency room costs are limited to $6,600 or $13,200, respectively, under federal law. There are two ways to administer the MOOP. One option is to combine the medical, prescription drug, and pediatric services. The second option is to separate medical, prescription drug, and pediatric dental services into distinct "silos".

Under the current benefit structure, a few services must be paid by the member beyond existing OOPLs. For example, after an individual meets the $500 medical OOPL, they continue to pay the $75 emergency room copay until the 2014 $6,350 MOOP is met. Another example is the $35 Level 3 drug copayment. There is no OOPL for Level 3 drugs. Therefore, the member must continue paying the Level 3 copayment until the $6,350 MOOP is met.

Staff investigated both options noted above with the health plans and the Study Group. While it is very unlikely that a participant would meet or exceed the MOOP limit in our program, the health plans expressed concern about system modifications needed to incorporate daily claim data transfers with Navitus Health Solutions (Navitus), and tracking and potentially adjusting claims if the MOOP was exceeded.

However, under a siloed approach -- for example with single MOOPs of $2,600 medical, $2,000 prescription drug and $2,000 for pediatric dental -- a member who utilizes many Level 3 prescription drugs could attain the prescription drug siloed MOOP and receive a richer benefit than if we applied an overall $6,600 MOOP. Further, since the health plans must initiate a daily data transfer with Navitus to track deductibles under the HDHP as required by federal law, staff feels that the HDHP data transfer process may also be used for tracking an overall MOOP under Uniform Benefits.

3D. Clarification to prescription drug coverage in the Schedule of Benefits and Definitions: ETF staff recommends clarifying prescription drug coverage

language in the Schedule of Benefits section and clarifying existing (or adding new) definitions in the Definitions section of the Uniform Benefits contract as shown in Attachment D, pages 4-12 through 4-24.

Staff feels that it is important to clarify language to codify existing practice. Staff recommends adding the definitions for "Preferred Drug" and "Non-Preferred Drug". Staff have consistently used the term "formulary drug" instead of "Preferred Drug" to refer to medications that were placed in either the Level 1 or 2 copay tier or the reduced Level 4 copay tier for Specialty Medications. Similarly, the term "non-formulary drug" was used in place of the term "Non-Preferred Drugs" to refer to medications that were placed in either the Level 3 or full Level 4 copay tiers.

This practice was confusing because a non-formulary drug was actually covered on the formulary. In addition, using "formulary" and "non-formulary" to identify drugs included on the formulary and covered by our benefits was inconsistent with Pharmacy Benefit Manager (PBM) industry terminology. An example of a Preferred vs. Non-Preferred drug on the formulary can be found in the Dibenzapine class of drugs in the Antipsychotic category. Seroquel, a brand name drug, is a Non-Preferred drug covered at the Level 3 copay, while the generic alternatives quetiapine and olanzapine are Preferred Drugs covered at the Level 1 and Level 2 copay tiers, respectively.

Staff also recommends updating the definition of "Specialty Medication". While throughout the PBM and health insurance industries the definition of a specialty drug has varied widely, this updated definition is based on the definition published by the Academy of Managed Care Pharmacy and provides a definition that is more consistent with how specialty medications are managed under the State and local group health insurance programs.

Finally, staff recommends adding the definition of Preferred Specialty Pharmacy to help clarify the reduced Level 4 copay tier, and to identify that the PBM may contract with more than one specialty pharmacy as a Preferred Specialty Pharmacy. The Schedule of Benefits section has also been updated to reflect the changes to the Definition section of the Uniform Benefits. Staff worked with the PBM to make these technical changes to the language to help clarify and codify the benefits provided under the Uniform Benefits contract.

SECTION 4: PROPOSED CHANGES NOT RECOMMENDED

ETF presented a number of other potential changes to the Study Group for discussion and consideration. The most notable issues that are not being recommended for implementation are summarized below. Staff will provide additional information upon request.

4A. Increase the Emergency Room (ER) Copayment to align with standards in the commercial market:

The Study Group examined whether to increase the current emergency room copayment of $75 (waived if the patient is admitted) to match copayments typically found in the commercial market. Health plans and Deloitte advised that the most common copays of this type are either $100 or $150. A member of the Study Group also asked for the pricing for a $125 copayment. The Deloitte-estimated savings appear in the chart below. Note, the annual savings represents savings for the state active population.

ER Copay	PMPM Savings	Annual Savings
$100	$.20 - $.22	$384,000 - $422,400
$125	$.40 -$.44	$768,000 - $844,800
$150	$.59 - $.65	$1,132,800 - $1,248,000

At this time, ETF staff does not recommend increasing this copayment. The Study Group was divided on this topic. Many Study Group members expressed concern about inflationary increases when salaries have not been adjusted for inflation. Historically, benefits have been reduced to offset a benefit change or addition. Members are also concerned about reducing benefits when the HDHP is being introduced, which will make comparing the fully-insured plan to the HDHP more challenging.

4B. Increase the Prescription Drug Copayments to align with standards in the commercial market:

The Study Group discussed increasing the current prescription drug copayments ($5 Level 1/$15 Level 2/ $35 Level 3/$50 Level 4) to match those typically found in the commercial market. Staff investigated national averages as reported by the Pharmacy Benefit Management Institute in its *2013-2014 Prescription Drug Benefit Cost and Plan Design Report*, and in the results of the Kaiser Family Foundation and Health Research & Educational Trust 2013 annual survey of employer health benefits. These reports and surveys suggest that doubling our current copays would better align with current industry standards. The Deloitte-estimated savings appear in the chart below. Note the annual savings represents savings for the state active population.

Drug Copays (Level1/2/3/4)	PMPM Savings	Annual Savings
$5/$23/$53/$75	$1.98	$ 3,801,600
$7/$23/$53/$75	$2.34	$ 4,492,800
$10/$30/$70/$100	$5.86	$11,251,200

At this time, ETF staff does not recommend increasing this copayment. The Study Group was also divided on this topic for the reasons outlined above in 4A.

4C. Coinsurance vs. Copayments:

The Study Group considered a proposal to remove the existing 90%/10% coinsurance cost-sharing measure, which has been in place for two years, and to replace it with an actuarially-equivalent copay arrangement for office visits. Deloitte commented that a benefit that utilizes both medical coinsurance and office visit copays is very unusual in the marketplace. The Study Group commented that members may find it difficult to understand and that staff efforts should focus on HDHP education in the near term. Health plans stated a consistent preference for coinsurance. Staff does not recommend replacing office visit coinsurance amounts with copays because under coinsurance, participants are more aware of associated health care costs. Coinsurance is also preferable because it automatically adjusts for inflation.

4D. Limit the use of certain extremely expensive specialty medications to Food and Drug Administration (FDA) approved use only:

Off-label use is the use of prescription drugs for an unapproved indication, in an unapproved age group, at an unapproved dosage, or under an unapproved form of administration. Navitus' pharmacy and therapeutics (P&T) committee has approved a list of specialty medications that are available only for an approved indication. The Study Group considered adopting this list for use under our program. The Office of the Commissioner of Insurance reported that in the state in 2011, just three complaints were sent to an Independent Review Organization (IRO) on this issue, where coverage of certain specialty drugs was limited. One of the complaints was overturned. There were no other similar complaints in 2012 and 2013. The group discussed how coverage of these drugs can be very emotional for members who see them as a last resort for treatment. The group decided not to pursue this limitation at this time, but perhaps consider a smaller list of such prescription drugs in future years.

4E.Telehealth:

Telehealth services use telecommunication and information technologies to provide clinical health care to patients, which can be particularly beneficial to patients living in rural or isolated areas. Staff asked health plans whether commercial plans currently allow for payment for telehealth services, and if so, what were the associated costs for covered services. Health plan responses varied widely. Health plans that cover these services stated that costs ranged from $38 to $88 per visit. Staff asked Deloitte for information about current industry standards for coverage of these services and the associated cost implications. Deloitte responded that telehealth services typically include patient consultation and evaluation, remote monitoring and specialist referral services. Based on its review of several studies, Deloitte stated that while telehealth practices may result in cost savings, it may also lead to an increase in services. Staff

and the Study Group concurred that further investigation is warranted. Staff will revisit this topic with the Study Group and Board for 2016.

4F. Therapy, Home Health and Skilled Nursing Facility Benefit Limitation:

The Study Group considered a proposal to limit the existing therapy, home health and skilled nursing facility benefits to align with those common in the commercial market. Currently, 50 visits are allowed for outpatient rehabilitation physical, speech and occupational therapy, and an additional 50 visits may be authorized by the health plan. For home care, the program currently covers 50 visits per participant per year with an additional 50 available if authorized by the health plan. For care at a Skilled Nursing Facility (SNF), the program allows up to 120 days per benefit period.

Some plans requested that these be reduced to align with their commercial standards, in part for ease of administration. Deloitte analyzed this coverage for employees of other states. Regarding therapies, they stated that coverage varies and about half the states have no limits on therapies and for the others, on average the limit was 48 visits per year. Deloitte commented that for home care visits, most states have no limit and have a SNF limit of 97 days per year on average. The Study Group and ETF staff do not recommend lowering these visit limits. Deloitte commented that reducing existing levels to those found in other states would result in minimal savings.

4G. Dental benefit increases:

Following the change to a Uniform Dental design effective January 1, 2014, a number of participants requested increases in dental benefits to more closely align with the services they received prior to the change. The Study Group reviewed enhancements requested for coverage of crown, endodontia (root canal), and occlusal guards, as these were services most often missed with Uniform Dental. Deloitte compiled pricing information for a number of coverage alternatives, including these increases:

1. $3.83 - $4.23 PMPM for 50% coverage of crowns,
2. $1.87 - $2.07 PMPM for 80% endodontia coverage, and
3. $.14 - $.16 for 80% coverage of occlusal guards all limited to the annual participant maximum of $1,000.

The Study Group generally agreed that no increases to dental benefits should be enacted for 2015. Rather, these benefits should be considered as part of the larger discussion to potentially administer a stand-alone dental program for 2016.

Summary of Cost Impact of Changes Not Recommended

Benefit Reduction	PMPM
ER copay to $100	$.20 to $.22
ER copay to $125	$.40 to $.44
ER copay to $150	$.59 to $.65
Increase drug copays to $5/$23/$53/$75	$2.34
Increase drug copays to $7/$23/$53/$75	$1.98
Double drug copays to $10/$30/$70/$100	$5.86
Total	**$2.18 - $6.51**

Benefit Increase	PMPM
50% dental crown coverage	$3.83 - $4.23
80% endodontia coverage	$1.87 - $2.07
80% occlusal guards coverage	$.14 - $.16
Total	**$5.84 - $6.46**

Staff will be at the Board meeting to answer any questions.

Attachments:

Attachment A – Notable changes to the Guidelines, Addendum, and Contracts
Attachment B – Excerpts from the Guidelines, Addendum and State and Local Contracts
Attachment C – Notable changes to Uniform Benefits
Attachment D – Excerpts from Uniform Benefits
Attachment E – Notable changes to Uniform Dental
Attachment F – Excerpts from Uniform Dental

NOTABLE CHANGES RECOMMENDED FOR THE 2015 GUIDELINES, STATE AND LOCAL CONTRACTS

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B)	**Contract (Attachment B)**		
Guidelines II., D., (new) 3. *Page # 1-7*		Added language to require all participating health plans to offer a High Deductible Health Plan (HDHP) that will operate in conjunction with an Health Savings Account (HSA) for State and HSA or Health Reimbursement Account (HRA) for locals.	To codify policy in conjunction with State statute.
Guidelines II., D., 6. (formerly 5) *Page # 1-8*		Added language requiring that health plan Health Risk Assessments (HRAs) include screenings for substance abuse, tobacco use and depression. If a member is identified as at-risk for any these or other disease states, information on intervention, treatment and coaching must be offered.	Refer to memo Section 1. A., on pages 2 and 3 of the memo.
Guidelines II., D., 6. (formerly 5) *Page # 1-8*		Add language requiring health plans to provide information to the Department of Employee Trust Funds (ETF) regarding the $150 wellness incentive that will be used for payroll tax purposes.	Notify health plans of the legal opinion of the Department of Administration regarding the taxability of this benefit. Document the operational requirement to facilitate that process.
Guidelines II., D., 10 (formerly 9). *Page # 1-9*		Require health plans to incorporate claims data into Wisconsin Health Information Organization (WHIO).	Refer to memo section 2. B., on page 5.
Guidelines II., D., 12. (formerly 11) *Page # 1-10*		Expand the current Shared Decision Making (SDM) program for Low Back Pain (LBP).	Refer to memo Section 1. B., on page 3 of the memo.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B)	**Contract (Attachment B)**		
Guidelines II., D., (new) 13. *Page # 1-10*		Require a credible Advanced Care Planning (ACP) program to include palliative care consultation and hospice care according to a variety of approaches approved by ETF.	Refer to memo Section 1. C., on pages 3 and 4 of the memo.
Guidelines II., D., 21. (formerly 19) *Page #s 1-12 through 1-13*		Added language for local employers who have work locations in multiple counties. Clarify that calculations for employer contributions should be done in each county and apply to those employees who report to work in that county.	Codified existing practice.
Guidelines II., D., (new) 23. *Page # 1-13*		Clarify that a subscriber's sick leave conversion credits can be split among multiple eligible surviving dependents upon request of the surviving spouse or surviving dependent.	Members have requested this flexibility.
Guidelines II., D., (new) 25. *Page # 1-13*		Require health plans to participate in WHIO for improved measurement and reporting.	Refer to memo section 2. B., on page 5.
Guidelines II., H. Rate Making Process *Page # 1-21*		Added language to require all participating health plans to offer an HDHP for State and local.	Technical change.
Guidelines II., J. Timeline *Page # 1-24*		Add language clarifying the dental provider guarantee and for dental Preferred Provider Organization (PPO) plans, describe 'designated providers'.	Technical change.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B)	**Contract (Attachment B)**		
Guidelines II., J. Timeline *Page # 1-25*		Add language clarifying that a static dental provider directory must be available during the year, to match the medical directory requirement.	The presentation of the directory on the health plan websites facilitates the enforcement of the provider guarantee provision.
	Article 2.3 (3) *Page # 3-8 State Same language for local*	Modify language to allow an employer to perform the two month retroactive premium adjustment for unreported terminations to exclude the current month of coverage from the calculation of the adjustment. This provides the employer more time.	Employer request.
	Article 2.4 (4) Page # *3-9 State same language for local*	Clarify requirement for health plan submittal of HEDIS data.	Technical change.
	Article 3.3 (2) (b) *Local only Page # 3-49*	Allow local employers to offer employee enrollment opportunities to include attaining 30 or more hours per week.	Employer request. This change should help to minimize local Pay or Play penalties.
	Article 3.12 (1), (3) Page # 3-20 State Same language for local	Modify leave of absence language to align federal non-rescission law and state statute.	Refer to memo Section 2. A., on pages 4 and 5 of the memo.
	Article 3.16 (2) *Page #s: 3-23 State 3-57 local*	Clarify language regarding annuitant premium adjustments when Medicare is primary payer.	Technical change.

Section & Page Number (in Attachment B)		Description	Reason for Change
Guidelines (Attachment B)	**Contract (Attachment B)**		
	Article 3.16 (5) *Page # 3-24 State same language for local*	Clarify language to reinforce that Continuants lose eligibility in our program upon reaching eligibility for Medicare.	Technical change.

6. The Board reserves the right on a case by case basis to request additional documentation of financial stability of a kind and in a form as appropriate.

Each plan must submit to the Board on an annual basis, information on its current financial condition including a balance sheet, statement of operations, financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles), and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin Law.) Failure to file annual financial statements (prior to July 1 following the end of the preceding contract period) shall constitute sufficient grounds for the Board to deny future renewals, or consider the plan to be non-qualifying.

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.

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

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

~~b.~~ e. 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. Each plan will offer health care coverage to all eligible participants through a High Deductible Health Plan (HDHP) that meets all applicable state or federal requirements

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

4.5. 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 providing credit to a plan's composite score during annual negation at a level determined by the Board.

5.6. Plans must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult members including members whose biometric results are obtained through the State's biometric screening vendor. Plans must provide a screening tool to participants in the annual Health Risk Assessment that includes screening for substance abuse, tobacco use, and depression. Participants who are identified as at-risk for substance abuse, depression, tobacco, diet, exercise, and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services. Plans must provide incentives of $150.00 in value to members who complete an HRA and biometric screening to encourage participation. HEALTH PLANS must provide information as specified by the Department for payroll tax purposes. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. Members may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The Board will reward health plans that administer HRAs and biometric tests to more than 50% of the Participants described above by crediting the plan's composite score during annual negotiation. 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.

6.7. 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.

7.8. 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.

~~8.~~9. Plans must provide the results of their annual CAHPS survey to the Department as follows:

a. Results must be based on responses from commercially insured adult Plan members in Wisconsin;

b. Survey must be conducted by a certified CAHPS survey vendor;

c. Results must utilize the current version of the CAHPS Health Plan survey as specified by the National Committee for Quality Assurance (NCQA) guidelines at the time the survey is administered;

d. Results must be for each standard NCQA composite;

e. Plans must submit timely results in a file format as specified by the Department;

f. Plans must submit separate results for each of its service areas, if available.

~~9.~~10. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, Wisconsin Health Information Organization (WHIO) claims 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.

~~10.~~11. 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.

Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

- Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.

- Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.

- Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.

- Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.

- Procedure to monitor emergency admissions to non-plan hospitals.

- Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.

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

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

- 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.

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.

~~11.~~12. Plans must provide a credible Shared Decision Making (SDM) program for Low Back Pain surgery consistent with the Prior Authorization requirement to all participants and may collaborate with providers or a vendor to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). The SDM process must also include an opportunity for members to discuss a particular intervention with their primary care provider, care manager, health educator or a vendor who is trained to have a discussion after the member has reviewed the PDA. Upon request by the Department, plans must report annual patient utilization rates and program impacts in accordance with Department guidance.

13. Health Plans and their contracting providers must provide a credible Advanced Care Planning (ACP) program that includes hospice care and a palliative care consultation in a manner that is consistent with the Disease Management initiatives of the Department.

the plan to elect coverage under another plan or allow all employees insured by the plan the option to continue to be insured by the plan or to elect coverage under another plan.

~~16.~~18. Each plan will offer the uniform benefit level provided public employees under the standard health benefit coverage. Each plan must meet any and all applicable state or federal requirements concerning benefits and cost-sharing which may be imposed on the State of Wisconsin as an employer, the plan as an insurer, or a federally qualified health benefit program. Rate adjustments, if any, required for such mandated benefit payments will occur on January 1 after the next contract period begins unless otherwise mutually agreed to in writing.

Each plan will offer the uniform benefit level to annuitants. With respect to annuitants eligible for Medicare, each plan will offer the uniform benefit and carve-out the benefits paid by Medicare so that annuitants on Medicare receive the same uniform benefit level as provided active employees except that premium for annuitants on Medicare is reduced.

~~17.~~19. Contracting organizations must participate in both the state group and the local public employer group.

~~18.~~20. The Board may allow plans that have substantially but not completely met the requirements of these Guidelines to participate as a health care plan provider, but not be considered "qualifying" for purposes of establishing the employer contribution toward premium when the contribution is based on a percentage of the lowest / average cost qualified plan. The reasons a plan may be considered "non-qualifying" shall include, but not be limited to:

1. Failure to submit required information in the format specified by the department,
2. Insufficient provider coverage in a service area (determined by the Board),
3. Failure to provide the benefit level as described in Section II. D., 3,
4. Failure to substantiate premium rate proposals, or
5. Failure to comply with the contract.

~~19.~~21. Non-qualifying plans. This section applies only to those for whom contributions are based on a percentage of the lowest / average cost qualified plan. Local government 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 (except for eligible employees who work less than half-time for whom the minimum contribution shall be at least 25% of premium). Local government employers who determine the employee premium contribution based on the tiered structure established for state employees must do so in accordance with Wis. Adm. Code § ETF 40.10. The county of the employer is considered the service area for local employers. At the request of a participating employer, the Department will review the service area used to determine the least / average cost qualified plan used for determining the employer's maximum premium contribution. If the Department reviews the service area, ~~it~~ the least / average cost plan will either be based on the zip code locations that includes at least 80% of the covered employees of the participating employer, or, when an employer has offices in multiple

counties, the least / average cost plan is determined by the county office to which the employee reports to work. Once the Department has made such an assessment, that service area will determine the least / average cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria. A non-qualifying plan approved by the Board for participation in the state Group Health Insurance Program may market its plan in any area. However, only the lowest / average cost qualified plan's premium rate would be used in the above calculations. No plan may qualify for determining employer contributions in its first year of operation under the Board's program. PPPs are not qualified in areas served by SMP. The service area for PPPs will be considered the subscriber's county of residence.

The Standard Plan premium rates for state employees will be the same statewide. However, premium rates for the Standard Plan for the local government program will depend upon the geographic location of the municipality. The state has been divided into the following premium areas:

Geographic Area	Cost Factor
Balance of State	1.0
Dane, Grant, Jefferson, La Crosse, Polk, St. Croix Counties	1.03
Kenosha, Ozaukee, Racine, Washington, Waukesha Counties	1.07
Milwaukee County, Out of State	1.1

~~20.~~22. Subscriber premium payments will be arranged through deductions from salary, accumulated sick leave account (state employees only), or annuity. For all other subscribers, premiums will be paid directly to the plan and plans must notify the Department of subscribers terminating or reinstating coverage as described in Section II., J.

23. In order to maintain family coverage that is in effect at the time of a subscriber's death, the Department may split sick leave credits between multiple surviving insured dependents upon request by the surviving spouse or a surviving dependent.

~~21.~~24. Plans will provide and receive all reasonable requests for data and other information as needed in a file format as identified by the Department after seeking input from plans. This includes requests for the pharmacy benefit manager to administer the pharmacy benefit program. Data file requests containing personal health identifiers must be submitted via the Department's secure FTP site, unless otherwise directed by the Department.

25. Each plan must submit all medical and prescription drug claims (except Medicaid) data to the Wisconsin Health Information Organization (WHIO) for the plan's commercial and Medicare lives residing in Wisconsin at a minimum. Claims shall be submitted to WHIO in a manner compliant with WHIO requirements.

~~22.~~26. Plans shall not recoup any payments it has made for prescriptions filled by participants on and after January 1, 2004.

~~23.~~27. Optional Dental Coverage. Plans may offer optional uniform 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

premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)

- Family (Employee Plus Eligible Dependents)

- High Deductible Health Plan (HDHP) Option

- Medicare Coordinated
  - Individual
  - Family (all insureds under Medicare)
  - Family (at least 1 under Medicare, at least 1 other not under Medicare)

- Graduate Assistants[1]:
  - Individual
  - Family

- Deductible, Coinsurance and HDHP Options for Local Program

1. Family rates (regular coverage) must be 2.5 times the individual rate.

2. Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in Table 7 of Addendum 1 without written justification. It may not exceed 50% of the single rate for regular coverage, unless determined by the Board's actuary to be lower; 2 eligible rate shall be 2 times the individual Medicare coordinated rate; family rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate. It may not exceed the calculated rate in Table 7 of Addendum 1 without written justification.

4. Deductible , Coinsurance and HDHP Options for Local Program: The ratio is to be determined annually by the Board's actuary based on the relative value of these ~~deductible~~ plans to the traditional plan.

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

6. The Board will consider rate proposals outside of these standards if the variation is supported by evidence of genuine demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the Board upward or downward to the nearest within

[1] Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

Due Date (Receipt by Dept)	Information Due	Date Submitted
July 2~~3~~4, 201~~4~~3	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June ~~1~~-data submission was unacceptable.)	
July 30, 201~~4~~3	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August 1~~2~~, 201~~4~~3	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 1~~3~~5, 201~~4~~3	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period.	
August 20, 201~~3~~4	• Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
August 2~~7~~6, 201~~4~~3	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals.	
August ~~31~~29, 201~~4~~3	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period.	
September 14~~2~~, 201~~4~~3	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September ~~2~~1~~2~~, is required. • For plans not participating in the group health insurance program in 201~~5~~4, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 201~~5~~4. Department approval by September ~~1~~24 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 2~~6~~4.** • Draft of letter the plan will mail to current subscribers summarizing dental benefit, accessing the plan's health risk assessment tool, and medical and dental provider network changes for the new calendar year, including a description of referral requirements, and, for dental providers, identify specific providers that are categorized as "designated in-network". Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September ~~1~~24, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24~~6~~, WITH FORWARDING REQUESTED.**	

Due Date (Receipt by Dept)	Information Due	Date Submitted
September 1~~7~~9, 201~~4~~3	• Put a PDF copy of your plan's medical and dental provider directory for the upcoming benefit year on your plan's web site and provide ETF with the location. The PDF must remain on your plan's web site through the benefit year.	
September 2~~5~~6, 201~~4~~3	• Dual-Choice kick off meeting in Madison.	
~~September~~ October 1~~3~~0, 201~~4~~3	• Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page. • Provide four (4) copies of all informational materials in final form to the Department. • Final dental benefit description that will be provided to members if the plan offers dental coverage.	
October ~~7~~6 – ~~November~~ October 31, 201~~4~~3	• Dual-Choice Enrollment Period.	
October 1~~0~~1, 201~~4~~3	• Report on disease management capabilities and effectiveness. [Section II., D., 1~~1~~8.] • 2nd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
January 1, 201~~4~~5	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of accessing the plan's health risk assessment tool and referral and grievance procedures must be included.	
January 10, 201~~4~~5	• 3rd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	
January 14, 201~~4~~5	• Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March 1, 201~~4~~5	• Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights.	
April 1, 201~~4~~5	• A Quality Improvement plan in the format set forth by the Department.	
April 1~~0~~1, 201~~4~~5	• 4th Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • Report direct pay terminations and reinstatements in the format as determined by the Department.	

2.3 CLERICAL AND ADMINISTRATIVE ERROR

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

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

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

(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. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months and in accordance with § 3.16 (3). No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

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

2.4 REPORTING

(1) EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish electronic eligibility files to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish electronic eligibility files while the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number and unique DEPARTMENT identifier) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

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

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

2.5 BROCHURES AND INFORMATIONAL MATERIAL

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

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Four (4) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor who shall provide the annual description of BENEFITS and such other information, or services it deems appropriate, including audit services.

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

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

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

3.3 SELECTION OF COVERAGE

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

(b) An EMPLOYEE shall be insured if coverage is selected as provided for in section 3.1 (2). If the EMPLOYEE is not eligible for EMPLOYER contribution toward PREMIUM at that time, section 3.3 (3) applies.

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

(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (a) may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (b) to be effective upon the date of the increase in the EMPLOYER contribution. The same enrollment opportunity is available to those who change from an appointment of less than, on average, 30 hours per week, to one that meets or exceeds that threshold. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.

avoid imputed income. If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one DOMESTIC PARTNER to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the domestic partnership terminate while carrying family coverage, the former DOMESTIC PARTNER may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the termination of domestic partnership.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

(1) Any insured EMPLOYEE may continue coverage during any EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, the EMPLOYEE is not deemed to have returned from leave ~~to work~~ and coverage will continue as an ~~active~~ EMPLOYEE on leave of absence~~shall not be resumed~~.

(2) The EMPLOYER contribution toward PREMIUM continues for the first three months of the LAYOFF or leave of absence for which PREMIUMS have not already been deducted, after which the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. Each payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid. Retroactive EMPLOYER refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE are not allowed.

(3) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days after ~~of~~ the return to work~~from leave~~. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. The EMPLOYEE becomes eligible for the EMPLOYER contribution toward PREMIUM for the coverage month the leave of absence ends.

(4) If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. EMPLOYEES shall also have the enrollment opportunities as described in section 3.3 (7) (a) while on leave of absence. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

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

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

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

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

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

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

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, 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 PARTICIPANT is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) ~~become effective~~ as the primary payor and coverage is provided under an annuitant ~~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

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

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

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

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

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

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

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT ~~becomes~~ is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) ~~become effective~~ as the primary payor and coverage is provided under an annuitant ~~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. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or

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. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively.

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

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

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

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

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

NOTABLE CHANGES RECOMMENDED FOR THE 2015 UNIFORM BENEFITS

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
I. Schedule of Benefits *Page #s 4-5 through 4-10*	Separate State from local for clarity. Clarify that emergency room copayment applies to the Maximum Out-of-Pocket (MOOP).	Technical changes.
I. Schedule of Benefits *Page #s 4-5 through 4-10*	Create High Deductible Health Plan (HDHP) schedule of benefits.	Refer to Section 3. A., of the memo on pages 4 and 5.
I. Schedule of Benefits *Page # 4-6*	Increase overall medical Out-of-Pocket Limit (OOPL) for inflation to $565 single/ $1,130 family. Will apply to State and local PO 6.	Refer to Section 3. B., of the memo on pages 5 and 6.
I. Schedule of Benefits *Page #s 4-7 and 4-10*	Add a footnote that specifically combines MOOP for medical, prescription drug and pediatric dental essential health benefits.	Clarification of MOOP position required under Affordable Care Act (ACA). Refer to Section 3. C., on pages 6 and 7 of the memo.
I. Schedule of Benefits *Page # 4-10*	Clarify that diagnostic services may require prior authorization.	Technical change.
I. Schedule of Benefits *Page #s 4-11 through 4-13*	Modify prescription drug language to be consistent with current practice, for example, changing the name for Level 3 prescription drugs from “Non-Formulary” to “Non-Preferred.”.	Refer to Section 3. D., of the memo on page 7.
I. Schedule of Benefits *Page # 4-12*	Increase Level 1 and Level 2 prescription drug OOPL for inflation to $485 single/ $970 family.	Refer to Section 3. B., of the memo on pages 5 and 6.
II. Definitions *Page # 4-15*	Add definition of Deductible to align with that of the federal Uniform Glossary except that it has been made more formal, for example, replacing “won’t” with “will not”.	To assist participants who enroll in the HDHP.
II. Definitions *Pages # 4-15*	Delete reference to temporary wards in definition of Dependent.	Technical change to align with definition in State and local contracts.
II. Definitions *Page #s 4-17 through 4-23*	• Modify definitions of Formulary, Level “M” Drug, Medicare Prescription Drug Plan, Participating Pharmacy, and Specialty Medications.	Refer to Section 3. D., of the memo on page 7.

NOTABLE CHANGES RECOMMENDED FOR THE 2015 UNIFORM BENEFITS

Section *Page # in Attachment D*	Description	Reason for Change
	• Add definitions for Non-Preferred Drug, Preferred Drug and Preferred Specialty Pharmacy.	
II. Definitions *Page # 4-20*	Add definition of Out-of-Pocket Limit (OOPL).	Technical change to assist participants in understanding the difference between OOPLs and MOOPs.
II. Definitions *Page #s 4-23 and 24*	Modify definition of Usual and Customary Charge.	Technical change to include references to prior authorizations and dental services.
III.C.1., Benefits and Services *Page # 4-35*	Add testing/ evaluation to the statement regarding when members may need to seek pre-authorization or referrals prior to incurring a mental health or alcohol and drug abuse service.	Health plan request for clarification of existing practice.
III.D.1.l., Benefits and Services Page # 4-40	Add Preferred Specialty Pharmacy to the language on specialty medications.	Technical change.
IV. A.7.i., Exclusions/ Limitations *Page # 4-43*	Clarify existing practice and specifically exclude claims for home childbirth delivery under Reproductive Services.	Health plan request to clarify existing practice.
IV.A.7.4., Exclusions/ Limitations *Page # 4-43*	Add language indicating that laboratory services provided in conjunction with infertility services are excluded once the diagnosis of infertility confirmed.	Health plan request to clarify existing practice.
IV.A.12.ad., Exclusions/ Limitations *Page # 4-48*	Modify cosmetic exclusion to specifically include removal of keloids resulting from piercing and hair restoration.	Health plan request to clarify existing practice.
IV.A.12.ad., Exclusions/ Limitations *Page # 4-49*	Modify the contractual limitation for outpatient physical, occupational and speech therapy (PT/OT/ST) to strike existing language (struck out below) that states benefits are only allowed ~~in the judgment of the attending physician~~ in addition to language that specifies coverage if expected to yield significant	The struck out phrase in the limitation has led to confusion in decisions of medical necessity for PT/OT/ST. The removal of this phrase was generally agreed to by the health plans and the study group to make the limitation clearer.

NOTABLE CHANGES RECOMMENDED FOR THE 2015 UNIFORM BENEFITS

Section ***Page # in Attachment D***	**Description**	**Reason for Change**
	patient improvement within two months after the start of treatment.	
VI.A., Miscellaneous Provisions *Page # 4-55*	Add language to support claim denial when based upon a lack of cooperation by participant.	Health plan request for technical change.

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 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.*~~

- *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. Out-of-network deductible amounts do not accumulate to the in-network out-of-pocket limit.*

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 Deductible, Coinsurance and medical Copayments: described below

Benefit: State of Wisconsin	**~~State of Wisconsin~~ eEligible 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~~**	**High Deductible Health Plan for eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor ****
Annual Medical Deductible	None	None	$1,500 per individual plan $3,000 per family plan Deductible applies to Out-of-Pocket-Limit (OOPL).

Uniform Benefits: Schedule of Benefits

Benefit: State of Wisconsin	Eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**	Medicare prime Participants	High Deductible Health Plan for eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor **
Annual Medical Coinsurance	90%/10% except as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.	90%/10%. Coinsurance applies to OOPL except as described below.
Annual Medical Out-of-Pocket Limit (OOPL)	$565~~500~~ Participant/$1,130~~1,000~~ aggregate family limit except as described below.*	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.*	$2,500 per individual plan $5,000 per family plan except as described below.
Routine, preventive services as required by federal law	100%	100%	100%
Illness/injury related services	90% (10% member cost to OOPL)	100%	90% (10% member cost to OOPL)
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%. (10% member cost to OOPL)	$60	After deductible, $75 copayment to OOPL. After deductible and copay 90% (10% member cost to OOPL)
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% (20% member cost to OOPL)	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)	80% (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).	90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost to OOPL).

Benefit: State of Wisconsin	Eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**	Medicare prime Participants	High Deductible Health Plan for eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor **
Cochlear Implants Participants under age 18	As required by Wis. Stat. §632.895 (16), 90% 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.	As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)
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.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for Participants under age 18	As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. §632.895 (16), 100%.	As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)
Temporo-mandibular Joint Disorders:	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.
Dental Implants:	90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.	100% following accident or injury up to a maximum health plan payment of $1,000 per tooth.	90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.
Prescription Drugs:	See below.	See below.	Subject to medical deductible above. After deductible, subject to copays below, to $2,500 per individual plan $5,000 per family plan OOPL.

Under no circumstances will You pay beyond the federal maximum out-of-pocket (MOOP) limit which is $6,600 single / $13,200 family.

Uniform Benefits: Schedule of Benefits

*Note that some services will continue to be paid by You past the OOPL, including emergency room and Level 3 prescription drug Copayments.

**State of Wisconsin Medicare eligible annuitants and their Medicare eligible dependents are limited to participation under the Medicare Prime Uniform Benefits Schedule of Benefits.

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor****	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants who are not eligible for nor enrolled in Medicare as the primary payor****
Annual Medical Deductible applies to Out-of-Pocket-Limit (OOPL).	None	None	$500 per individual $1,000 aggregate per family	$1,500 per individual plan $3,000 per family plan
Annual Medical Coinsurance	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to Out-of-Pocket-Limit (OOPL).	90%/10% except as described below. Coinsurance applies to OOPL except as described below.	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.	90%/10%. Coinsurance applies to OOPL except as described below.
Annual Medical Out-of-Pocket Limit (OOPL)	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.*	$565 Participant/$1,130 aggregate family limit except as described below.*	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.*	$2,500 per individual plan $5,000 per family plan except as described below.
Routine, preventive services as required by federal law	100%	100%	100%	100%
Illness/injury related services	100%	90% (10% member cost to OOPL)	100%	90% (10% member cost to OOPL)

Benefit: Participating Wisconsin Public Employer's (WPE)	WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)	WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**	WPE eligible Participants in PO 4 including Medicare eligible and enrolled	High Deductible Health Plan WPE eligible (PO7) Participants who are not eligible for nor enrolled in Medicare as the primary payor**
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$60	$75 does not accumulate to OOPL, after copay 90%. (10% member cost to OOPL)	$60	After deductible, $75 to OOPL. After deductible and copay 90% (10% member cost to OOPL)
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)	80% (20% member cost to OOPL)	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)	80% (20% member cost to OOPL)
Cochlear Implants for Participants age 18 and older	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL)	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).	90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost to OOPL).
Cochlear Implants Participants under age 18	100% hospital charges hospital, device, surgery for implantation and follow-up sessions to train on use.	As required by Wis. Stat. §632.895 (16), 90% 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.	As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)

Uniform Benefits: Schedule of Benefits

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor****	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants who are not eligible for nor enrolled in Medicare as primary payor****
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.	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.
Hearing Aids for Participants under age 18	As required by Wis. Stat. §632.895 (16), 100%.	As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. §632.895 (16), 100%.	As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)
Temporo-mandibular Joint Disorders:	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.
Dental Implants:	100% following accident or injury up to a maximum health plan payment of $1,000 per tooth.	90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.	100% following accident or injury up to a maximum of $1,000 per tooth.	90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor****	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants who are not eligible for nor enrolled in Medicare as primary payor****
Prescription Drugs:	See below.	See below.	See below.	Subject to medical deductible above. After deductible, subject to copays below, to $2,500 per individual plan $5,000 per family plan OOPL.

Under no circumstances will You pay beyond the federal maximum out-of-pocket (MOOP) limit which is $6,600 single / $13,200 family.

*Note that some services will continue to be paid by You past the OOPL, including emergency room and Level 3 prescription drug Copayments.

**Wisconsin Public Employer Medicare eligible annuitants and their Medicare eligible dependents are limited to participation under the PO2 Uniform Benefits Schedule of Benefits.

- ~~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~~ Prior authorization may be required.
- 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. 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. 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.

Uniform Benefits: Schedule of Benefits

- 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.

- 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 as required by Wis. Stat. §632.895 (11): 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 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 uniform 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 (Except Specialty Medications):**

NOTE: Drugs that are not included on the Formulary are considered non-Formulary drugs and are not covered by the benefits of this program.

Copayments:

Level 1* Copayment ~~for Formulary Prescription Drugs:~~ $~~5~~.00

The Level 1 Copayment applies to ~~Formulary~~ Preferred Generic Drugs and certain lower-cost ~~Formulary~~ Preferred Brand Name Drugs. Level 1 Copayments accumulate toward the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 ~~Formulary~~ Drugs for that benefit year.

Level 2** Copayment ~~for Formulary Prescription Drugs~~: $15.00
The Level 2 Copayment applies to ~~Formulary~~ Preferred Brand Name Drugs, and certain higher-cost ~~Formulary~~ Preferred Generic Drugs. Level 2 Copayments accumulate toward the Level 1/Level 2 annual OOPL until the Level 1/Level 2 OOPL is met after which You pay no more out-of-pocket expenses for Level 2 ~~Formulary~~ Drugs for that benefit year.

Level 3 Copayment ~~for Covered Non-Formulary Prescription Drugs~~: $35.00
The Level 3 copayment applies to Non-Preferred Brand Name Drugs and certain high-cost, ~~non-Formulary Prescription~~ Generic Drugs for which alternative and/or equivalent Preferred Generic Drugs and Preferred Brand Name Drugs ~~Formulary drugs~~ are available and covered. Level 3 Copayments do ***not*** accumulate toward an annual OOPL. You must continue to pay Level 3 copayments even after other annual OOPLs have been met.

Level 1/Level 2 Annual Out-of-Pocket Limit (OOPL)
(The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):
$485~~410~~ per individual or $970~~820~~ per family for all Participants, except:
$1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.

~~•~~ **Specialty Medications**
~~Note: The specialty prescription drug pharmacy with which the PBM is contracted shall be considered the preferred Participating Pharmacy for Specialty Medications.~~

Copayments:
Level 4 Copayment ~~for Formulary and Covered, Non-Formulary Specialty Medications~~: $50.00
~~Formulary~~ Preferred Specialty Medications: ~~the~~
The Level 4 Copayment applies when medications are obtained from a Participating Pharmacy other than ~~the preferred Participating~~a Preferred Specialty Pharmacy. Level 4 copayments for ~~Formulary~~ Preferred Specialty Medications accumulate toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for ~~Formulary~~ Preferred Specialty Medications for that benefit year.

~~Non-Formulary~~ Non-Preferred Specialty Medications: ~~the~~
The Level 4 Copayment applies whether medications are obtained at ~~the preferred Participating~~ a Preferred Specialty Pharmacy or another Participating Pharmacy. Level 4 copayments for ~~non-Formulary~~ Non-Preferred Specialty ~~medications~~ Medications do ***not*** accumulate toward any annual OOPL. You must continue to pay copayments for Level 4 ~~Non-Formulary~~ Non-Preferred Specialty Medications even after other annual OOPLs have been met.

Reduced Level 4 Copayment ~~for Formulary Specialty Medications obtained from the preferred Participating Pharmacy~~: $15.00
~~The reduced~~ Reduced Level 4 ~~Formulary Specialty Medications~~ copayment applies when ~~Formulary~~ Preferred Specialty Medications are obtained from ~~the preferred Participating~~ a Preferred Specialty Pharmacy. Reduced Level 4 Copayments accumulate toward the Level 4 annual OOPL until the Level 4 OOPL is met after which You pay no more out-of-pocket expenses for ~~Formulary~~ Preferred Specialty Medications for that benefit year. This reduced Copayment does ***not*** apply to ~~non-Formulary~~ Non-Preferred Specialty Medications.

Level 4 Annual Out-of-Pocket Limit (OOPL)
(The amount You pay for Your Level 4 Preferred Specialty Medications.)
–$1,000 per individual or $2,000 per family for all participants.

- **Disposable Diabetic Supplies and Glucometers Coinsurance:** ~~Payable at 80%, which will be applied~~20% member Coinsurance applies to the prescription drug Level 1/Level 2 annual OOPL.

- **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. Prior authorization is required if the first quit attempt is extended by the prescriber.

- **DEDUCTIBLE:** Deductible: The amount You owe for health care services Your Health Plan covers before Your Health Plan begins to pay. For example, if Your deductible is $1,500, Your plan will not pay anything until You have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the deductible. The deductible may not apply to all services.

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

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

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

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

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

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

   b. After attaining age 26, as required by Wis. Stat. § 632.885 a Dependent includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

4. A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with

Examples of Emergencies are listed in Section III., A., 1., e. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.

- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** ~~A~~ Means a list of prescription drugs, ~~established~~ developed by a committee established by the PBM. The committee is made up of physicians and pharmacists~~, which are determined to be medically- and cost-effective~~. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies. Drugs that are not included on the Formulary are considered non-Formulary drugs and are not covered by the benefits of this program.

- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.

- **HABILITATION SERVICES:** Means excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during the calendar year.

- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.

- **HOSPITAL:** Means an institution that:

  1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or

  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

  The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.

- **HOSPITAL CONFINEMENT** or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

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

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

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

- **LEVEL "M" DRUG**: ~~means~~ Means an injectable, prescription medication covered by Medicare Parts B and D when the Medicare Prescription Drug Plan is the primary payer. Level M Drugs are required to be on the Medicare Prescription Drug Plan's Medicare Part D ~~formulary~~ Formulary but are not included on the commercial coverage ~~formulary~~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

  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~~ Means the prescription drug coverage provided by the PBM to Covered Individuals 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.

- **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.

- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM's ~~provider~~ directory of Participating Pharmacies.

- **NON-PREFERRED DRUG:** Means a drug the PBM has determined offers less value and/or cost-effectiveness than preferred drugs. This would include Non-Preferred Generic Drugs, Non-Preferred Brand Name Drugs and Non-Preferred Specialty Medications included on the Formulary, which are covered by the benefits of this program with a higher Copayment.

- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Health Plan unless it is an Emergency or Urgent Care.

- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:

  1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician

  2. Re-assessment and intervention (individual and group)

  3. Diabetes outpatient self-management training services (individual and group sessions)

  4. Dietitian visit

- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.

- **OUT-OF-POCKET LIMIT (OOPL):** The most You pay during a policy period (usually a calendar year) before Your health plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or charges for health care your health plan does not cover. Note: charges for Copayments such as emergency room and Level 3 prescription drugs, payments for out-of-network services or other expenses do not accumulate toward this limit.

- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.

- **PARTICIPATING PHARMACY:** ~~A~~ Means a pharmacy who has agreed in writing to provide the services to Participants that are administered by the PBM and covered under the policy ~~to Participants~~. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.

- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug

claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.

- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.

- **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.

- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.

- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **PREFERRED DRUG:** Means a drug the PBM has determined offers more value and/or cost-effective treatment options compared to a Non-Preferred Drug. This would include Preferred Generic Drugs, Preferred Brand Name Drugs and Preferred Specialty Medications included on the Formulary, which are covered by the benefits of this program.

- **PREFERRED SPECIALTY PHARMACY:** Means a Participating Pharmacy which meets criteria established by the PBM to specifically administer Specialty Medication services, with which the PBM has executed a written contract to provide services to Participants, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one Participating Pharmacy as a Preferred Specialty Pharmacy.

- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital, or elsewhere, necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, Domestic Partners, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.

- **SKILLED NURSING FACILITY:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.

- **SPECIALTY MEDICATIONS:** Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all Participating Pharmacies; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.~~require special storage and handling and, as a result, are more costly and usually not available from all Participating Pharmacies.~~

- **STATE:** Means the State of Wisconsin as the policyholder.

- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.

- **URGENT CARE:** Means care for an accident or Illness which is needed sooner than a routine doctor's visit. If the accident or Injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals or Prior Authorizations to Non-Plan Providers are not subject to Usual and Customary Charges. ~~However,~~ Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. ~~H~~However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital/dental services.

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

Participants should contact the Health Plan prior to any services, including testing or evaluation, to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37.

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided as required by an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject to cost sharing as outlined in the Schedule of Benefits**. The Participant's Coinsurance will be applied to the annual out-of-pocket limit. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.

the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.

k. The PBM reserves the right to designate certain over-the-counter drugs on the Formulary.

l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or Preferred Specialty Pharmacy. ~~in~~ In some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

2. Insulin, Disposable Diabetic Supplies, Glucometers

The PBM will list approved products on the Formulary. Prior Authorization is required for anything not listed on the Formulary.

a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug Copayment, as described on the Schedule of Benefits.

b. Disposable Diabetic Supplies and Glucometers will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket limit for prescription drugs.

3. Other Devices and Supplies

Other devices and supplies administered by the PBM that are subject to a 20% Coinsurance and applied to the annual out-of-pocket limit for prescription drugs are as follows:

- Diaphragms
- Syringes/Needles
- Spacers/Peak Flow Meters

c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.

e. All separately billed donor-related services, except for kidney transplants.

f. Non-human organ transplants or artificial organs.

7. Reproductive Services

a. Infertility services which are not for treatment of Illness or Injury (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.

b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c. Services for storage or processing of semen (sperm); donor sperm.

d. Harvesting of eggs and their cryopreservation.

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

f. Surrogate mother services.

g. Maternity services received out of the Plan Service Area one month prior to the estimated due date, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control, for example, family emergency).

h. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i. Services of home delivery for childbirth.

j. Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8. Hospital Inpatient Services

a. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

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

ac. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

ad. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to Congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an Illness or accidental Injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

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

af. Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is Emergency ambulance transportation.

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

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

B. Limitations

1. Copayments or Coinsurance are required for:
   a. State of Wisconsin program Participants, except for retirees for whom Medicare is the primary payor, for all services unless otherwise required under federal and state law.
   b. State of Wisconsin Participants for whom Medicare is the primary payor, and for all Participants of the Wisconsin Public Employers program, and/or limitations apply to, the following services: Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental Injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.

3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of

available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.

7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which~~, in the judgment of the attending physicians,~~ are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the Health Plan, provide any relevant and reasonably available information which the Health Plan believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

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

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

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

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

B. Physical Examination

The Health Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this plan (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the Health Plan, each Participant shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The Health Plan may employ a professional staff to provide case management services. As part of this case management, the Health Plan or the Participant's attending physician may recommend that a Participant consider receiving treatment for an Illness or Injury which differs from the current treatment if it appears that:

a. the recommended treatment offers at least equal medical therapeutic value; and

b. the current treatment program may be changed without jeopardizing the Participant's health; and

c. the charges (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the Health Plan agrees to the attending physician's recommendation or if the Participant or his/her authorized representative and the attending physician agree to the Health Plan's recommendation, the recommended treatment will be provided as soon as it is available. If the

NOTABLE CHANGES RECOMMENDED FOR UNIFORM DENTAL

Section ***Page # in Attachment F***	**Description**	**Reason for Change**
Definitions *Page #s 5-1, 5-3*	• Define: Dental Plan Administrator, Dental Plan, Dental Provider, Designated In-Network Dental Provider, In-Network Dental Provider and Out-of-Network Dental Provider. • In addition, a Note is added to this section to inform the member to contact their dental plan administrator to learn if out-of-network coverage is offered.	To clarify a number of significant terms in the certificate. Three terms are currently defined. Those are In-Network Dental Provider, Designated Out-of-Network Dental Provider and Other Out-of-Network Dental Provider.
Exclusion 2. *Page # 5-2*	Modify exclusion to clarify that only allowable services begun while covered under the State's Uniform Dental program may be finished under a succeeding plan following, for example, an It's Your Choice Enrollment change.	Technical change.
Exclusion 12. *Page # 5-3*	Change timely filing limit for dental claims from 90 days to 12 months.	Align with medical certificate.
Coverage Grid *Page # 5-4*	• Clarify designated in-network and out-of-network provider coverage. • Also specify that maximum limits are per participant.	Address confusion about meaning of "Designated Providers".
Restorative Benefits *Page # 5-6*	Add a footnote directing members to see a Note on fillings on an earlier page in the certificate of coverage.	Enhance member understanding of coverage.
Periodontic Benefits *Page # 5-6*	Add language to clarify that periodontal coverage is available in addition to routine cleaning.	Technical change.
Adjunctive Service Benefits *Page #s 5-6, 5-7*	Reorganize Current Dental Terminology (CDT) code listing into numerical order.	Technical change.

ATTACHMENT F

Uniform Dental Benefits Certificate of Coverage

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

All dental benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. The Uniform Dental Benefits are wholly incorporated in the Master Contract.

This is a list of Uniform Dental Benefits and is based upon the Current Dental Terminology © American Dental Association. Codes are provided as a reference and may be subject to change; Plans may substitute alternative codes to provide essentially equivalent coverage.

DEFINITIONS

Dental Plan Administrator: The health plan or third party administrator responsible for providing dental insurance benefits under the Group Insurance Board's program, and which is chosen by the enrolled subscriber's health plan to provide the ~~u~~Uniform ~~d~~Dental benefits during the calendar year.

Dental Plan: Means all benefits, limitations, and exclusions included in the Uniform Dental Benefit Certificate.

Dental Provider: Means a dentist or any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Dental Plan benefits.

Designated In-Network Dental Provider: Means a Dental Provider who has been approved for in-network level payment by the Health Plan for providing dental services, but does not have a written agreement to provide direct dental care services, supplies, or other items covered under the policy to participants. These providers are determined by the ~~h~~Health ~~p~~Plan, specifically for areas in which there is insufficient access to in-network providers. The ~~h~~Health ~~p~~Plan is not required to have Designated In-Network Dental Providers.

In-Network Dental Provider: A Dental Provider who has agreed in writing by executing a participation agreement to provide or direct dental care services, supplies, or other items covered under the policy to participants. The Dental Provider's written participation agreement must be in force at the time of such services, supplies or other items covered under the policy are provided to the participant.

Out-of-Network Dental Provider: Means a Dental Provider who does not have a signed participating Dental Provider agreement and is not listed on the most current edition of the Dental Plan's professional directory of In-Network and Designated In-Network Dental Providers. Health plans that wish to offer out-of-network coverage will use the reimbursement rates as listed in the Key Contract Provisions chart on page 5-4.

NOTE: Check with your Dental Plan Administrators to see if you have out-of-network coverage.

No payment will be made for a benefit that is not listed.

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- During the first year a person is insured, benefits begin on the effective date and continue through December 31 of that year.

- Covered ~~P~~procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for Plan review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.
- Note that uniform medical benefit may provide coverage for oral surgery.

LIMITATIONS

The following services ***are limited*** under this Dental Plan:

- Oral Exams limited to two per year.
- Full Mouth or Panoramic x-rays limited to once every 60 months.
- Bite wing x-rays limited to two sets per year.
- Cleaning of teeth limited to two times per year.
- Fluoride treatment allowed only for a child under age 19, limited to two times per year.
- Sealants allowed only for a child under age 16, and must be applied to non-restored, non-decayed first and second permanent molars, limited to once per tooth per lifetime.
- Routine pediatric dental services as required under federal law.

**Special note on fillings: On anterior (front) teeth you will have 100% coverage subject to your benefit maximum for both amalgam (silver) and composite/resin (tooth colored) fillings. On posterior (back) teeth, you have 100% coverage subject to your benefit maximum for amalgam (silver) fillings only. If you have a composite/resin (tooth colored) filling on a posterior tooth, you will be responsible for the difference between the amount your provider charges for an amalgam and a composite/resin filling.

EXCLUSIONS

The following are **not c~~C~~overed s~~S~~ervices** under this Dental Plan:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer Liability laws.
2. Services or appliances~~, including prosthetics (crowns, bridges or dentures),~~ started prior to the date the patient became eligible for coverage under the State of Wisconsin's Group Health Insurance Program's Uniform Dental Benefit. ~~this Dental Plan.~~
3. Prescription drugs, pre-medications or relative analgesia charges for anesthesia connection with covered oral surgery procedures.
4. Preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. Appliances, restorations or procedures for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for

correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques or for splints, unless necessary as a result of accidental injury.

9. Replacement of lost or broken retainer.
10. Treatment by other than a Dental Provider, his or her employees, or his or her agents. A Plan may designate and authorize out-of-network providers in the absence of an existing in-network provider or provider network.
11. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
12. Claims not submitted to Dental Plan within ~~90 days~~12 months, or if later, as soon as reasonably possible, from the date the procedure was provided.
13. Dental procedures in cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Procedures and services not specifically provided under this Certificate of Coverage and procedures and services excluded by Dental Plan.
15. Any oral surgical procedures not specifically listed as a covered benefit or for which coverage exists under the medical policy.

~~**Types of Dental Providers:**~~

- ~~**In-Network Dental Provider** – Services as provided in the grid below.~~
- ~~***Designated Out-of-Network Dental Provider** – A health plan may designate and authorize out-of-network providers so that at least one dentist is available in each county or major city, if applicable. Services as provided in the grid below.~~
- ~~**Other Out-of-Network Dental Provider** – When a health plan has an existing network of providers in a particular county or major city, if applicable, and the dental provider that you want to see is neither an In-Network Dental Provider nor a Designated Out-of-Network Dental Provider as described above, services for other Out-of-Network Dental Providers will be paid at 0%. If you are uncertain about whether your preferred dental provider is an in-network provider, designated out-of-network provider, or other out-of-network provider, contact your health plan.~~

Key ~~Plan~~ Contract Provisions Type of Dental Provider *Only certain Dental Plan Administrators offer out-of-network coverage. Contact your Dental Plan Administrator for details on your network coverage.*			Covered Services (Examples)
	In-Network and Designated In-Network Provider	~~Designated~~ Out-of-Network Provider*	
Deductible:	$0	$0	
Annual Benefit Max:	$1,000 per participant	$1,000 per participant	
Diagnostic / Preventive:	100%	75%	Routine Evaluations X-Rays Fluoride
Restorative:	100%	50%	Fillings
Periodontal:	80%	50%	Limited to Periodontal Maintenance
Adjunctive Services:	80%	50%	Local Anesthesia
Orthodontia:	50% Children Only)	50% (Children Only)	
Ortho Lifetime Max:	$1,500 per participant	$1,500 per participant	

***Check with your Dental Plan Administrator to find out if you have out-of-Network dental benefits**

DIAGNOSTIC/PREVENTATIVE:

ROUTINE ORAL EVALUATION - exams are limited to two per year. Note that comprehensive exams are not done multiple times in a year.

- D0120 Periodic oral evaluation.
- D0145 Oral evaluation for patients under three years of age.
- D0150 Comprehensive oral evaluation – new/established patient or a patient who has been absent from dental care for more than three years; included as one of the two exams per year.

RESTORATIVE:

AMALGAM RESTORATIONS**
**see note on fillings on page 5-2 of this certificate

- D2140 Amalgam filling - one surface.
- D2150 Amalgam filling - two surfaces.
- D2160 Amalgam filling - three surfaces.
- D2161 Amalgam filling – four/more surfaces.

RESIN RESTORATIONS**
**see note on fillings on page 5-2 of this certificate

- D2330 Resin filling - one surface anterior.
- D2331 Resin filling - two surfaces anterior.
- D2332 Resin filling - three surfaces anterior.
- D2335 Resin filling – four/more surfaces anterior.
- D2390 Resin Crown anterior.
- D2391 Resin filling - one surface posterior; benefits limited.
- D2392 Resin filling - two surfaces posterior; benefits limited.
- D2393 Resin filling - three surfaces posterior; benefits limited.
- D2394 Resin filling – four/more surfaces posterior; benefits limited.

MISCELLANEOUS RESTORATIVE

- D2940 Sedative filling; limited to once per lifetime per tooth.
- D2951 Pin retention per tooth; limited to once per tooth.
- D2999 Unspecified restorative procedure by report.

PERIODONTIC:

- D4910 Periodontal maintenance. Coverage is limited to two procedures per one benefit period in addition to routine cleanings

ORAL SURGERY:

Please note that eligible oral surgical procedures are covered under the medical plan when furnished by a Plan Provider.

ADJUNCTIVE SERVICES:

- D9110 Emergency treatment/palliative.
- D9210 Local anesthesia not in conjunction with operative or surgical procedures.
- D9215 Local anesthesia used in conjunction with operative or surgical procedures.
- D9220 General anesthesia – 30 minutes.
- D9221 General anesthesia – 15 minutes.
- D9230 Nitrous oxide sedation.
- D9241 Intravenous sedation analgesia – 30 minutes.
- D9242 Intravenous sedation analgesia – 15 minutes.
- D9610 Therapeutic parenteral drugs, single administration.
- D9612 Therapeutic parenteral drugs.

- D9910 Application of Desensitizing.
- D9911 Apply desensitizing resin.
- D9930 Treatment of complications.
- D9999 Unspecified adjunctive procedure.
- ~~D9220 General anesthesia – 30 minutes.~~
- ~~D9221 General anesthesia – 15 minutes.~~
- ~~D9230 Nitrous oxide sedation.~~
- ~~D9241 Intravenous sedation analgesia – 30 minutes.~~
- ~~D9242 Intravenous sedation analgesia – 15 minutes.~~

ORTHODONTIC SERVICES - limited to age 19, 50% coverage.

- D8010 Limited orthodontic treatment of primary dentition.
- D8020 Limited orthodontic treatment of transitional dentition.
- D8030 Limited orthodontic treatment of adolescent dentition.
- D8040 Limited orthodontic treatment of adult dentition.
- D8050 Interceptive orthodontic treatment of primary dentition.
- D8060 Interceptive orthodontic treatment of transitional dentition.
- D8070 Comprehensive orthodontic treatment of transitional dentition.
- D8080 Comprehensive orthodontic treatment of adolescent dentition.
- D8090 Comprehensive orthodontic treatment of adult dentition.
- D8660 Pre-orthodontic treatment visit; may also be billed out as any combination of D0330, D0340, D0350, and D0470.
- D8680 Orthodontic retention (removal of appliances, construction/placement).
- D8690 Orthodontic treatment (alternative billing to a contract fee).
- D8999 Unspecified orthodontic procedure, by report.
- D9310 Consultation – diagnostic services other than requesting provider.