



**State of Wisconsin
Group Health Insurance Program Agreement**

**Issued by the State of Wisconsin
Department of Employee Trust Funds
On behalf of the Group Insurance Board**

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in UNIFORM BENEFITS (of this AGREEMENT) or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Group Health Insurance Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

ANNUITANT

When not specified, ANNUITANT means all ANNUITANTS, including state and LOCAL.

STATE ANNUITANT means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under [Wis. Adm. Code § ETF 50.40](#), a currently insured recipient of a disability benefit under [Wis. Stat. § 40.65](#); or a terminated EMPLOYEE with twenty (20) years of creditable service.

LOCAL ANNUITANT means:

- 1) Any currently insured retired EMPLOYEE of a participating EMPLOYER: receiving an immediate annuity under the Wisconsin Retirement System, or a long-term disability benefit under [Wis. Adm. Code § ETF 50.40](#), or a disability benefit under [Wis. Stat. § 40.65](#), or a person with twenty (20) years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by the DEPARTMENT under [Wis. Stat. § 40.19 \(4\) \(a\)](#).
- 2) A retired public employee under [Wis. Stat. § 40.02 \(25\) \(b\) 11](#), who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under [Wis. Stat. § 40.65](#) or Long-Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under [Wis. Stat. § 40.51 \(10\)](#) to elect the Local Annuitant Health Program (LAHP).

BENEFITS means those items and services as listed in UNIFORM BENEFITS. A PARTICIPANT'S right to BENEFITS is subject to the terms, conditions, limitations and exclusions of the HEALTH BENEFIT PROGRAM.

BOARD means the Group Insurance Board.

BUSINESS DAY means each calendar DAY except Saturday, Sunday, and official State of Wisconsin holidays (see also: DAY).

CONFINEMENT as defined in UNIFORM BENEFITS.

CONTINUANT means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in the HEALTH BENEFIT PROGRAM.

CONTRACT means this document which includes all exhibits, attachments, supplements, and endorsements or riders.

CONTRACTOR means the licensed insurer who is the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in UNIFORM BENEFITS.

EFFECTIVE DATE as defined in UNIFORM BENEFITS.

EMPLOYEE

When not specified, EMPLOYEE means all EMPLOYEES, including state and LOCAL.

STATE EMPLOYEE means an eligible EMPLOYEE of the State of Wisconsin as defined under [Wis. Stat. § 40.02 \(25\) \(a\), 1., 2., or \(b\), 1m., 2., 2g., or 8.](#)

LOCAL EMPLOYEE means an eligible EMPLOYEE as defined under [Wis. Stat. § 40.02 \(46\)](#) or [40.19 \(4\) \(a\)](#), of an EMPLOYER as defined under [Wis. Stat. § 40.02 \(28\)](#), other than the state, which has acted under [Wis. Stat. § 40.51 \(7\)](#), to make health care coverage available to its EMPLOYEES.

EMPLOYER

When not specified, EMPLOYER means all EMPLOYERS, including state and LOCAL.

STATE EMPLOYER means an eligible State of Wisconsin agency as defined in [Wis. Stat. § 40.02 \(54\)](#).

LOCAL EMPLOYER means an employer who has acted under [Wis. Stat. § 40.51 \(7\)](#), to make health care coverage available to its EMPLOYEES.

HEALTH BENEFIT PROGRAM means the Group Health Insurance Program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) as defined in UNIFORM BENEFITS.

HOSPITAL as defined in UNIFORM BENEFITS.

IN-NETWORK refers to 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 CONTRACTOR agrees to give PARTICIPANTS lists of affiliated providers. Some providers require prior authorization by the CONTRACTOR in advance of the services being provided.

INPATIENT means a PARTICIPANT admitted as a bed patient to a health care facility or in twenty-four (24)-hour home care.

IT'S YOUR CHOICE OPEN ENROLLMENT means the enrollment period referred to in the DEPARTMENT materials as the It's Your Choice enrollment period that is available at least annually to insured SUBSCRIBERS allowing them the opportunity to change CONTRACTORS and/or coverage and also to eligible individuals to enroll for coverage in any CONTRACTOR offered by the BOARD.

LOCAL means a Wisconsin Public Employer who has acted under [Wis. Stat. § 40.51 \(7\)](#), to participate in the HEALTH BENEFIT PROGRAM for its EMPLOYEES.

MINIMUM PROVIDER ACCESS STANDARDS means those as defined under [Wis. Stat. § 609.22](#) and [Wis. Admin. Code INS 9.32](#).

OUT-OF-NETWORK refers to a provider who does not have a signed participating provider agreement and is not listed on the most current edition of the CONTRACTOR'S professional directory of providers. Care from an OUT-OF-NETWORK provider may require prior-authorization from the CONTRACTOR unless it is an emergency or urgent care.

PARTICIPANT means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT for enrollment and are entitled to BENEFITS.

PHARMACY BENEFIT MANAGER (PBM) as defined in UNIFORM BENEFITS.

PREMIUM means the rates shown in the It's Your Choice materials that includes the medical, pharmacy, and dental (when applicable) components, and administration fees required by the BOARD. Those rates may be revised by the BOARD annually, effective on each succeeding January 1 following the effective date of this AGREEMENT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

SECURE means the confidentiality, integrity, and availability of the DEPARTMENT'S data is of the highest priority and must be protected at all times. All related hardware, software, firmware, protocols, methods, policies, procedures, standards, and guidelines that govern, store, or transport the data must be implemented in manners consistent with current industry standards,

such as, but not limited to the Health Insurance Portability and Accountability Act (HIPAA), Genetic Information Nondiscrimination Act (GINA), National Institute of Standards and Technology (NIST) 800-53, and Center for Internet Security (CIS) Critical Security Controls to ensure the protection of all DEPARTMENT data.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

UNIFORM BENEFITS means the BENEFITS described in [Section 400](#) that are administered to PARTICIPANTS enrolled in the HEALTH BENEFIT PROGRAM.

100 GENERAL

105 Introduction

This State of Wisconsin Health Benefit Program Agreement (“AGREEMENT”) is for the purposes of administering the HEALTH BENEFIT PROGRAM. The HEALTH BENEFIT PROGRAM is the umbrella term used to describe the program in whole, including the State of Wisconsin Group Benefits Program and the Wisconsin Public Employers Group Benefits Program, herein referred to as “state” and “LOCAL”, respectively. The HEALTH BENEFIT PROGRAM is administered for the Group Insurance Board (BOARD) by the State of Wisconsin Department of Employee Trust Funds (DEPARTMENT).

By statute, the BOARD has the authority to negotiate the scope and content of the HEALTH BENEFIT PROGRAM for EMPLOYEES and ANNUITANTS of the State of Wisconsin, as well as for local units of government who choose to participate. The DEPARTMENT regularly provides the most current rosters for state agencies and authorities as well as the local employer roster (forms ET-1404 and ET-1407, respectively).

Eligible PARTICIPANTS have the opportunity to choose a benefit plan design. A minimum of two (2) competing benefit plans is required per [Wis. Stat. § 40.51 \(6\)](#).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

- 1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.
- 2) To provide excellent customer service to PARTICIPANTS.
- 3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.
- 4) To provide high-quality services at a competitive price.
- 5) Accurate, timely and responsive administration of health care claims.
- 6) Assist the BOARD in achieving strategy goals of:
 - a) Managing total costs.
 - b) Supporting PARTICIPANTS by providing them with tools and resources needed to manage their health and health purchasing decisions.
 - c) Promoting behavior change and accountability.

- d) Retain managed care elements that provide value.
- 7) To offer tools for PARTICIPANTS to increase engagement, including:
 - a) Knowledge of provider cost and quality.
 - b) Wellness and disease management.
 - c) Self-responsibility.
- 8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.
- 9) To continuously evaluate and incorporate innovative approaches to health care delivery.

115 General Requirements

The CONTRACTOR must meet the minimum requirements of [Wis. Stat. § 40.03 \(6\) \(a\)](#) and this AGREEMENT. The CONTRACTOR must:

- 1) Share data, claims information and other operational information as necessary for the smooth functioning of the program, for example to the BOARD'S Pharmacy Benefit Manager (PBM), consulting actuary, DEPARTMENT'S data warehouse and the wellness and disease management vendor, using the most recent file and data specifications provided by the DEPARTMENT.
- 2) Administer deductibles and out-of-pocket maximums that depend upon information sharing from one CONTRACTOR, or vendor specified by the DEPARTMENT, to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOP).
- 3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.
- 4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.
- 5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.
- 6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.
- 7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

- 8) Apply effective methods for containing costs for medical services, HOSPITAL CONFINEMENTS or other BENEFITS to be provided with effective peer and utilization review mechanisms for monitoring health care costs and the administration of Coordination of Benefit (COB) provisions.
- 9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.
 - a) This includes a formal grievance procedure, which at a minimum complies with applicable federal or state law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the enrollee expresses, in writing, dissatisfaction with the administration or claims practices or provision of services by the CONTRACTOR. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefit contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.
 - b) When necessary, the BOARD intends to take a proactive approach in resolving complaints. The CONTRACTOR must cooperate fully with the efforts of the DEPARTMENT in resolving complaints. Adverse decisions are subject to review by the BOARD for contractual compliance if the PARTICIPANT is not satisfied with the CONTRACTOR'S action on the matter.
 - c) The CONTRACTOR must retain records of grievances and submit an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. The annual summary report will contain data and be in a format established by the DEPARTMENT.
- 10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.
- 11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.
- 12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.
- 13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.
- 14) Provide notification of all significant events:

- a) Each CONTRACTOR shall notify the BOARD in writing of any "Significant Event" within ten (10) calendar DAYS after the CONTRACTOR becomes aware of it. (In the event of insolvency, the BOARD must be notified immediately.) As used in this provision, a "significant event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the CONTRACTOR'S ability to meet its obligations under this AGREEMENT, including, but not limited to, any of the following: disposal of major assets; loss of fifteen percent (15%) or more of the CONTRACTOR'S membership; termination or modification of any contract or subcontract if such termination or modification will have a material effect on the CONTRACTOR'S obligations under this AGREEMENT; the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring; the withdrawal of, or notice of intent to withdraw, dissolution of existing relationship, state licensing or certification, United States Department of Health and Human Services (HHS) qualification or any other status under state or federal law; default on a loan or other financial obligations; strikes, slow-downs or substantial impairment of the CONTRACTOR'S facilities or of other facilities used by the CONTRACTOR in the performance of this AGREEMENT.
- b) In addition, any change in the ownership of or controlling interest in the CONTRACTOR, any merger with another entity or the CONTRACTOR'S acquisition of another organization that participates in the HEALTH BENEFIT PROGRAM is a "significant event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (fifty-one percent (51%)) interest in the CONTRACTOR or any transfer of ten percent (10%) or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.
- c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the HEALTH BENEFIT PROGRAM and its PARTICIPANTS. The BOARD agrees to keep the information disclosed as required under paragraph (b) above, confidential under [Wis. Stat. § 19.36 \(5\)](#) of the Wisconsin Public Records Law until the earliest of one of the dates noted below unless the CONTRACTOR waives confidentiality or a court orders the DEPARTMENT or BOARD to disclose the information or the DEPARTMENT or BOARD determines that under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records.

The BOARD also agrees to notify the CONTRACTOR of a request to disclose the information as a public record prior to making such disclosure, so as to permit the CONTRACTOR to defend the confidentiality of the information. Information disclosed by a CONTRACTOR concerning any change in ownership or controlling interest, any merger or any acquisition of another entity will be disclosed by the BOARD as a public record beginning on the earliest of the following dates:

- i) The date the pending change in ownership or controlling interest, any merger or any acquisition of another entity becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.
 - ii) The date such action becomes effective.
 - iii) Sixty (60) DAYS after the BOARD receives the information.
 - d) The BOARD shall reserve the right to institute action as it deems necessary to protect the interests of the PARTICIPANTS of the HEALTH BENEFIT PROGRAM as the result of a "significant event."
- 15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.
- 16) Comply with the provider network access standards set forth in [WI Adm. Code § INS 9.32](#).
- 17) Provide coverage for both state and LOCAL PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.
- 18) Have legal and technical staff available to the DEPARTMENT for consultation as needed for program administration, and for assistance with any appeals processes. The CONTRACTOR shall monitor the development of and provide notification and information to the DEPARTMENT in a timely manner concerning state or federal regulations or legislation that may affect the HEALTH BENEFITS PROGRAM.
- 19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.
- 20) Comply with all applicable requirements and provisions of the [Americans with Disabilities Act \(ADA\) of 1990](#). Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

120 Board Authority

- 1) [Wis. Stat. § 40.03 \(6\) \(a\)](#), provides authority for the BOARD to enter into contracts with insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans, or, provide any group insurance plan on a self-insured basis in which case the BOARD shall approve a written description setting forth the terms and conditions of the plan, and may contract directly with providers of HOSPITAL, medical or ancillary services to provide eligible and enrolled EMPLOYEES with the BENEFITS.

- 2) The BOARD shall establish enrollment periods, known as the IT'S YOUR CHOICE OPEN ENROLLMENT period, which shall permit eligible EMPLOYEES, ANNUITANTS, and CONTINUANTS to enroll or transfer coverage to any benefit plan offered by the BOARD as required by [Wis. Stat. § 40.51](#). Unless otherwise provided by the BOARD, the IT'S YOUR CHOICE OPEN ENROLLMENT period shall be held once annually in the fall of each year with coverage effective the following January 1.
- 3) The BOARD reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.
- 4) In cases where data submitted by the CONTRACTOR is deemed to be inadequate by the BOARD, DEPARTMENT, or the BOARD'S consulting actuary, the BOARD may take any action up to and including limiting new enrollment into the benefit plan administered by the CONTRACTOR.
- 5) In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a significant event or significant loss of primary providers and/or HOSPITALS, or no longer meets the MINIMUM PROVIDER ACCESS STANDARDS in this AGREEMENT, or if the BOARD so directs due to a significant event as described in [Section 115](#), the BOARD may do any of the following, including any combination of the following:
 - a) Terminate the CONTRACT upon any notice it deems appropriate, including no notice.
 - b) Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR change to another benefit plan.
 - c) Authorize a special enrollment period so that a SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR may voluntarily change to another benefit plan.
 - d) Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.
 - e) Require that prior to making a selection between benefit plans, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.
 - f) Take no action.
- 6) The BOARD may forfeit a SUBSCRIBER'S rights to the HEALTH BENEFIT PROGRAM if a PARTICIPANT fraudulently or inappropriately assigns or transfers rights to an ineligible individual(s), or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

- 7) The BOARD may initiate disenrollment efforts in situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care provider. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. The BOARD may limit re-enrollment options in the HEALTH BENEFITS PROGRAM.
- 8) The BOARD shall determine all policy for the HEALTH BENEFIT PROGRAM. In the event that the CONTRACTOR requests, in writing, that the BOARD issue program policy determinations or operating guidelines required for proper performance of the AGREEMENT, the DEPARTMENT shall acknowledge receipt of the request in writing and respond to the request within a mutually agreed upon time frame.
- 9) The BOARD must be notified of any major system changes to the CONTRACTOR'S administrative and/or operative systems.

125 Eligibility

125A General

For HEALTH BENEFIT PROGRAM purposes, eligible EMPLOYEES include:

- 1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS), as described in [Wis. Stat. § 40.02 \(25\) \(a\)](#).
- 2) Elected state officials ([Wis. Stat. § 40.02 \(25\) \(a\) 2](#)).
- 3) Members or EMPLOYEES of the legislature ([Wis. Stat. § 40.02 \(25\) \(a\) 2](#)).
- 4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under [Wis. Stat. § 40.02 \(25\) \(a\) 3](#).
- 5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance, as described in [Wis. Stat. § 40.02 \(40\)](#).
- 6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave as described in [Wis. Stat. § 40.02 \(40\)](#).
- 7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority ([Wis. Stat. § 40.02 \(25\) \(b\)](#)):
 - a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.
 - b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

- c) Certain visiting faculty members in the UW System.
 - d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.
 - e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.
 - f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight percent (28%) or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one percent (21%) or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.
 - g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.
 - h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.
- 8) LOCAL EMPLOYEES as described in [Wis. Stat. § 40.02 \(46\)](#) or 40.19 (4) (a).
- 9) ANNUITANTS and CONTINUANTS ([Wis. Stat. § 40.02 \(25\) \(b\)](#)), which includes the following:
- a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under [Wis. Stat. § 40.25 \(1\)](#).
 - b) The surviving spouse of a SUBSCRIBER.
 - c) The surviving insured domestic partner of a SUBSCRIBER.
 - d) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty

(20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

- e) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll in the HEALTH BENEFIT PROGRAM at a later date. Enrollment is restricted to the IT'S YOUR CHOICE OPEN ENROLLMENT period in the fall for coverage effective the following January 1, unless there is a HIPAA qualifying event.
 - f) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.
 - g) Any retired LOCAL EMPLOYEE under [Wis. Stat. § 40.02 \(25\) \(b\) 11](#), who is receiving an annuity under the Wisconsin Retirement System (but not those only receiving a duty disability benefit under [Wis. Stat. § 40.65](#) or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under [Wis. Stat. § 40.51 \(10\)](#) to elect the Local Annuitant Health Program (LAHP).
 - h) Any LOCAL ANNUITANT receiving an annuity through a program administered by the DEPARTMENT under [Wis. Stat. § 40.19 \(4\) \(a\)](#).
 - i) PARTICIPANTS who meet federal or state continuation provisions. See [Section 260](#).
- 10) Disabled persons entitled to benefits under [Wis. Adm. Code § ETF 50.40](#) or [Wis. Stat. § 40.65](#) include:
- a) Insured EMPLOYEES or former EMPLOYEES who choose to continue coverage when the EMPLOYEE'S Long-Term Disability Insurance (LTDI) benefit under [Wis. Adm. Code § ETF 50.40](#) or a duty disability benefit under [Wis. Stat. § 40.65](#) is approved.
 - b) Previously insured EMPLOYEES or former EMPLOYEES whose coverage lapsed and who are eligible and apply for an LTDI benefit under [Wis. Adm. Code § ETF 50.40](#), or a duty disability benefit under [Wis. Stat. § 40.65](#).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the

date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the HEALTH BENEFIT PROGRAM (including state and LOCAL). In the event it is determined that a DEPENDENT is covered by two (2) separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have thirty (30) DAYS to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The EFFECTIVE DATE will be the first of the month following receipt of the application.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in 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 or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible 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 benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/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.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT 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.

125G Notice of Qualifying Event

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS, such as divorce. The CONTRACTOR must

provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT.

130 Premiums

For EMPLOYEES and most ANNUITANTS, 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 CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see [Section 255](#).

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with [Wis. Stat. § 40.51 \(6\)](#). The tiered structure is based on recommendations from the BOARD'S consulting actuary. Each CONTRACTOR'S claims experience will be reviewed to determine in which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the CONTRACTOR'S efficiency as determined by the BOARD's consulting actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest employee premium contribution level. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total PREMIUM.

For changes in coverage effective after the 1st of the month, the difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

LOCAL EMPLOYERS that base their contribution on a percentage of the lowest / average cost qualified plan must pay at least 50% but not more than 105% of the lowest costs / 88% of the average cost qualified plan in the LOCAL EMPLOYER'S service area (except for eligible employees who work less than half-time. The county of the LOCAL EMPLOYER is considered the service area. At the request of a LOCAL EMPLOYER, the DEPARTMENT will review the service area used to determine the lowest /average cost qualified plan used for determining the LOCAL EMPLOYER'S maximum PREMIUM contribution.

130A Medicare Participant Premiums

A 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) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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.

Except in cases of fraud which shall be subject to [Section 155F](#), 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 payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with UNIFORM BENEFITS. 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 (6) months. 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 refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with UNIFORM BENEFITS. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see [Sections 125F](#) and [220H](#).

130B Rate-Setting Process

The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. (See attachment.) The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any rate or take other action up to and including limiting new enrollment with the CONTRACTOR when the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.

The CONTRACTOR must submit statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically the STATE and LOCAL EMPLOYEES and DEPENDENTS covered thereunder if experience rated. See Appendix 6. If the premium is community-rated then the CONTRACTOR should give some indication of the percentage the STATE and LOCAL EMPLOYEE groups represent of the total covered community. The BOARD will require each CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant along with supporting documentation deemed necessary by the BOARD's consulting actuary.

The CONTRACTOR will be subject to the provisions of [Wis. Stat. Chapter 40](#), and the administrative rules of the DEPARTMENT. **The BOARD reserves the right to reject any CONTRACTOR'S bid when the BOARD believes it is not in the best interests of the HEALTH BENEFIT PROGRAM.** The BOARD reserves the right to reopen the bid process after final bids are submitted when the BOARD determines that it is in the best interests of the HEALTH BENEFIT PROGRAM.

Rates shall be uniform statewide, except that CONTRACTORS may submit different rates which result from separate plans with mutually exclusive provider networks. CONTRACTORS may separate higher cost providers within geographic areas under the tiered structure into separate

plans if lower rates are achieved while provider access is maintained. The state and LOCAL groups must be separately rated in accordance with generally accepted actuarial principles. The LOCAL group is to be rated as a single entity for each plan. CONTRACTORS shall provide rates for each of the program options for the LOCAL group.

The DEPARTMENT reserves the right to audit, at the expense of the CONTRACTOR, the financial and utilization data and other data the organization uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

Rate adjustments, if any, required for a benefit mandated by applicable state or federal law will occur on January 1 after the next benefit period begins unless otherwise mutually agreed to in writing.

The BOARD limits CONTRACTORS to the following PREMIUM categories, and each CONTRACTOR must provide coverage for each PREMIUM category:

- 1) Individual (EMPLOYEE Only)
- 2) Family (EMPLOYEE Plus Eligible DEPENDENTS)

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

- 3) HDHP Option for eligible non-Medicare individual and family health insurance rates.
- 4) Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in the utilization data submission without written justification. It may not exceed 50% of the single rate for regular coverage, unless the BOARD's consulting actuary determines that percentage to be lower. Medicare family 2 eligible rate shall be 2 times the individual Medicare coordinated rate; Medicare family 1 rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).
 - a) Individual
 - b) Family 2 (all insureds under Medicare)
 - c) Family 1 (at least 1 under Medicare, at least 1 other not under Medicare)
- 5) 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 the utilization data submission without written justification.
 - a) Individual
 - b) Family

6) Deductible, Coinsurance and HDHP Options for LOCAL Program: The ratio is to be determined annually by the BOARD's consulting actuary based on the relative value of these plans to the Traditional plan, (program option 2/12).

a) Individual

b) Family

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 consulting actuary.

The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within range percentage to conform to these requirements. The CONTRACTOR will then have the option of accepting the adjusted rates or withdrawing from the HEALTH BENEFIT PROGRAM.

The BOARD will assess administration fees to cover expenses of the DEPARTMENT. This charge is added by the BOARD to the rates quoted by each CONTRACTOR and is collected prior to transmittal of the premiums to the CONTRACTOR.

135 Financial Administration

By the end of each month, the DEPARTMENT will transmit payment to the CONTRACTOR for that month's premium based on the number of enrolled SUBSCRIBERS per the DEPARTMENT'S records. The DEPARTMENT will deduct the pharmacy premium, dental premium if applicable, and other fees required by the BOARD.

135A Prohibited Fees

The CONTRACTOR is prohibited from including in their premium bid:

- 1) The cost to handle any claims paid outside of UNIFORM BENEFITS.
- 2) The cost to administer any optional health and wellness benefit(s) beyond UNIFORM BENEFITS.
- 3) Any fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135B Included Services

The CONTRACTOR may not charge an additional fee for the following services:

- 1) Expert services. At the request of the DEPARTMENT, the CONTRACTOR shall make available qualified medical consultants to assist the DEPARTMENT in its reviews of questionable claims, claims recommended for denial for medical reasons, reconsiderations and appealed claim determinations.

- 2) Mailing & Postage. The CONTRACTOR will pay for all mailing, postage and handling costs for the distribution of materials as required by [Section 140](#), or by other express provisions of this CONTRACT.
- 3) Pilot Programs. At the request of the DEPARTMENT, the CONTRACTOR shall enter into a pilot or limited-term trial. See [Section 215C](#).

135C Recovery of Overpayments

The CONTRACTOR shall have procedures to recover or collect overpayments made under this AGREEMENT, including those payments made for an ineligible person.

135D Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

135E Amounts Owed by Contractor

Funds owed to the BOARD must be paid within thirty (30) calendar DAYS from notification of penalties or monies owed. The CONTRACTOR has thirty (30) calendar DAYS to document any dispute of amounts owed. After thirty (30) DAYS, the DEPARTMENT may collect owed funds by deducting the amounts from the payments made to the CONTRACTOR, and the CONTRACTOR may be subject to further penalties.

135F Automated Clearinghouse (ACH)

The CONTRACTOR shall support an ACH mechanism that allows for the DEPARTMENT to submit premium payments.

140 Participant Materials and Marketing

140A Informational / Marketing Materials

- 1) All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes written and electronic communication, such as marketing, informational, letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage.

All HEALTH PLANS must comply with [Section 1557](#) of the Affordable Care Act (ACA) and Federal civil rights laws. Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990, as well as those whose primary language is not English.

The notice in Appendix A of the federal [Section 1557](#) ACA regulations must be published in conspicuously-visible font size in all significant communications and significant publications, both print and web, related to the State of Wisconsin Group Health Benefits Program. The

CONTRACTOR must use the notice as provided below, or a significantly similar version that meets the regulation requirements.

“Significant communications” and “significant publications,” while not defined in the law, are interpreted broadly to include the following:

- a) Documents intended for the public, such as outreach, education, and marketing materials;
- b) Written notices requiring a response from an individual; and,
- c) Written notices to an individual, such as those pertaining to rights and benefits.

The notice is as follows:

“[Name of CONTRACTOR] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of CONTRACTOR]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact [Name of CONTRACTOR’S Civil Rights Coordinator].

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.”

Wherever the above notice in Appendix A. appears, it is also required to contain the tagline in Appendix B., translated into at least the top fifteen (15) languages spoken by individuals with limited English proficiency in the State of Wisconsin. That tagline reads:

“ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).”

For purposes of consistency with the DEPARTMENT’S It’s Your Choice (IYC) materials, it is required to use the [top fifteen \(15\) list](#) provided on the Centers for Medicare and Medicaid Services’ [website](#). The CONTRACTOR shall use the [translations](#) of the above-referenced tagline as provided by the federal Department of Health and Human Services.

- 2) The CONTRACTOR must ensure that its marketing and communication materials are culturally sensitive and professional in content, appearance, and design. At the request of the DEPARTMENT, the CONTRACTOR must replace images or artwork on the dedicated website, web-portal, or promotional materials within seven (7) BUSINESS DAYS of the CONTRACTOR’S receipt of the DEPARTMENT’S request. The DEPARTMENT reserves the right to require removal of any objectionable content sooner.
- 3) The CONTRACTOR’S costs for developing and distributing communications to PARTICIPANTS in order to correct an error in previous CONTRACTOR communication(s) that was the result of a CONTRACTOR error will be at the cost of the CONTRACTOR.
- 4) The DEPARTMENT reserves the right to require the CONTRACTOR to provide notification to PARTICIPANTS as directed.

140B It’s Your Choice Open Enrollment Materials

Each CONTRACTOR will be required to prepare informational materials in a form and content acceptable to the BOARD, as determined by the DEPARTMENT, and clearly indicate any changes from the previous year’s materials when submitting draft materials to the DEPARTMENT for review and approval.

- 1) The CONTRACTOR shall issue written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT’S YOUR CHOICE OPEN ENROLLMENT period identifying those providers (individual and groups or clinics, HOSPITALS, and other facilities) that will not be IN-NETWORK for the upcoming benefit period and include any specific language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. This notification cannot be combined with informational materials sent to non-PARTICIPANTS. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) this written notice was issued.
- 2) The CONTRACTOR shall submit the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT’S YOUR CHOICE OPEN ENROLLMENT period:

- a) CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and website address.
 - b) Content for the CONTRACTOR'S plan description page, including available features.
 - c) Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory.
- 3) The CONTRACTOR shall submit all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval.
 - 4) The CONTRACTOR shall submit three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final format must be provided to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.

145 Information Systems

- 1) The CONTRACTOR'S systems must have the capability of adapting to any future changes that become necessary as a result of modifications to the state and LOCAL programs and its requirements. The CONTRACTOR'S systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, as requirements may change.
- 2) If the CONTRACTOR has plans to migrate to a different data or web platform, the DEPARTMENT must be notified no less than six (6) months in advance of the migration.
- 3) The CONTRACTOR must transmit data SECURELY using current industry standard SECURE transmission protocols, e.g., sFTP/SSH or SSL/TLS. This may require software on desktops or an automated system that collects files from the CONTRACTOR'S repository and SECURELY transmits data.
- 4) The CONTRACTOR'S data centers, network, web-portal and personal computers (PCs) must be protected by an up-to-date firewall. PCs and applications must be updated with the latest security fixes and continually maintained and up-to-date. Servers must be SECURED with only authorized staff allowed access to servers. Data that is at rest must be encrypted using strong industry standard encryption. The CONTRACTOR must have a password policy with a complex password scheme, which, at a minimum, meet these criteria:
 - a) A minimum of eight (8) characters,
 - b) Does not use the user's name or user ID in the password,
 - c) Requires users to change passwords at least every sixty (60) DAYS,
 - d) Does not repeat any of the last twenty-four (24) passwords used, and
 - e) The password must contain at least three (3) of these four (4) data types:

- i) Upper case alphabetic letters (A - Z),
- ii) Lower case alphabetic letters (a - z),
- iii) Numeric (0 - 9),
- iv) Special characters (all special characters available on the keyboard).

Other password complexity rules may be acceptable, if approved by the DEPARTMENT.

An audit program must be in place to ensure above practices are being followed. The CONTRACTOR'S staff must be trained and follow SECURE computing best practices. Wireless networks must be protected using strong encryption and password policies. Connectivity to all networks, wired or wireless, must be protected from unwanted/unknown connections. Any sub-contractors must agree to and abide by all the network and data security requirements.

- 5) All data backups must be handled or transmitted SECURELY. Offsite storage must be audited for compliance (i.e. physical security, all used tapes are accounted for). A business recovery plan must be documented and tested annually, at a minimum, by the CONTRACTOR, and submitted to the DEPARTMENT.
- 6) The CONTRACTOR must be able to confirm that emails sent to program PARTICIPANTS and/or EMPLOYERS have been successfully transmitted and will track failed emails and initiate requests to be whitelisted for EMPLOYER groups that may be blocking the CONTRACTOR'S email communication. The CONTRACTOR must deliver failed messages to PARTICIPANTS in another format), within ten (10) BUSINESS DAYS, (e.g. hard copy mail, phone call) if the email transmission is not successful.
- 7) Upon request by the DEPARTMENT, the CONTRACTOR must be able to generate and provide a listing of all individuals that were electronically sent a particular document or communication by the CONTRACTOR or the CONTRACTOR'S subcontractor, the date and time that the document or communication was generated, and the date and time that it was sent to particular individuals. The CONTRACTOR must also provide a listing of those who were sent the communication piece in another format as required by 6), above.
- 8) The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) DAYS to the DEPARTMENT. Examples of a major system change include a new platform for enrollment, claims payment or data submission system. This does not apply to any program fixes, modifications and enhancements.

150 Data Requirements

150A Data Integration and Technical Requirements

- 1) The DEPARTMENT is currently in the process of consolidating multiple legacy information technology systems to a single BENEFITS administration system. This new system will become the system of record for enrollment and demographic information. The upgrade to this new system may impact the formatting or data fields required for transmitting enrollment files and may also impact the way in which enrollment data is communicated to the CONTRACTOR. The CONTRACTOR must make any necessary updates to its system to accommodate changes to the enrollment file, per the most recent 834 Companion Guide as issued by the DEPARTMENT. The next roll-out for the new system is currently scheduled for 2018.
- 2) The DEPARTMENT'S systems identify PARTICIPANT records using an eight (8)-digit member ID. This member ID is transmitted to and must be stored by the CONTRACTOR to communicate information about PARTICIPANTS. The CONTRACTOR must support use of the DEPARTMENT'S member ID in all interfaces that contain PARTICIPANT data. Further, the CONTRACTOR must supply member ID values on any communication or data transmission that refers to individual PARTICIPANTS, including but not limited to HIPAA 834 file transfers, reports, data extracts, and invoices. Given the ubiquitous and central nature of the member ID in the DEPARTMENT'S systems, it is strongly preferred that the member ID is stored in the CONTRACTOR'S system directly, thereby facilitating ad hoc queries, data integrity, and referential integrity within the CONTRACTOR'S system.
- 3) The CONTRACTOR must follow the DEPARTMENT'S SECURE file transfer protocols (sFTP) using the DEPARTMENT'S sFTP site to submit and retrieve files from DEPARTMENT or provide another acceptable means for SECURE electronic exchanging of files with the DEPARTMENT, as approved by the DEPARTMENT.
- 4) The CONTRACTOR'S system(s) must be able to accept and accommodate a HIPAA 834 file transfer from the DEPARTMENT, per the most recent 834 Companion Guide (see Appendix 1) as issued by the DEPARTMENT.
 - a) The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt.

The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.

- b) The CONTRACTOR shall assist with a full file comparison (FFC) of enrollment data at the frequency as directed by the DEPARTMENT by submitting a file to the DEPARTMENT containing current enrollment data. The DEPARTMENT will verify that data, compare that data with the DEPARTMENT'S data, and generate an exception report. The CONTRACTOR will be responsible for resolving differences between the

DEPARTMENT'S data and the CONTRACTOR'S data, updating the CONTRACTOR'S data, and informing the DEPARTMENT, as appropriate.

The CONTRACTOR shall maintain an exception report spreadsheet that includes the error details and final resolution, and submit it to the DEPARTMENT, at the frequency directed by the DEPARTMENT. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT.

- c) Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY.
- 5) The CONTRACTOR must establish and maintain a SECURE data transfer with the DEPARTMENT'S data warehouse and as otherwise noted in this section. The CONTRACTOR data transfers include, but will not be limited to:
- a) Claims Data - The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document (see Appendix 4), all claims processed for PARTICIPANTS. At least ninety-five percent (95%) of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred percent (100%) of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.
 - b) Provider Data – The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document (see Appendix 5), the specified data for all IN-NETWORK providers including subcontracted providers. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.
 - c) Pharmacy Claims Data – The CONTRACTOR must establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data as required under [Section 240](#). The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a daily file from the DEPARTMENT'S PBM that will be in a file format compliant with the most recent Pharmacy Data Specifications (see Appendix 2) provided by the DEPARTMENT with consultation with the PBM.
 - d) Wellness and Disease Management Data – The CONTRACTOR must establish a data transfer process to retrieve this data from the DEPARTMENT'S data warehouse for its

PARTICIPANTS and integrate the data into its medical management program. This data includes results from biometric screenings, health risk assessments, and unique PARTICIPANT enrollment in wellness health coaching and/or disease management programs as provided by the wellness and disease management vendor to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a weekly file from the wellness and disease management vendor that will include this data. The file format must comply with the most recent Wellness Data Specifications (see Appendix 3) as provided by the DEPARTMENT.

- e) Dental Claims Data – The CONTRACTOR shall establish a data transfer process to retrieve dental claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data into its medical management program. This data is based on claims data as provided by the DEPARTMENT'S dental benefits administrator to the DEPARTMENT'S data warehouse.
 - f) Benefit Accumulator Data - On each BUSINESS DAY, the CONTRACTOR must submit and retrieve data files with the vendor designated by the DEPARTMENT for the purpose of calculating the benefit accumulator for medical and pharmacy benefits. The CONTRACTOR must retrieve the pharmacy accumulator data and apply it to any combined deductibles and/or maximum out-of-pocket amounts for PARTICIPANTS. The CONTRACTOR must work with the DEPARTMENT to audit the benefit accumulator against the DEPARTMENT'S PBM to ensure the accumulator amounts are in sync.
- 6) Delays in submitting program data to DEPARTMENT'S data warehouse must be communicated via email to the DEPARTMENT Program Manager or designee within one (1) DAY of the scheduled transfer.
 - 7) For data transfers between vendors of the state and LOCAL program not specified in this AGREEMENT, the CONTRACTOR must establish vendor to vendor data transfers within ninety (90) calendar DAYS of written notification from the DEPARTMENT to do so.
 - 8) All file formats are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM.
 - 9) The CONTRACTOR data provided to vendors of the state and LOCAL program must be accurate, complete and timely. The CONTRACTOR must not place restrictions on the use of the data provided to the state and LOCAL program vendors.
 - 10) Health information provided to the DEPARTMENT will be de-identified, unless authorized by the PARTICIPANT for the purpose of appeal, issue resolution, or fraud investigation.

150B Data Submission Requirements

The CONTRACTOR shall cooperate with the DEPARTMENT's designated data warehouse vendor by submitting to the vendor all of the following data on a schedule to be determined by the DEPARTMENT:

- 1) Data on payments for BENEFITS provided to PARTICIPANTS under this CONTRACT. Payment data shall include claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties; and
- 2) Data on other financial transactions associated with claim payments, including charged amount, allowed amount, and charges to members as co-payments, coinsurance, and deductibles; and
- 3) Data on the providers of those BENEFITS provided under this CONTRACT; and
- 4) Other data, as specified by the DEPARTMENT.

The CONTRACTOR shall comply with the DEPARTMENT'S specifications for submission of the required data elements in the standard formats attached to this CONTRACT.

To comply with the data submission requirements, the CONTRACTOR must follow the specified data file layout and formatting of all data elements within it and the DEPARTMENT'S specifications for data filtering and extraction. The CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the data dictionary. The claim adjustment data the CONTRACTOR submits must follow the logic the CONTRACTOR defines in the documentation. The CONTRACTOR must provide the DEPARTMENT'S eight (8)-digit member ID on all claim files. On all provider and claim files, the CONTRACTOR must supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES).

The CONTRACTOR must designate someone as a data steward who is knowledgeable of its data and the systems that generate it. The data steward shall attend data submission planning meetings scheduled by the DEPARTMENT'S data warehouse vendor on the DEPARTMENT'S behalf and shall be the key point of contact for the DEPARTMENT'S data warehouse vendor on the submission of data and the correction of data errors should they occur.

The CONTRACTOR shall follow the data transmission instructions provided by the DEPARTMENT'S data warehouse vendor, which shall include industry-standard electronic transmission methods via secure Internet technology.

The quality of CONTRACTOR's data submissions will be assessed by the DEPARTMENT'S data warehouse vendor for timeliness, validity and completeness. If the DEPARTMENT'S data warehouse vendor determines that the data submitted by CONTRACTOR fails to meet the DEPARTMENT'S data warehouse vendor's thresholds for data quality, the CONTRACTOR must cooperate with the DEPARTMENT'S data warehouse vendor in submitting corrected data.

The CONTRACTOR must submit data and corrected data when necessary by the dates indicated by the DEPARTMENT'S data warehouse vendor.

The CONTRACTOR agrees to financial penalties for failure to submit data in accordance with this AGREEMENT, and which are assessed by the DEPARTMENT'S data warehouse vendor on behalf of the DEPARTMENT. Charges or penalties that are the direct result of the CONTRACTOR's failure to meet the DEPARTMENT'S data submission requirements, timelines

or other requirements in this AGREEMENT that impact the DEPARTMENT'S data warehouse will be deducted from a future payment(s) owed the CONTRACTOR.

During the initial implementation of the DEPARTMENT'S data warehouse, the CONTRACTOR will have two chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted more than one (1) BUSINESS DAY after the deadline for data file submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted after the deadline for submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARTMENT will charge the CONTRACTOR a per occurrence penalty for any failure to communicate to the DEPARTMENT'S data warehouse vendor a change to the valid values or data fields in the CONTRACTOR'S next data file submission by ten (10) BUSINESS DAYS before the next data file submission deadline.

The penalties assessed in [Section 150B](#) apply to the penalty maximum described in [Section 315](#).

155 Miscellaneous General Requirements

155A Reporting Requirements and Deliverables:

- 1) The CONTRACTOR must submit all reports and deliverables, and comply with all material requirements set forth in this AGREEMENT.
- 2) Each report submitted by the CONTRACTOR to the DEPARTMENT must:
 - a) Be verified by the CONTRACTOR for accuracy and completeness prior to submission,
 - b) Be delivered on or before scheduled due dates,
 - c) Be submitted as directed by the DEPARTMENT,
 - d) Fully disclose all required information in a manner that is responsive and with no material omission, and
 - e) Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report.
- 3) THE DEPARTMENT requirements regarding the frequency of report submissions may change during the term of the CONTRACT. The CONTRACTOR must comply with such changes within forty-five (45) DAYS.
- 4) The CONTRACTOR must notify the DEPARTMENT regarding any significant changes in its ability to collect information relative to required data or reports

- 5) The CONTRACTOR must fully support the BOARD and the DEPARTMENT in responding timely to informational requests made by the Legislature.

155B Performance Standards and Penalties

The CONTRACTOR must guarantee performance sufficient to fulfill the needs of the CONTRACT. The CONTRACTOR must meet all performance standards listed in [Section 315](#). After the CONTRACT start date, if additional resources are needed, the CONTRACTOR will bear all costs necessary to satisfy the requirements of the CONTRACT.

Written notification of each failure to meet a performance standard that is listed in [Section 315](#) will be given to the CONTRACTOR prior to assessing penalties. Upon notification by the DEPARTMENT, the CONTRACTOR will have five (5) BUSINESS DAYS to cure the failure, or if agreed to by the DEPARTMENT, to provide an action plan of how the failure will be cured. Additional DAYS can be approved by the DEPARTMENT Program Manager if deemed necessary. If the failure is not resolved within this warning/cure period, penalties may be imposed retroactively to the date of failure to perform. The imposition of penalties is not in lieu of any other remedy available to the DEPARTMENT/BOARD.

If the DEPARTMENT elects to not exercise a penalty clause in a particular instance, this decision shall not be construed as an acceptance of the CONTRACTOR'S performance. The DEPARTMENT retains the right to pursue future assessment of that performance requirement and associated penalties.

The DEPARTMENT shall be the sole determinant as to whether or not the CONTRACTOR meets a performance standard.

155C Nondiscrimination Testing

The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete [Internal Revenue Code \(IRC\) Sec. 105 \(h\)](#) compliant nondiscrimination testing for the DEPARTMENT at least annually. The DEPARTMENT or its designee will provide a schedule, process for testing, and data requirements. The CONTRACTOR shall complete any necessary requirements by the due date(s) specified by the DEPARTMENT or its designee.

155D Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand (\$200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits.

155E Audit and Other Services

The CONTRACTOR shall be required to maintain sufficient documentation to provide for the financial/management audit of its performance under this AGREEMENT. These shall include, but are not limited to, program expenditures, claim processing efficiency and accuracy, and customer service.

At its discretion, the BOARD may require independent third party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit. The BOARD may also designate a common vendor which shall provide the annual description of BENEFITS and such other information or services it deems appropriate.

The CONTRACTOR shall address any areas for improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. The BOARD shall be notified of all identified areas for improvement and the status of all improvements as necessary.

The BOARD shall make a diligent attempt to select a third party audit firm that is not a competitor of the CONTRACTOR or affiliated with or under the control of a competitor of the CONTRACTOR.

The frequency and extent of such audits shall be determined by the BOARD or DEPARTMENT. Records of paid claims must be maintained in a format and in a media acceptable to the DEPARTMENT.

The CONTRACTOR shall agree to a Service Organization Control (SOC) 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the Statement of Standard for Attestation Engagements (SSAE) 18 and provide a copy of the CPA's report to the DEPARTMENT. The DEPARTMENT will allow time on a case-by-case basis to provide this information if the CONTRACTOR doesn't currently have a completed SSAE 18 audit. The audit report must be submitted annually.

The CONTRACTOR shall submit a Model Audit Rule (MAR) Certification on an annual basis.

The CONTRACTOR shall submit financial stability documentation on an annual basis, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles).

The CONTRACTOR must also cooperate fully with audits and/or reviews conducted by the State of Wisconsin Legislative Audit Bureau (LAB). The LAB conducts periodic and other audits at the requests of legislators.

The CONTRACTOR shall make financial records, claims documentation, and all other relevant records available for review or audit as requested by the DEPARTMENT and shall assist as needed in review of these records.

155F Fraud and Abuse

1) Participant Fraud

a) Policy on Participant Fraud

No person other than a PARTICIPANT is entitled to BENEFITS under this AGREEMENT. The SUBSCRIBER or any of his or her DEPENDENTS are not authorized by this AGREEMENT to assign or transfer their rights under the AGREEMENT, aid any other

person in obtaining BENEFITS to which they are entitled or knowingly present or cause a false or fraudulent claim. The SUBSCRIBER'S rights to coverage under the HEALTH BENEFITS PROGRAM are forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise falsely or fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment rights may be limited as determined by the BOARD.

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

b) Contractor Responsibility Related to Participant Fraud

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any suspected or identified PARTICIPANT fraud. The CONTRACTOR must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT. Fraud may result in the reprocessing of claims and recovery of overpayments. See [Section 135C](#).

2) Contractor Provider Review Requirements

The CONTRACTOR, within thirty (30) DAYS of the execution of this CONTRACT, must submit a fraud and abuse review plan to the DEPARTMENT. Upon the DEPARTMENT'S approval of the plan, the CONTRACTOR must perform QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provide results of material findings to the DEPARTMENT.

Examples of potential provider fraud that could be included in QUARTERLY reviews:

- a) Billing for items or services not rendered;
- b) Billing for work already reimbursed by another insurer;
- c) Overcharging for services or supplies;
- d) Completing an unjustified Certificate of Medical Necessity (CMN) form;
- e) Double billing resulting in duplicate payment;
- f) Misrepresenting medical diagnoses or procedures to maximize payments;
- g) Inappropriate use of place of service codes;
- h) Knowing misuse of provider identification numbers resulting in improper billing;

- i) Providing medically unnecessary services;
- j) Routinely waiving deductibles/coinsurances;
- k) Submitting bills exceeding the limiting charge;
- l) Unbundling (billing for each component of the service instead of billing or using an inclusive code);
- m) Up-coding the level of service provided; and,
- n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including [Wis. Stat. § 134.98](#), HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

- 1) A description of the incident(s).
- 2) The identified root cause(s).
- 3) The actual or estimated number of PARTICIPANTS impacted.
- 4) The actual impact list (as soon as known).
- 5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).
- 6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H Department May Designate Vendor

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.

155I Contract Termination

In addition to the provisions in the Department Standard Terms and Conditions, the following applies if the CONTRACT is terminated:

- 1) Any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:
 - a) The CONTRACT maximum is reached.
 - b) The attending physician determines that CONFINEMENT is no longer medically necessary.
 - c) The end of twelve (12) months after the date of termination.
 - d) CONFINEMENT ceases.
- 2) If the BOARD terminates this CONTRACT, then all rights to BENEFITS shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include, but are not limited to: transferring the patient to another facility; billing the BOARD a fee for service rendered; or permitting OUT-OF-NETWORK providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.
- 3) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.
- 4) The CONTRACTOR must submit claims data as specified in [Section 150](#) during a six (6) month run-out period following the CONTRACT termination date. The DEPARTMENT will withhold twenty-five percent (25%) of premium payment for the last month of the contract period, to be paid not later than ninety (90) days following the contract termination date, unless there are issues receiving timely run-out claims data.
- 5) If the CONTRACTOR terminates this CONTRACT, the CONTRACTOR shall not again be considered for participation in the HEALTH BENEFIT PROGRAM under [Wis. Stat. § 40.03 \(6\) \(a\)](#) for a period of three (3) calendar years.

155J Transition Plan

Upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT. The transition plan must be approved by the DEPARTMENT prior to the transition begin date. Also see the Department Standard Terms and Conditions.

155K Insolvency

The CONTRACTOR shall maintain appropriate bonding and/or reinsurance and shall submit documentation upon request by the DEPARTMENT. The appropriate bonding and/or reinsurance ensures that, in the event the CONTRACTOR becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the CONFINEMENT ceases, the attending physician determines CONFINEMENT is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer coverage to another CONTRACTOR.

160 Submission of New Proposals

The organization must submit a proposal to the BOARD to participate in the HEALTH BENEFIT PROGRAM. The proposal must address each requirement in this section.

The organization must also meet the requirements in this AGREEMENT in order to secure approval from the BOARD to participate in the HEALTH BENEFIT PROGRAM. These requirements have been developed to explain and clarify the general requirements set forth under [Wis. Stat. § 40 Subchapter IV](#), [Wis. Adm. Code § ETF 10](#) and [Wis. Adm. Code § ETF 40](#). Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stat. Chapters 150, 185 (185.981-.985), 600-646, and Public Laws 93-222 (the HMO Assistance Act of 1973) and 94-460 (Health Maintenance Organization Amendments of 1976) and other applicable state/federal health benefit law provisions.

The BOARD may allow an organization that has substantially but not completely met the requirements of this AGREEMENT to participate but not be considered qualified in the first year of operation in the HEALTH BENEFIT PROGRAM for purposes of establishing the EMPLOYER contribution toward PREMIUM when the contribution is based on a percentage of the lowest / average cost qualified plan.

160A Operating Experience

The organization must have at least one (1) year of operating experience and must be able to demonstrate that the organization has broad-based community support. In determining the operating experience requirements, the BOARD shall consider the period of time elapsing from the date the organization first opens its door to the general public to render health care services to the date that such coverage would be effective for public employees.

To document the community support requirement, the organization must submit information on current enrollments, projected growth and historical data that would support the fact that it has

experienced steady growth since its inception. The organization must provide a current listing of employer/employee groups participating under the program or actively sponsoring participation in the plan. If the organization is so large that providing a listing of each and every participating employer/employee group would be an inconvenience, the BOARD will accept a representative listing of 20 such groups.

The BOARD may waive the one year operating experience and community support requirement(s) in those health service areas where the BOARD has determined there is a need for the promotion of innovative approaches to the delivery of health care such as the concept of direct provider contracting.

160B Financial Requirements

The organization must be able to demonstrate that it has the financial resources necessary to carry out its obligations to PARTICIPANTS covered under the HEALTH BENEFIT PROGRAM.

The BOARD prefers to approve only those organizations that have reached the "breakeven point" and are operating at a level where program income equals expenses. However, the BOARD will consider organizations that are not yet self-sufficient, if it provides evidence that it can meet its short and long-term financial obligations.

In determining financial stability, the BOARD will consider financial soundness of arrangements for health care services, adequate working capital (both current and projected), and insolvency protection for subscribers. See [Section 155L](#) for additional detail on insolvency.

The organization must submit documentation of financial stability that may include one or more of the following:

- 1) Federal qualification under Public Law 93-222 (Health Maintenance Assistance Act of 1973), or subsequent amendments.
- 2) Incorporation and regulation under the provisions of Chapter 185 and/or 600 through 646 of the Wisconsin Statutes pertaining to insurance plans.
- 3) Posting financial bond guaranteeing benefit payments in the event the organization fails to meet the continuing requirements for inclusion under the HEALTH BENEFIT PROGRAM and is terminated, or the organization ceases operation. The size of the performance bond required will be based on the number of enrollees and premium income involved.
- 4) The organization has sponsors who are incorporated under Chapter 613 of the Wisconsin Statutes or otherwise possess an appropriate certificate of authorization to transact insurance business under Wis. Stat. § 601.04, and will guarantee future benefit payments.
- 5) Other documentation such as reinsurance as provided by Chapter 627 of the Wisconsin Statutes and as authorized by the Commissioner of Insurance. Terminations will be handled in a manner consistent with the intent of Wis. Adm. Code § INS 6.51 (6) and (7), Rules of the Commissioner of Insurance (register date December 1984).
- 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.

160C Comprehensive Plans

The BOARD will only consider those organizations that 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 organization whose premium is not satisfactory to the BOARD.

Organizations that will be considered under these program requirements to be allowed in any service area include any of the following types of organizations defined in [Wis. Stat. § 609.01 \(2\)](#) and [\(4\)](#):

- 1) Independent practice association HMO (IPA's).
- 2) Prepaid group practice HMO.
- 3) Staff model HMO.
- 4) Point of service HMO (POS-HMO).
- 5) Preferred Provider Plan (PPP).

Organizations that embrace the characteristics of one or more of the type of organization models described above may be considered by the 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.

160D Provider Agreements

The organization must submit the following as part of its proposal:

- 1) If professional services are provided through contractual arrangements, such as an Independent Practice Association (IPA), a sample copy of the actual contractual agreement established between the organization and the participating physicians who will be providing professional services. If more than one type of contract is used then include a sample of each.
- 2) Detailed explanation of any relationship between the organization and hospitals which would be IN-NETWORK for the HEALTH BENEFIT PROGRAM. Specify whether there is a contractual relationship between the organization and the hospital(s) involved or if the relationship is limited only to the extent that physicians providing services under the program have staff privileges with the hospital(s).
- 3) Detailed explanation of how providers and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how compensation is established, reviewed and changed. The intent is to secure information on how a CONTRACTOR reimburses its providers; the BOARD is not interested in specific fees or salary information.

- 4) Detailed explanation of medical specialties associated directly or indirectly with the organization. For those organizations where medical specialists are used as referral physicians rather than primary care, the organizations must submit documentation to demonstrate that the referral physician(s) has, in fact, agreed to accept such referrals. If there is a contractual arrangement where an organization has contracted with a clinic/individual practitioner to provide either primary or referral care, such contractual agreements must be identified and included with the proposal.
- 5) Except for those benefits which require the PARTICIPANT to satisfy a deductible or be subject to copayment or coinsurance, the contract for professional or hospital services must contain a provision whereby the physician and/or hospital and/or health care provider (as defined under [Wis. Stat. § 655.001 \(8\)](#)) agrees to accept the payments provided by the organization as full payment for covered services. Each organization must certify that it will "hold harmless" the PARTICIPANT from any effort(s) by third parties to collect payments for medical/hospital services, including those efforts due to the CONTRACTOR'S untimely payment of claim.

This provision shall be considered as satisfied if arrangements have been made which prevent the PARTICIPANT from being held liable for hospital or professional charges except for those benefits which require the enrollee to satisfy a deductible; be paid on a copayment or coinsurance basis; or in those instances where the PARTICIPANT failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of the UNIFORM BENEFITS plan requirements shall not be subject to the "hold harmless" provision.

160E Capital Equipment and Expenditures

The organization must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically providing services but rather, functioning as a sponsor, include within your proposal the following statement:

"Section 160E. of the AGREEMENT is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

If the approval of capital equipment and expenditures is subject to review by state and/or federal agencies, the applicant should provide information on all reporting requirements.

160F Enrollment and Reporting

If an organization submits a proposal to participate in the HEALTH BENEFIT PROGRAM and the proposal is approved by the BOARD, the organization will be offered to active and retired EMPLOYEES at a time established by the BOARD (IT'S YOUR CHOICE OPEN ENROLLMENT) subject to the following:

- 1) The organization must secure a minimum of 100 SUBSCRIBER contracts or demonstrate that 10% of the eligible EMPLOYEES in the service area have opted to participate in the program. The service area means the entire geographic area in which the organization is qualified. See [Section 230A](#).
- 2) The BOARD may waive the minimum participation requirement set forth under 1) above provided the organization submits a marketing plan which demonstrates that this minimum

number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a similar extent by employees of other groups and the location is convenient to potential SUBSCRIBERS. This marketing plan will be considered confidential by the BOARD insofar as permitted by Wisconsin Law.

160G Rate-Making Process

The organization must submit initial premium rates as described in [Section 130B](#). The organization must include a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate that will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/LOCAL group or other groups, etc. This information will be treated as confidential by the BOARD insofar as permitted by Wisconsin Law.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates.

160H Submission of Proposals

The proposal must be received by April 15 and include:

- 1) Fifteen (15) copies.
- 2) Specific listing of the organization's pre-authorization and referral requirements.
- 3) Description of case management and disease management activities.
- 4) List and count of providers under contract arranged by county of practice for state employees, and by zip code for LOCAL employees. An electronic version of the listing must also be made available. The BOARD will expect an updated listing in July in order to determine what region will constitute the CONTRACTOR'S service area.
- 5) Copy of your detailed contingency plan in the event of strike, disaster, etc. The plan must address the method used for providing services and processing claims under such circumstances.
- 6) Organizational chart.
- 7) Statement of agreement to abide by all the terms and conditions set forth in the AGREEMENT.
- 8) If a PPP, include a schedule of benefits.

The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

160I Implementation

The CONTRACTOR is required to have an Implementation Manager and Implementation Team available to manage the project from the CONTRACT start date until all implementation tasks are complete, as determined by the DEPARTMENT, and all remaining responsibilities are transferred over to the Account Manager and key staff. The Implementation Manager must be available

Monday through Friday from 8:00 a.m. to 4:30 p.m. CST/CDT to assist DEPARTMENT staff. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned, normal business hours. The CONTRACTOR will continuously assess the implementation process to ensure a smooth and successful implementation. The Account Manager who will be responsible for the CONTRACT must be an active member of the Implementation Team.

The CONTRACTOR must conduct status meetings with the DEPARTMENT concerning project development, project implementation and CONTRACTOR performance at least twice a week during implementation and for the first two to three (2-3) months following the launch of the benefit period, unless otherwise approved by the DEPARTMENT in writing. Meetings may be in person or by teleconference/webinar, as determined by the DEPARTMENT.

The DEPARTMENT reserves the right to make on-site visits.

The CONTRACTOR is required to perform and/or manage the following activities by the due date to be indicated by the DEPARTMENT:

- 1) Implementation Plan: The CONTRACTOR shall submit an implementation plan in a mutually agreed upon format to the DEPARTMENT Program Manager or designee.
- 2) Fraud and Abuse Review Plan: The CONTRACTOR shall submit a fraud and abuse review plan to the DEPARTMENT.
- 3) Nondiscrimination Testing Plan: The CONTRACTOR will work with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.
- 4) Program Information: All program informational materials for the upcoming benefit period shall be submitted to the DEPARTMENT Program Manager or designee for review and approval, including:
 - a) Informational mailing to be sent to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.
 - b) Web content that consists of customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period.
- 5) Employer Meeting and Health Fairs: The CONTRACTOR shall attend the It's Your Choice EMPLOYER Kick-Off meeting and shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area
- 6) Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number shall be operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.

- 7) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files shall be fully tested and are ready for program operation.
- 8) Grievance Procedure: The CONTRACTOR shall submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.
- 9) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational.
- 10) Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information shall be launched.
- 11) Data Transfers: The data transfer process to the DEPARTMENT'S data warehouse, or other DEPARTMENT vendor as designated by the DEPARTMENT, shall be established, tested, and working correctly for the following transfers:
 - a) Pharmacy Data
 - b) Wellness and Disease Management Data
 - c) Provider Data
 - d) Claims Data

200 PROGRAM REQUIREMENTS

205 Enrollment

CONTRACTORS must participate in the annual IT'S YOUR CHOICE OPEN ENROLLMENT offering. The IT'S YOUR CHOICE OPEN ENROLLMENT period is scheduled for each fall prior to the covered program year. During the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR will accept any SUBSCRIBER who transfers from one benefit plan to another without requiring evidence of insurability, or waiting periods, or exclusions as defined in [Wis. Adm. Code INS 3.31 \(3\)](#) and any eligible EMPLOYEE or state retiree under [Wis. Stat. § 40.51 \(16\)](#) who enrolls.

Although the DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR shall maintain an enrollment/eligibility system to support the HEALTH BENEFIT PROGRAM.

205A Enrollment Files

The daily and full file compare of the DEPARTMENT'S HIPAA 834 enrollment files must be fully tested and are ready for program operation no later than forty-five (45) calendar DAYS prior to the effective (i.e., "go-live") date. Also see [Section 150A](#).

The CONTRACTOR shall have flexibility to accommodate the DEPARTMENT'S benefit administration system (BAS) IT upgrade, which the DEPARTMENT anticipates would impact this program starting in year 2018. The BAS system will be the system of record for participant demographic and benefit information, and the upgrade may impact the formatting or data fields required for transmitting enrollment files and may also affect the way in which enrollment is communicated to the CONTRACTOR.

205B Identification (ID) Cards

The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. The CONTRACTOR must issue new ID cards upon enrollment and BENEFIT changes that impact the information printed on the ID cards.

The CONTRACTOR shall issue the ID cards, along with a welcome packet for newly enrolled PARTICIPANTS, within the timeframes described below:

- 1) The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 2) below.
- 2) For elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTRACTOR must notify the

DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID cards were issued.

The CONTRACTOR must provide replacement cards upon request at no cost to the PARTICIPANT. The CONTRACTOR must also have a process to make available a temporary, printable ID card.

205C Participant Information

The CONTRACTOR must provide the following information, at a minimum, to PARTICIPANTS upon enrollment:

- 1) Information about PARTICIPANT requirements, including prior authorizations and referrals.
- 2) Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website and directions on how to request a printed copy of the provider directory.
- 3) Directions on how to change their Primary Care Provider.
- 4) The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, telehealth services, and website address.

The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process described in [Section 140B](#).

The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required form 1095-Cs.

205D Disabled Child Eligibility

The CONTRACTOR shall report to the DEPARTMENT at least annually the results from its process to verify the eligibility of adult disabled children age twenty-six (26) or older, which includes checking that the:

- 1) Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year, and
- 2) Support and maintenance requirement is met, and
- 3) Child is not married.

205E Date of Death

The CONTRACTOR shall collect and track the date of death and report it to the DEPARTMENT as needed.

205F Coordination of Benefits (COB)

The CONTRACTOR shall collect from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually.

210 Primary Care Provider

SUBSCRIBERS and DEPENDENTS shall be required to select a primary care provider (PCP). The PCP may be a physician, physician assistant, nurse practitioner or other provider as approved by the BOARD. Modifications to this list may be approved by the DEPARTMENT. 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, twenty-four (24) hours a DAY, seven (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 specialty 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 CONTRACTOR must monitor all PARTICIPANT records to ensure there is an assigned, IN-NETWORK PCP at all times. If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR will assign a PCP, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP.

If PARTICIPANTS select a PCP that is OUT-OF-NETWORK, the CONTRACTOR must contact the PARTICIPANTS within five (5) BUSINESS DAYS to assist them in selecting an IN-NETWORK PCP. Also see [Section 265E](#).

The CONTRACTOR must have a process to allow a PARTICIPANT to change PCPs in a reasonable time and to communicate to the PARTICIPANT how to make this change. The CONTRACTOR will assist the PARTICIPANT in selecting a PCP.

215 Medical Management

215A Disease Management / Prior Authorizations / Utilization Review

The CONTRACTOR shall collaborate and support activities related to population health management as directed by the BOARD.

The CONTRACTOR shall have utilization management processes that are evidence-based and focus on quality, positive PARTICIPANT outcomes, and cost savings. The CONTRACTOR shall use these processes for evidence based medical policy development for coverage of new technologies and to provide input to the DEPARTMENT on benefit design changes, as appropriate. The CONTRACTOR shall provide these policies to PARTICIPANTS upon request.

The CONTRACTOR shall utilize data provided by the PBM, wellness and disease management vendor, and DEPARTMENT'S data warehouse for identifying PARTICIPANTS suitable for case, complex case, and/or disease management programs.

The CONTRACTOR must demonstrate effective and appropriate means of identifying, monitoring and directing PARTICIPANT'S care by providers such as utilization review (UR) and chronic care/disease management, and wellness/prevention programs. The CONTRACTOR shall report annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS 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. The CONTRACTOR shall also include details on the HEALTH BENEFIT PROGRAM'S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR 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 the DEPARTMENT.

Examples of the minimum UR procedures that CONTRACTORS shall have in place include the following:

- 1) Written guidelines that providers must follow to comply with the CONTRACTOR'S UR program.
- 2) Formal UR program consisting of preadmission review, concurrent review, discharge or transition of care and post-service medical review and individual case management.
- 3) Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews of all program denials and PARTICIPANT appeals procedure.
- 4) Authorization procedure for referral to OUT-OF-NETWORK providers and monitoring of physician referral patterns.
- 5) Procedure to monitor emergency admissions to OUT-OF-NETWORK HOSPITALS.
- 6) Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
- 7) If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category, have a process to enroll the PARTICIPANTS into the appropriate wellness, disease management, or chronic care management programs. The CONTRACTOR must coordinate this effort with the program(s) offered by the DEPARTMENT'S wellness and disease management vendor.

Failure to provide effective UR may be grounds for BOARD action.

Prior Authorizations

The CONTRACTOR must also offer an integrated prior authorization process that provides PARTICIPANTS with a consolidated medical and benefit (such as deductible, coinsurance and copayment) determination. Prior authorizations with out-of-pocket cost sharing information, including the possibility of balance billing if applicable, must be provided to PARTICIPANTS in writing. In urgent situations, prior authorizations may be provided verbally, as long as the PARTICIPANT is notified of cost sharing responsibilities, and it is documented in the PARTICIPANT'S records/file. The CONTRACTOR must still follow up with a written notice. This provision also applies when a provider is seeking the prior authorization on the PARTICIPANT'S behalf.

If the cost sharing is not disclosed at the time of prior authorization, the CONTRACTOR shall hold the PARTICIPANT harmless for out-of-pocket amounts above that of an equivalent IN-NETWORK service, and shall not charge this difference to the DEPARTMENT.

The CONTRACTOR shall work with the DEPARTMENT to develop strategies for OUT-OF-NETWORK costs, including, but not limited to, the use of PARTICIPANT incentives, prior authorization, and negotiating provider fees.

The CONTRACTOR shall be responsible for the full cost of any services not covered under this CONTRACT for which the CONTRACTOR provides written prior authorization to the PARTICIPANT and/or provider for the non-covered service.

215B Department Initiatives

The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives. Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The CONTRACTOR may coordinate with HOSPITALS, provider groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.

The current DEPARTMENT Initiatives are:

- 1) Care Coordination – The CONTRACTOR must ensure care coordination is offered for PARTICIPANTS with high-risk health condition(s) by conducting outreach within three (3) to five (5) BUSINESS DAYS of a PARTICIPANT'S initial discharge from an INPATIENT HOSPITAL stay of more than twenty-four (24) hours.
- 2) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.
- 3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis 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 or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

- 4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.
- 5) Advance Care Planning (ACP) / Palliative Care - The CONTRACTOR must provide a credible ACP program that includes hospice care and palliative care. The CONTRACTOR must ensure ACP conversation(s) and/or palliative care consultation(s) are offered to all PARTICIPANTS with a serious disease and/or a likely survival of less than twelve (12) months.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in UNIFORM BENEFITS to all PARTICIPANTS. BENEFITS are reviewed annually and any BENEFIT changes must be implemented as directed by the BOARD. This shall include developing the necessary reporting and/or data transfers needed by the DEPARTMENT and other vendors to administer the change.

The CONTRACTOR will offer the HDHP described in UNIFORM BENEFITS to all enrolled PARTICIPANTS.

220B Telehealth / Nurse Line

- 1) The CONTRACTOR must provide telehealth services as directed by the DEPARTMENT.
- 2) The CONTRACTOR must provide a twenty-four (24)-hour nurse line available at no cost to all PARTICIPANTS.

220C Emergency / Urgent / Catastrophic Care

The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK or OUT-OF-NETWORK providers at the IN-NETWORK level of benefits. This OUT-OF-NETWORK care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in UNIFORM BENEFITS unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger nationwide networks may offer coverage through affiliated

networks as long as there is no additional cost to the HEALTH BENEFIT PROGRAM or PARTICIPANT for doing so.

The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, and/or a transfer to a more suitable facility when appropriate.

The CONTRACTOR must submit to the DEPARTMENT a QUARTERLY report of all claims (including non-urgent and non-emergent) paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT.

220D Inpatient When Changing Coverage

The CONTRACTOR will administer claims and medical management services for any PARTICIPANT who is CONFINED as INPATIENT at the time of a transfer of coverage to another CONTRACTOR, when the facility in which the PARTICIPANT is CONFINED is not part of the succeeding CONTRACTOR'S network. In this instance, the CONTRACTORS will work together to facilitate a seamless transition in claims administration, medical management services, if applicable, and transferring the PARTICIPANT to an IN-NETWORK facility, if appropriate.

Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if CONFINED as an INPATIENT, but only until the attending physician determines that CONFINEMENT is no longer medically necessary, the maximum BENEFIT is reached, the end of twelve (12) months after the date of termination, or the CONFINEMENT ceases, whichever occurs first.

220E Federal / State Requirements

The CONTRACTOR must meet any and all applicable state or federal requirements concerning BENEFITS and cost-sharing which may be imposed on EMPLOYERS participating in the HEALTH BENEFIT PROGRAM, the CONTRACTOR, a federally qualified health benefit program, or as contained in this AGREEMENT.

220F Out-of-Network Services for Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in UNIFORM BENEFITS to PARTICIPANTS enrolled in Medicare, carving out the benefits paid by Medicare so that PARTICIPANTS enrolled in Medicare receive the same UNIFORM BENEFITS level as provided to EMPLOYEES.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

The CONTRACTOR is responsible for resolving discrepancies in claims payments for all Medicare data match inquiries.

220H End Stage Renal Disease - Medicare Participants

If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, the HEALTH BENEFIT PROGRAM shall pay as the primary payer for the first thirty (30) 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 payer after this thirty (30)-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 (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

220I Ancillary Services

If the PARTICIPANT receives anesthesiology, radiology or pathology (includes all lab tests) services at an IN-NETWORK clinic or HOSPITAL, it will be covered at the IN-NETWORK level of benefits even if that care is not provided by an IN-NETWORK provider.

220J Transfer of Benefit Maximums / Deductible / Out-of-Pocket Limits

PARTICIPANTS may have the opportunity to change benefit plans during a benefit period in certain situations (e.g., due to a change in residence, change from or to the HDHP).

- 1) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPs under UNIFORM BENEFITS will continue to accumulate for the benefit period in the following situations:
 - a) If a PARTICIPANT changes the level of coverage (e.g., single to family), but does not change benefit plans.
 - b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.
- 2) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPs under UNIFORM BENEFITS will start over at zero (\$0) dollars as of the EFFECTIVE DATE of the change in the following situations:
 - a) If a PARTICIPANT changes benefit plans.

- b) If a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.
- 3) Accumulations to the annual pharmacy and uniform dental (if applicable) benefits continue to accumulate for the benefit period regardless of a benefit plan/CONTRACTOR change. For HDHPs, medical and pharmacy accumulations are combined.

The CONTRACTOR must cooperate with the DEPARTMENT and the new CONTRACTOR to transfer BENEFIT accumulations upon a PARTICIPANT'S mid-year transfer to coverage under a new CONTRACTOR. The CONTRACTOR shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of an explanation of benefits.

The CONTRACTOR shall apply any and all Maximum Out-of-Pocket (MOOP) limits as required by state and federal law.

220K Coordination / Non-Duplication

The CONTRACTOR'S administration of BENEFITS provisions must conform to [Wis. Adm. Code INS 3.40](#).

220L Wellness

- 1) The CONTRACTOR must receive written approval annually from the DEPARTMENT prior to offering any financial incentive or discount programs to PARTICIPANTS.
- 2) The CONTRACTOR must participate in collaboration efforts between the DEPARTMENT, its wellness and disease management vendor, and other vendors, as directed by the DEPARTMENT.
- 3) The CONTRACTOR must accept PARTICIPANT level data transfers from the DEPARTMENT'S wellness and disease management vendor.
- 4) The CONTRACTOR shall use the PARTICIPANT level data from DEPARTMENT'S wellness and disease management vendor to identify PARTICIPANTS appropriate for complex/chronic case management and enroll PARTICIPANTS in such programs.
- 5) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data at stated in 4) above and in [Section 215A](#).
- 6) The CONTRACTOR must report, as directed by the DEPARTMENT, all incentive payments issued to PARTICIPANTS for DEPARTMENT distribution to EMPLOYER payroll centers for tax reporting purposes. The CONTRACTOR must link all payment records to the primary SUBSCRIBER and avoid duplication for instances of a reissued incentive.
- 7) Provider obtained biometric screenings as required by the DEPARTMENT'S wellness program shall be provided by the CONTRACTOR at the PARTICIPANT'S request, for no cost

to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting and shall be in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.

225 Quality

- 1) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in encouraging and/or requiring IN-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.
- 2) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, its support for the DEPARTMENT'S initiatives in monitoring and improving quality of care. 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.
- 3) The CONTRACTOR must collect Healthcare Effectiveness Data and Information Set (HEDIS) measures and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as specified by the National Committee for Quality Assurance (NCQA) guidelines. Upon request by the DEPARTMENT, the CONTRACTOR shall provide information about subcontractors used to audit the HEDIS results and administer the CAHPS survey.
 - a) Annually, the CONTRACTOR shall submit to the DEPARTMENT audited HEDIS data results for the previous calendar year for its commercial membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. The results must include integration of the prescription drug data from the PBM. CONTRACTORS utilizing a vended solution to produce HEDIS results, shall utilize a vendor certified by NCQA.
 - b) The CONTRACTOR shall submit the results of its annual CAHPS survey to the DEPARTMENT as follows:
 - i) Results must be based on responses from commercially insured adult members in Wisconsin;
 - ii) Survey must be conducted by a certified CAHPS survey vendor;
 - iii) Results must utilize the current version of the CAHPS survey as specified by the NCQA guidelines at the time the survey is administered;
 - iv) Results must be for each standard NCQA composite;
 - v) Results must be submitted annually and in a file format as specified by the DEPARTMENT; and,

- vi) Separate results must be submitted for each region, if applicable.
- 4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using quality measures available in the data warehouse and visual business intelligence tool, and will establish quality metrics, baseline results, and target levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage quality improvement. See Appendix 8 for the quality measures that will be evaluated as part of this CONTRACT.

Prior to the DEPARTMENT holding the CONTRACTOR accountable for any of these measures, either through financial means and/or through publishing the measure results, the DEPARTMENT will provide the CONTRACTOR with an opportunity to review and validate the DEPARTMENT'S results within a specific timeframe, as determined by the DEPARTMENT.

- 5) The CONTRACTOR shall collaborate with providers on quality initiatives to address current population health issues. The CONTRACTOR shall report to the DEPARTMENT semi-annually any initiatives and pilot programs offered by the CONTRACTOR or the CONTRACTOR'S IN-NETWORK providers, including information on patient engagement and outcomes.

230 Provider Contracts

The CONTRACTOR shall have staff solely dedicated to network management and provider relations that includes a credentialing process, collaboration on quality initiatives, and provider communications. The CONTRACTOR must engage in regular provider negotiations to strategically realize cost savings to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must, at a minimum, provide an annual update on provider discount negotiations efforts and outcomes to be included in the rate renewal reports. The DEPARTMENT reserves the right to require more frequent status updates on provider negotiation strategies, efforts, and outcomes.

Upon request by the DEPARTMENT, the CONTRACTOR shall agree to disclose the cost savings calculated with implementing any provider contract reimbursement methods as directed by the BOARD. This may include a detailed explanation of how providers and HOSPITALS are compensated as described in [Section 160D](#), 3.

The CONTRACTOR must certify annually that their provider contracts meet the requirements in [Section 230](#). The DEPARTMENT reserves the right to review any contracts with providers that are IN-NETWORK for the HEALTH BENEFIT PROGRAM.

The CONTRACTOR must submit provider data to the DEPARTMENT'S data warehouse as specified in [Section 150](#). The DEPARTMENT will not amend its contract with the data warehouse vendor in a manner that directly or indirectly changes the terms of this section without prior notice to the CONTRACTOR. The DEPARTMENT'S notice to the CONTRACTOR will allow for comment by the CONTRACTOR, and when requested by the CONTRACTOR, discussion between the DEPARTMENT and the CONTRACTOR about the proposed changes.

Provider agreements for transplants are expected to specify that re-transplantation due to immediate rejection that occurs within the first thirty (30) DAYS of a transplant shall be covered and is not subject to the UNIFORM BENEFITS exclusion on retransplantation.

The CONTRACTOR shall use best efforts to incorporate into Wisconsin provider agreements:

- 1) Guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.
- 2) HOSPITAL readmissions reduction program and the community-based care transitions program as described by Medicare.

Provider contracts must include a provision whereby the provider agrees to accept the CONTRACTOR'S payment as full payment for covered services, not including PARTICIPANT cost-sharing as outlined in UNIFORM BENEFITS. The CONTRACTOR must hold the PARTICIPANT harmless from any efforts(s) by third parties to collect payments for covered services as described in [Section 160D](#), 5.

The CONTRACTOR must provide a copy of the current provider administrative manual upon request by the DEPARTMENT.

230A Provider Access Standards

The CONTRACTOR must provide an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. See Appendix 7. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in [Section 150](#).

The DEPARTMENT will use this data to determine the counties in which the CONTRACTOR is qualified. CONTRACTORS are determined to be qualified on a county by county basis by meeting the provider access standards in this section and the operating experience specified in [Section 160A](#). The BOARD reserves the right to offer the State Maintenance Plan (SMP) in those counties in which a qualified, Tier 1 plan is not available. See [Section 130](#) for information about tiers. A Preferred Provider Plan (PPP) is not qualified in areas served by the SMP.

The DEPARTMENT may also determine a CONTRACTOR is non-qualified in a county in the following situations:

- 1) The CONTRACTOR does not meet the provider access standards and has at least one (1) PCP in the county and/or major city.
- 2) The CONTRACTOR meets the provider access standards and the DEPARTMENT determines the CONTRACTOR is not effectively administering the HEALTH BENEFIT PROGRAM in accordance with this AGREEMENT (e.g., failure to provide effective medical management, etc.).

The DEPARTMENT shall list the CONTRACTORS determined to be qualified in each county in the IT'S YOUR CHOICE OPEN ENROLLMENT materials. At its discretion, the DEPARTMENT may also list the CONTRACTORS determined to be non-qualified in the county.

Providers will be sorted by zip code based on where they are physically located within each county and major city in the region. Major cities are those that have over thirty-three percent (33%) of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior. These providers must agree to accept new patients unless specifically indicated otherwise.

In addition to the access standards set forth in [Wis. Stat. § 609.22](#), the CONTRACTOR must meet at least 90% geoaccess in the county for INPATIENT HOSPITALS and PCPs (includes Internal Medicine, Family Medicine and General Medicine) or the following minimum requirements for all counties and major cities in the county to be qualified:

- 1) There must be at least one (1) general HOSPITAL under contract and/or routinely utilized by IN-NETWORK providers per county or major city. If a HOSPITAL is not present in the county, CONTRACTORS must sufficiently describe how they provide access to providers.
- 2) The ratio of full time equivalent (FTE) PCPs accepting new patients to total PARTICIPANTS in a county or major city is at least one per two thousand (1.0/2,000) with a minimum of five (5) PCPs per county or major city. The PCPs counted for this requirement must be able to admit patients to an IN-NETWORK HOSPITAL in the county or major city.
- 3) A chiropractor must be available in each county or major city.

The BOARD reserves the right to allow for exceptions in certain counties when the CONTRACTOR can demonstrate this criteria cannot be met.

The BOARD reserves the right to make enrollment and eligibility decisions as necessary to implement the HEALTH BENEFIT PROGRAM, including whether to make a Tier 1 option available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or make a Tier 2 plan available in any county. The DEPARTMENT may take such action as necessary to implement this intent.

230B Provider Directory

The CONTRACTOR must make a provider directory available to PARTICIPANTS during the annual IT'S YOUR CHOICE OPEN ENROLLMENT period and throughout the benefit period. Providers listed in these directories are subject to the access standards above, including accepting new patients, unless otherwise noted. The CONTRACTOR is required to have a current provider directory easily accessible on their website at all times. The provider directory must include a revision date and all past versions within a benefit period and must be provided to the DEPARTMENT upon request for the purposes of resolving complaints.

The provider data submission and the published provider directory must be in alignment for the IT'S YOUR CHOICE OPEN ENROLLMENT for the upcoming benefit period.

230C Continuity of Care

The CONTRACTOR must comply with the continuity of care provisions under [Wis. Stat. § 609.24](#) for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. In the event a provider or provider group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the SUBSCRIBER shall be held harmless and indemnified. This does not apply in the loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care.

At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR must:

- 1) Send written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information:
 - a) How to find a new IN-NETWORK provider or facility;
 - b) The continuity of care provision as it relates to this situation; and,
 - c) Contact information for questions.
- 2) Update the provider directory on the CONTRACTOR'S website.

The CONTRACTOR shall keep a record of this notification mailing and shall provide documentation, by SUBSCRIBER and indicating the mailing address used, upon the DEPARTMENT'S request.

The CONTRACTOR will assist the PARTICIPANT in selecting a new IN-NETWORK provider or facility and obtaining any necessary referrals and/or authorizations.

If the CONTRACTOR removes providers from its network for the next benefit period, the CONTRACTOR is prohibited from adding those providers back to the network until the subsequent benefit period unless approved by the DEPARTMENT. This provision does not apply to normal attrition.

230D Provider Contracts Shall Include Compliance Plans

All new (and upon renewal of) provider contracts shall include requirements that provider staff be educated about health care laws, rules and regulations, applicable standards, and how to identify and report inappropriate behavior.

Examples of the types of contract provisions that should be in place include:

- 1) Effective internal controls to assure compliance with Federal and State laws, rules, regulations and internal policies and procedures.
- 2) Staff training on identification and prevention of unlawful and unethical conduct.
- 3) Create a centralized source for distributing information on health care statutes, regulations and other program directives.
- 4) Establish procedures that allow the prompt, thorough investigation of possible misconduct by employees and independent contractors.
- 5) Certify as to the accuracy, completeness and truthfulness of all data submitted to payers.

235 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in UNIFORM BENEFITS. Targets for claims processing performance standards and associated penalties are specified in [Section 315B](#).

The CONTRACTOR shall comply with [Wis. Stat. § 628.46](#) with regard to any interest due for late payment of claims submitted by an OUT-OF-NETWORK provider.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

240 Data

The CONTRACTOR is 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 other data as required by the DEPARTMENT, using the most recent file and data specifications provided by the DEPARTMENT. Where appropriate, such as for the catastrophic claims data report, the CONTRACTOR is expected to separate out pharmacy claims from the DEPARTMENT'S PBM from any pharmacy claims that are paid by the CONTRACTOR.

The CONTRACTOR shall provide and receive all reasonable requests for data and other information as needed in a file format as identified by the DEPARTMENT. The CONTRACTOR will place no restraints on the use of the data.

The CONTRACTOR shall submit all medical and prescription drug claims (except Medicaid) data to WHIO for the CONTRACTOR'S commercial and Medicare lives residing in Wisconsin at a minimum. Claims shall be submitted to WHIO in a manner compliant with WHIO requirements.

The CONTRACTOR agrees to assign ID numbers according to the system established by the DEPARTMENT. Social security numbers shall be incorporated into the PARTICIPANT'S data file

and may be used for identification purposes only and not disclosed and used for any other purpose.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with external review in accordance with applicable federal or state law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections [160I](#), [245E](#), and [245F](#).

Any dispute about BENEFITS or claims arising under this AGREEMENT shall first be submitted for resolution through the CONTRACTOR'S and/or PBM'S (if applicable) internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT for administrative review.

Grievances regarding non-covered services or services excluded from coverage by the HEALTH BENEFIT PROGRAM shall be handled like any other grievance. Written inquiries received by the CONTRACTOR not related to BENEFITS determinations shall be resolved by the CONTRACTOR within ten (10) BUSINESS DAYS following the CONTRACTOR'S receipt of the inquiry.

If any PARTICIPANT has a problem or complaint relating to a determination of BENEFITS, he/she should contact the CONTRACTOR. The CONTRACTOR shall assist the PARTICIPANT in trying to resolve the matter on an informal basis, and may initiate a claim review of the BENEFITS determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a formal grievance. A claim review is not a substitute for a grievance.

The following provides an overview of the steps in the PARTICIPANT grievance process. Details are provided in Sections 245A – H.

- 1) Claim review (optional for PARTICIPANT);
- 2) PARTICIPANT notice;
- 3) Investigation and resolution;
- 4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,
- 5) Federal external review (not all grievances eligible).

245B Claim Review

The CONTRACTOR shall perform a claim review when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, the CONTRACTOR shall notify the PARTICIPANT of the decision. If the decision is to uphold the denial of BENEFITS, the PARTICIPANT shall receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a grievance.

245C Participant Notice

The CONTRACTOR must provide the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar days to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based.

245D Investigation and Resolution Requirements

Investigation of any grievance will be initiated by the CONTRACTOR within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within three (3) DAYS of the CONTRACTOR'S receipt of the grievance.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an external review in accordance with applicable federal or state law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific UNIFORM BENEFITS contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.

In the event the PARTICIPANT disagrees with the grievance committee's final decision, they may submit a written request for review to the DEPARTMENT within sixty (60) calendar DAYS of the date of the final grievance decision letter. The DEPARTMENT will review and communicate the outcome of the review to the PARTICIPANT. In the event that the PARTICIPANT disagrees with the outcome, they may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within sixty (60) calendar DAYS of the date of the DEPARTMENT'S final review letter.

The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by [Wis. Stat. § 40.03 \(6\) \(i\)](#) and [Wis. Adm. Code ETF 11.01 \(3\)](#). However, the DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate that can be resolved through the external review process under applicable federal or state law.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by [Wis. Stat. § 40.03 \(6\) \(i\)](#) and [Wis. Adm. Code ETF 11.01 \(3\)](#). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S

request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by [Wis. Stat. § 40.08 \(12\)](#) and [Wis. Adm. Code ETF 11.15](#).

245F External Review

The PARTICIPANT shall have the option to request an external review subject to applicable federal or state law. In accordance with federal or state law, any decision by an Internal Review Organization (IRO) is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the external review decision is rendered.

Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR must notify the DEPARTMENT of the outcome.

The CONTRACTOR shall not be in breach of this AGREEMENT solely because the external reviewer does not comply with the timeframes set forth in the statutes or regulations.

245G Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a CONTRACTOR shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the CONTRACTOR shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolve disputes or to formulate determinations. Such information must be provided at no charge within fifteen (15) BUSINESS DAYS, or by an earlier date as requested by the DEPARTMENT.

245H Department Request for Grievance

The DEPARTMENT may require the CONTRACTOR to treat and process a complaint received by the DEPARTMENT as a grievance and the DEPARTMENT will forward the complaint to the CONTRACTOR on behalf of the PARTICIPANT. The CONTRACTOR shall process the complaint as a grievance in compliance with the HEALTH BENEFIT PROGRAM'S provisions regarding a formal grievance.

245I Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. This requirement does not extend to cases of subrogation.

245J Penalty for Noncompliance

If a departmental determination overturns a CONTRACTOR'S decision on a PARTICIPANT'S grievance, the CONTRACTOR shall comply with the determination within ninety (90) calendar DAYS of the date of the determination. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within ninety (90) calendar DAYS.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see [Section 260D](#).

If the ANNUITANT or CONTINUANT contacts the CONTRACTOR directly to cancel coverage, the CONTRACTOR is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. The applicable portion of PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt.

The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see [Section 125E](#).

260 Continuation

260A Right to Continue Coverage

A PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue group coverage as required by state and federal law. Application must be postmarked within sixty (60) calendar DAYS of the date the PARTICIPANT is notified of the right to continue or sixty (60) calendar DAYS from the date coverage ceases, whichever is later. The CONTRACTOR shall bill the continuing PARTICIPANT directly for the required PREMIUM.

260B Subscriber Nonpayment of Premiums

A PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of thirty-six (36) months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later, except in the following circumstances:

- 1) When coverage is canceled,
- 2) PREMIUMS are not paid when due, or
- 3) Coverage is terminated as permitted by state or federal law.

The CONTRACTOR shall bill the CONTINUANT directly for required PREMIUMS.

As required by federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the CONTRACTOR'S requirement for the amount due. However, the CONTRACTOR may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. A reasonable time period is considered thirty (30) calendar DAYS after the notice is given.

The CONTRACTOR must notify the DEPARTMENT within one (1) month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the CONTRACTOR are limited to one (1) month following the termination date.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in [Wis. Stat. § 632.897](#), and/or a Marketplace plan, in the event of termination of employment.

260D Surviving Dependents

As required by [Wis. Adm. Code ETF 40.01](#), the surviving covered DEPENDENT of a covered EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously covered under a contract of a deceased EMPLOYEE or ANNUITANT, or a child of the EMPLOYEE or ANNUITANT who is in the process of being adopted by the deceased EMPLOYEE or ANNUITANT, or born within nine (9) months after the death of the EMPLOYEE or ANNUITANT, will be eligible for coverage under the survivor's contract until such time that they are no longer eligible.

Coverage under this section shall be effective on the first DAY of the calendar month following the date of death of the covered EMPLOYEE or ANNUITANT, and shall remain in effect until such time as the DEPENDENT coverage would normally cease had the death not occurred.

PREMIUMS shall be paid:

- 1) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then

- 2) Directly to the CONTRACTOR.

265 Miscellaneous Program Requirements

265A Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

- 1) Manage the entire range of services specified in the CONTRACT;
- 2) Respond to DEPARTMENT requests and inquiries;
- 3) Provide daily operational support;
- 4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,
- 5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the HEALTH BENEFIT PROGRAM. Meetings may be in person or by teleconference/webinar, as determined by the DEPARTMENT.

The CONTRACTOR must not modify any of the services or program content provided as part of this CONTRACT without prior written approval by the DEPARTMENT Program Manager.

The CONTRACTOR shall achieve a ninety-five percent (95%) satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265B Customer Service

The CONTRACTOR shall operate a customer service department for the HEALTH BENEFIT PROGRAM between 7:30 a.m. and 6:00 p.m., CST/CDT Monday through Thursday and 7:30 a.m. to 5:00 p.m. CST/CDT on Friday at a minimum, except for legal holidays. PARTICIPANTS must also be able to submit questions using e-mail and/or via a website. The call center must be equipped with Telephone Device for the Deaf (TDD) in order to serve the hearing impaired population. Calls and correspondence to customer services representatives shall be tracked, recorded, and retrieved when necessary by name or the DEPARTMENT'S eight (8)-digit member ID.

The CONTRACTOR must have a dedicated toll free number for the HEALTH BENEFIT PROGRAM and have customer service staff who are sufficiently trained to respond appropriately to PARTICIPANT inquiries, correspondence, complaints, and issues. The dedicated toll free number must not have more than two (2) menu prompts to reach a live person.

The CONTRACTOR shall notify the DEPARTMENT Program Manager of any disruption in customer service availability or toll-free access regardless of reason for disruption, within one (1) hour of realization that a problem exists.

The CONTRACTOR must monitor and report to the DEPARTMENT the performance standards for the HEALTH BENEFIT PROGRAM that include call answer timeliness and call abandonment rate. Targets for the customer service performance standards and associated penalties are specified in [Section 315C](#) and are based on the dedicated toll free number for the HEALTH BENEFIT PROGRAM.

The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and email and/or website. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls shall be indexed and properly recorded to allow for reporting and analysis based on a distinct transaction. On a monthly basis, the CONTRACTOR must submit a report by month for a rolling twelve (12) month period showing the volume and type of inquiry with a break-down by topic. The report must include a comparison to the same month of the previous calendar year and illustrate trends.

The system must track and log the following detail:

- 1) The PARTICIPANTS identifying information;
- 2) The date and time the inquiry was received;
- 3) The reason for the inquiry (including a reason code using a coding scheme);
- 4) The origin of the transaction (e.g., inbound call, the DEPARTMENT, EMPLOYER group);
- 5) The representative that handled the inquiry;
- 6) For phone inquiries, the length of call; and,
- 7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five percent (5%) each year

of all PARTICIPANT inquiries made by each submission type (e.g. phone, email, website) must be audited (e.g. by lead worker, supervisor, manager, auditor, etc.) to ensure accurate information was given to PARTICIPANTS and appropriate coaching and training is given to customer service representatives who failed to accurately respond to PARTICIPANTS. At the DEPARTMENT'S request, the CONTRACTOR must provide the audit results.

The CONTRACTOR must respond directly to PARTICIPANTS upon the DEPARTMENT'S request. For matters designated as urgent by the DEPARTMENT, the CONTRACTOR must contact the PARTICIPANT within one (1) BUSINESS DAY of receiving a request from the DEPARTMENT and actively communicate to the DEPARTMENT'S Program Manager or designee on issue resolution status until the issue is resolved.

265C Contractor Web Content and Web-Portal

The CONTRACTOR must provide dedicated web content (that may be via a microsite that meets all criteria below) and a web-portal as part of the AGREEMENT. Web content will provide basic program information. The web-portal will be used to present and track PARTICIPANT level information, such as claim status and BENEFIT accumulation.

- 1) The CONTRACTOR must host and maintain customized web pages and a web-portal dedicated to PARTICIPANTS of the HEALTH BENEFIT PROGRAM.
 - a) The CONTRACTOR must submit the web content and web-portal design for review as directed by the DEPARTMENT.
 - b) The DEPARTMENT must approve the content prior to publishing.
 - c) The web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market which include the Microsoft's products Internet Explorer and Edge, Mozilla Firefox, Chrome and Safari. Ongoing adoption and support of future browser versions and other browsers that gain significant market share is required.
 - d) The web-portal must be simple, intuitive and easy to use and navigate.
 - e) The web-portal must be able to render effectively on any form factor for mobile devices which include smartphones and tablets.
 - f) The website and web-portal must have mobile capabilities. At a minimum the mobile capabilities must allow the PARTICIPANT to access program information.
 - g) The website must ensure response time averaging two (2) seconds or better, and never more than three (3) second response time, from the time the CONTRACTOR receives the request to the time the response is sent, for all on-line activities. Response time is defined as the amount of time between pressing the "return" or "enter" key or depressing a mouse button and receiving a data-driven response on the screen, i.e., not just a message or indicator that a response is forthcoming.

- h) The solution must use SSL/TLS for end-to-end encryption for all connections between the user devices and the portal with the use of browsers or smartphone applications (apps).
 - i) The portal must be SECURED with a minimum of SHA2-256 (or similar system such as SHA-256 as approved by the DEPARTMENT) bit EV certificates to provide the latest in encryption and cryptography.
 - j) The portal must disable SSL/TLS negotiations which are using non-SECURE protocols and weak ciphers.
 - k) The CONTRACTOR must provide the DEPARTMENT reports on the current security safeguards enabled for the website and web-portal, upon the DEPARTMENT'S request.
 - l) After the initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website and web-portal test environment for the DEPARTMENT'S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website and web-portal. No less than two (2) weeks prior to the annual launch dates for each, the CONTRACTOR must have final content and functionality completed, as determined by the DEPARTMENT.
 - m) Prior to any launch of the CONTRACTOR website or web-portal, the CONTRACTOR must test the accessibility of the website and web-portal on multiple web browsers and from multiple internet carriers to ensure system capability.
 - n) The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website content for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period. The DEPARTMENT will annually communicate the due date for this submission. Upon DEPARTMENT approval, the updated website content is launched at least two (2) weeks prior to the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.
 - o) The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links from the website or web-portal to an external (governmental and non-governmental) website/portal or webpage.
 - p) The CONTRACTOR will notify the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation.
- 2) Basic information must be available on the CONTRACTOR'S website without requiring log in credentials, including:
- a) General information about the HEALTH BENEFIT PROGRAM and other programs offered by the BOARD;
 - b) Directions on how to access the HEALTH BENEFIT PROGRAM provider directory and Summary of Benefits and Coverage (SBC);

- c) Information about PARTICIPANT requirements, including prior authorizations and referrals;
 - d) Ability for PARTICIPANTS to submit questions via the website; and,
 - e) Contact information including the dedicated toll-free customer service phone number, business hours, 24-hour nurse line, and mailing address.
- 3) To ensure accessibility among persons with a disability, the CONTRACTOR'S website must comply with Section 508 of the Rehabilitation Act of 1973 (29 USC Section 794d) and implementing regulations at 36 CFR 1194 Subparts A-D. The website must also and conform to W3C's Web Content Accessibility Guidelines (WCAG) 2.0 (see <http://www.w3.org/TR/WCAG20/>).
- 4) The website must be hosted in a SECURE data center with system monitoring, managed firewall services and managed backup services within the United States and available twenty-four (24) hours a DAY, seven (7) DAYS a week, except for regularly scheduled maintenance.

The data center network shall include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of midnight and 5:00 a.m. CST/CDT or another time agreed to by the DEPARTMENT Program Manager, and must be scheduled in advance with a notification on the program website/portal. Unscheduled disruption to the availability of the website or web-portal must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

The CONTRACTOR must have a regular patch management process defined for the infrastructure. The CONTRACTOR must have a defined maintenance time window for system patches, software upgrades. Outages in the system must be communicated through the web-portal or via alerts.

- 5) The CONTRACTOR must be able to link user profiles and site access permissions to the daily enrollment file provided by the DEPARTMENT and make updates based on current enrollment within three (3) BUSINESS DAYS of data receipt. The CONTRACTOR may utilize another process for validation if the process is pre-approved by the DEPARTMENT.
- 6) The CONTRACTOR must have web-portal content and functionality updated, tested and approved by the DEPARTMENT Program Manager or designee at least fourteen (14) calendar DAYS prior to the benefit period start date. The web-portal will securely authenticate the user. After the user is authenticated, all web-portal features must be available without the need for an additional login. Available features must include:
- a) User name and password creation and recovery;

- b) Enrollment confirmation;
- c) Secure upload functionality for submitting program required documentation;
- d) Communication functions that allow users to submit SECURE questions to the CONTRACTOR and allow the CONTRACTOR to push general and targeted communications to users via USPS, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT; and,
- e) Incentive payment status, if applicable (e.g., pending, issued, etc.).

265D Patient Rights and Responsibilities

The CONTRACTOR shall comply with and abide by the Patient's Rights and Responsibilities as provided in the DEPARTMENT'S It's Your Choice materials. CONTRACTORS that have their own Patient's Rights and Responsibilities may use them unless there is a conflict. In this case the Patient's Rights and Responsibilities which are more favorable to the PARTICIPANT will apply.

265E Errors

Clerical errors made by the EMPLOYER, the DEPARTMENT or the CONTRACTOR shall not invalidate BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated, nor create eligibility for any BENEFITS where none otherwise existed under the HEALTH BENEFIT PROGRAM.

Retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six (6) months of PREMIUMS paid, except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare.

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 (6) months and in accordance with UNIFORM BENEFITS.

No retroactive PREMIUM refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation.

Subscriber Errors

In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP that is not IN-NETWORK with the selected CONTRACTOR, the CONTRACTOR shall notify the SUBSCRIBER within five (5) BUSINESS DAYS of the DEPARTMENT'S transmission of the enrollment data, and aid him/her in selecting an IN-NETWORK PCP. If the SUBSCRIBER is not responsive to the CONTRACTOR'S efforts, the CONTRACTOR will assign a PCP, notify the PARTICIPANT in writing and provide instructions for changing the assigned PCP.

If the CONTRACTOR offers more than one (1) network to PARTICIPANTS and the networks change on January 1st, a SUBSCRIBER who failed to make an election during the IT'S YOUR CHOICE OPEN ENROLLMENT period to change networks in order to maintain access to his or

her current providers may change to the appropriate network during the next IT'S YOUR CHOICE OPEN ENROLLMENT period or other enrollment opportunity as specified in this AGREEMENT.

Contractor / Provider / Subcontractor Errors

If the CONTRACTOR or its provider or subcontractor sends erroneous or misleading information to PARTICIPANTS, the DEPARTMENT may require the CONTRACTOR to send a corrected mailing at the cost of the CONTRACTOR to inform PARTICIPANTS.

265F Examination of Records

The DEPARTMENT, or its designee, shall have the right to examine any records of the CONTRACTOR relating to the HEALTH BENEFIT PROGRAM in compliance with [Wis. Stat. § 40.07](#) and any applicable federal or other state laws and rules. The information shall be furnished within ten (10) BUSINESS DAYS of the request or as directed by the DEPARTMENT. All such information is the sole property of the DEPARTMENT.

Upon a showing satisfactory to the BOARD that the CONTRACTOR is required by law to maintain a copy of such information, the DEPARTMENT and the CONTRACTOR shall agree to terms, conditions and provisions permitting the CONTRACTOR to maintain information to the minimum extent and for the minimum time required by law. Any such agreement shall require the CONTRACTOR to:

- 1) Keep confidential and properly safeguard each "medical record" and all "personal information", as those terms are respectively defined in [Wis. Admin. Code ETF 10.01 \(3m\)](#) and [ETF 10.70 \(1\)](#), that are included in such information;
- 2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,
- 3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate [Wis. Stat. § 40.07 \(1\) or \(2\)](#), respectively, if the disclosure was made by the DEPARTMENT.

265G Record Retention

The CONTRACTOR agrees that the BOARD, until the expiration of seven (7) years after the termination of this AGREEMENT, and any extensions, shall have access to and the right to examine any of the CONTRACTOR'S pertinent books, financial records, documents, papers, and records and those of any parent, affiliate, or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the CONTRACTOR involving transactions related to this AGREEMENT.

Any records that relate to: (1) litigation or settlement of claims arising out of the performance of this AGREEMENT; or (2) costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions, must be retained for seven (7) years after the conclusion of the litigation, regardless of the termination date of the contract.

The CONTRACTOR further agrees that the substance of this clause shall be inserted in any subcontract that the CONTRACTOR enters into with any subcontractor to carry out any of the CONTRACTOR'S obligations under this AGREEMENT.

265H Disaster Recovery and Business Continuity

The CONTRACTOR shall ensure that critical PARTICIPANT, provider and other web accessible and/or telephone-based functionality and information, including the website, are available to the applicable system users, except during periods of scheduled system unavailability agreed upon by the DEPARTMENT and the CONTRACTOR. Unavailability caused by events outside of the CONTRACTOR'S span of control is outside of the scope of this requirement. Any scheduled maintenance shall be scheduled in advance with notification on the PARTICIPANT website and web-portal.

265I Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

Local governments seeking to participate in the HEALTH BENEFIT PROGRAM are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the CONTRACTOR and DEPARTMENT'S pharmacy benefit manager. Also see [Section 155M](#).

265J Gifts and/or Kickbacks Prohibited

No gifts from the CONTRACTOR or any of the CONTRACTOR'S subcontractors are permissible to any EMPLOYEES whose work relates to the HEALTH BENEFIT PROGRAM, or members of the BOARD. Neither the CONTRACTOR nor any of its subcontractors shall request or receive kickbacks.

265K Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten percent (10%) interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book of business.

Report	Description	Frequency
1) Direct Pay Terminations Report	The CONTRACTOR provides written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. (See Sections 255 and 260B.)	See description
2) Claims Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. (See Section 150A, 5, a. and 150B.)	Monthly
3) Customer Service Inquiry Report	The CONTRACTOR must submit a report by month for a rolling twelve (12) month period showing the volume and type of inquiry with a break-down by topic. The report must include a comparison to the same month of the previous calendar year and illustrate trends. (See Section 265B.)	Monthly
4) Provider Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document, the specified data for all IN-NETWORK providers including subcontracted providers, and any OUT-OF-NETWORK providers for which the CONTRACTOR has processed or expects to process claims. (See Section 150A, 5, b and 150B.)	Monthly
5) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. (See Section 155F, 2.)	Quarterly
6) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand (\$200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. (See Section 155D.)	Quarterly

Report	Description	Frequency
7) OUT-OF-NETWORK Claims	The CONTRACTOR submits to the DEPARTMENT a report of all claims paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT. (See Section 220C.)	Quarterly
8) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
9) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives. Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The current DEPARTMENT Initiatives are: Care Coordination, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. (See Section 215B.)	Semi-annually
10) Pilot Programs and Initiatives	The CONTRACTOR reports to the DEPARTMENT any initiatives and pilot programs offered by the CONTRACTOR or the CONTRACTOR'S IN-NETWORK providers, including information on patient engagement and outcomes. (See Section 225, 5.)	Semi-annually
11) Taxable Income Report for PARTICIPANT Incentive Payments	The CONTRACTOR reports, as directed by the DEPARTMENT, all incentive payments issued to PARTICIPANTS for DEPARTMENT distribution to EMPLOYER payroll centers for tax reporting purposes. (See Section 220L, 6.)	Semi-annually
12) Business Recovery Plan and Simulation Report	The CONTRACTOR submits to the DEPARTMENT a business recovery plan that is documented and tested annually, at a minimum. (See Section 145, 5.)	Annually
13) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. (See Section 225, 3, b.)	Annually
14) Coordination of Benefits (COB) Report	The CONTRACTOR collects from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and reports this information to the DEPARTMENT at least annually. (See Section 205F.)	Annually
15) Disabled Adult Children Eligibility Verification Report	The CONTRACTOR reports to the DEPARTMENT results from its process to verify the eligibility of adult disabled children age twenty-six (26) or older, which includes checking that the: <ul style="list-style-type: none"> • Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year; and, • Support and maintenance requirement is met; and, • Child is not married. (See Section 205D.)	Annually
16) Financial and Utilization Data Submission (formerly Addendum 1)	The CONTRACTOR submits to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. (See Section 115, 10 and 130B.)	Annually

Report	Description	Frequency
17) Financial Stability Documentation	The CONTRACTOR submits financial stability documentation, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public account in accordance with generally accepted accounting principles). (See Section 155E.)	Annually
18) Grievance Summary Report	The CONTRACTOR retains records of grievances and submits an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. (See Section 115, 9, c.)	Annually
19) Group Experience / Utilization Report	The CONTRACTOR reports annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors, demonstrating support for technology and automation in the format as determined by the DEPARTMENT. The CONTRACTOR also includes details on the HEALTH BENEFIT PROGRAM'S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR 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 the DEPARTMENT. (See Section 215A.)	Annually
20) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results for the previous calendar year for its commercial membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. (See Section 225, 3, a.)	Annually
21) MAR Certification	The CONTRACTOR submits a MAR Certification. (See Section 155E.)	Annually
22) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually
23) SOC 1, Type 2 Audit Report	The CONTRACTOR agrees to a SOC 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the SSAE 18 and provides a copy of the CPA's report to the DEPARTMENT. (See Section 155E.)	Annually

310 Deliverables

As required by the CONTRACT, the CONTRACTOR must provide deliverables specified in the sections below.

310A Deliverables to the Department

Instructions on submitting the deliverable and specific due dates will be provided by the DEPARTMENT annually.

Deliverable	Description	Frequency
1) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. (See Section 205B , 2.)	Upon identification of issue
2) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. (See Section 205B , 2.)	January
3) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. (See Section 265A .)	April August
4) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. (See Section 230A .)	June
5) Premium Rate Bid	The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The BOARD will require each CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant along with supporting documentation deemed necessary by the BOARD's consulting actuary. (See Section 130B .)	June - July
6) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: <ul style="list-style-type: none"> • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. (See Section 140B , 2.)	July
7) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. (See Section 140B , 3.)	July

Deliverable	Description	Frequency
8) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. (See Section 140B, 4.)	September
9) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. (See Section 140B, 1.)	September
10) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. (See Section 140B, 1.)	October
11) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. (See Section 150A, 4, b.)	As directed by the DEPARTMENT
12) Enrollment Reconciliation Report Full File Compare (FFC)	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. (See Section 150A, 4, b.)	As directed by the DEPARTMENT
13) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. (See Sections 265C, 1a and 1p.)	As directed by the DEPARTMENT
14) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred eighty (180) DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM. (See Section 145, 8.)	As needed
15) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. (See Section 265A.)	As needed
16) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. (See Section 245I.)	As needed

Deliverable	Description	Frequency
17) Notification of Privacy Breach	The CONTRACTOR notifies the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 , HIPAA, and GINA. (See Section 155G.)	As needed
18) Notification of Significant Events	The CONTRACTOR provides notification of all significant events as described in Section 115 , 14.	As needed
19) External Review Determination	Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR notifies the DEPARTMENT of the outcome. (See Section 245F.)	See description
20) Medicare Enrollment Denial	The CONTRACTOR notifies the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare. (See Section 220G.)	See description
21) Transition Plan	The CONTRACTOR provides a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT. (See Section 155J.)	Upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. (See Section 205B.)	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards

Deliverable	Description	Frequency
2) PARTICIPANT Enrollment Information	<p>The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment:</p> <ul style="list-style-type: none"> • Information about PARTICIPANT requirements, including prior authorizations and referrals. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website and directions on how to request a printed copy of the provider directory. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. <p>(See Section 205C.)</p>	Upon enrollment
3) SUBSCRIBER Notification of Changes	<p>The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. (See Section 140B, 1.)</p>	September
4) PARTICIPANT Notification of Terminated Provider Agreement	<p>At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information:</p> <ul style="list-style-type: none"> • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. <p>(See Section 230C.)</p>	See description
5) PARTICIPANT Notification of Grievance Rights	<p>The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. (See Section 245C.)</p>	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	<p>In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an external review in accordance with applicable federal or state law, using the language approved by the DEPARTMENT. (See Section 245E.)</p>	See description

Deliverable	Description	Frequency
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897 , and/or a Marketplace plan, in the event of termination of employment. (See Section 260C.)	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. (See Section 210.)	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. (See Section 205C.)	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. (See Section 205C.)	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in [Section 150B](#) and [Section 315](#) shall not exceed three percent (3%) of the CONTRACTOR'S total medical premium in any given quarter. Performance standards will be measured by the DEPARTMENT on a QUARTERLY basis. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

315A Account Management

Performance Standards	Penalties
<p>1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five percent (95%) satisfaction or better (defined as “top two-box” satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). (See Section 265A.)</p>	<p>Ten thousand (\$10,000) dollars for each percentage point for which the standard is not met, per survey</p>
<p>2) Approval of Communications: All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. (See Sections 140A, 1 and 265C, 1.)</p>	<p>Five thousand (\$5,000) dollars per incident</p>

315B Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards.

Performance Standards	Penalties
<p>1) Processing Accuracy: At least ninety-seven percent (97%) level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. (See Section 235.)</p>	<p>Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each month</p>
<p>2) Claims Processing Time: At least ninety-five percent (95%) of all claims received must be processed within thirty (30) DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. (See Section 235.)</p>	

315C Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards.

Performance Standards	Penalties
<p>1) Call Answer Timeliness: At least eighty percent (80%) of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. (See Section 265B.)</p>	<p>Five thousand (\$5,000) dollars for each percentage point for which the standard is not met in each month)</p>
<p>2) Call Abandonment Rate: Less than three percent (3%) of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. (See Section 265B.)</p>	
<p>3) Open Call Resolution Turn-Around-Time: At least ninety percent (90%) of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. (See Section 265B.)</p>	
<p>4) Electronic Written Inquiry Response: At least ninety-eight percent (98%) of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. (See Section 265B.)</p>	

315D Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided.

Performance Standards	Penalties
<p>1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. (See Section 150A, 5, a and 150B.)</p>	<p>One thousand (\$1,000) dollars per DAY for which the standard is not met</p>
<p>2) Provider Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document, the specified data for all IN-NETWORK providers including subcontracted providers, and any OUT-OF-NETWORK providers for which the CONTRACTOR has processed or expects to process claims. (See Section 150A, 5, b and 150B.)</p>	

Performance Standards	Penalties
<p>3) Data File Corrections: Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT. (See Sections 150A, 5, a and b.)</p>	<p>One thousand (\$1,000) dollars per DAY for which the standard is not met</p>
<p>4) Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. (See Section 155G.)</p>	

315E Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met.

Performance Standards	Penalties
<p>1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. (See Section 150A, 4, a and c.)</p>	<p>One thousand (\$1,000) dollars per DAY for which the standard is not met</p>
<p>2) Enrollment Discrepancies and Exceptions: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT. (See Section 150A, 4, a. and b.)</p>	
<p>3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. (See Section 205B, 1.)</p>	
<p>4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. (See Section 205B, 2.)</p>	

Performance Standards	Penalties
<p>5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. (See Section 255.)</p>	<p>One thousand (\$1,000) dollars per DAY for which the standard is not met</p>

315F Other

Performance Standards	Penalties
<p>1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. (See Section 155E.)</p>	
<p>2) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. (See Section 145, 8.)</p>	<p>One thousand (\$1,000) dollars per DAY for which the standard is not met</p>
<p>3) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. (See Section 115, 19.)</p>	<p>Five thousand (\$5,000) dollars per incident</p>
<p>4) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must:</p> <ul style="list-style-type: none"> • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. <p>(See Section 155A, 2.)</p>	<p>Twenty-five hundred (\$2,500) dollars per report or deliverable for which the standard is not met</p>

400 UNIFORM BENEFITS

NOTE: Uniform Benefits are reviewed and updated annually. These Uniform Benefits will be updated with any benefit changes approved by the Group Insurance Board for 2018.

These are the Uniform Benefits or “Summary Plan Description” offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It’s Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under [Wis. Stat. § 40.02 \(25\) \(b\) 11](#), or any DEPENDENT of such an employee, and, if eligible, has acted under [Wis. Stat. § 40.51 \(10\)](#) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the HEALTH PLAN(S), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the 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 an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-POCKET LIMIT (OOPL).

Except as specifically stated for EMERGENCY and URGENT CARE (see Sections [III, A, 1](#) and [III, A, 2](#)), YOU do not have coverage for services from OUT-OF-NETWORK PROVIDERS unless YOU receive a PRIOR AUTHORIZATION from YOUR HEALTH PLAN before such services are obtained.

The covered benefits are subject to the following:

State of Wisconsin:

DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

State of Wisconsin			
Benefits	PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor ³	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP) ³
Annual Medical DEDUCTIBLE	<p>\$250 individual/\$500 family.</p> <p>DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL).</p> <p>The family DEDUCTIBLE is EMBEDDED.</p> <p>Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.</p>	None.	<p>\$1,500 per individual plan / \$3,000 per family plan</p> <p>DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL).</p> <p>The family DEDUCTIBLE is NON-EMBEDDED and applies to prescription drugs.</p> <p>Medical DEDUCTIBLE does not apply to preventive services*.</p>
Annual Medical COINSURANCE	<p>After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%.</p> <p>Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs.</p> <p>COINSURANCE applies OOPL except as described below.</p>	<p>BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.</p>	<p>After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%.</p> <p>Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs.</p> <p>COINSURANCE applies to OOPL except as described below.</p>
Annual medical OUT-OF-POCKET LIMIT (OOPL)	<p>\$1,250 individual / \$2,500 family limit except as described below.¹</p> <p>The OOPL is EMBEDDED.</p> <p>Does not apply to prescription drugs. See separate prescription drug benefits for details.</p>	<p>None except as described below for DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.¹</p>	<p>After DEDUCTIBLE: \$2,500 per individual plan / \$5,000 per family plan.</p> <p>The OOPL is NON-EMBEDDED.</p> <p>Applies to prescription drugs.</p>

State of Wisconsin			
Benefits	PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor ³	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP) ³
Annual MAXIMUM OUT-OF-POCKET (MOOP)	\$6,850 individual / \$13,700 family limit. The MOOP is EMBEDDED.	Not applicable.	Not applicable.
*Routine, Preventive Services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.
Primary Care Office Visit COPAYMENT applies to: <ul style="list-style-type: none"> • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives (if BENEFIT PLAN offers) • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy 	PARTICIPANT pays \$15 COPAYMENT per visit. DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays \$15 COPAYMENT per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: <ul style="list-style-type: none"> • Specialists • URGENT CARE 	PARTICIPANT pays \$25 COPAYMENT per visit. DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the OOPL, but not the DEDUCTIBLE.	No medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays \$25 COPAYMENT per visit.

State of Wisconsin			
Benefits	PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor ³	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP) ³
			COPAYMENT applies towards meeting the annual OOP.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOP).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOP).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays \$75 COPAYMENT (counts towards to OOP). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOP).	PARTICIPANT pays \$60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays \$75 COPAYMENT (counts towards OOP). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOP).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOP). ²	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOP per PARTICIPANT; no family limit). ²	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOP). ²
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOP). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOP or MOOP).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL CHARGES. MEDICARE/BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOP or MOOP).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOP). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOP).

State of Wisconsin			
Benefits	PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor ³	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP) ³
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).
Hearing Aids for PARTICIPANTS age 18 and older. One aid per ear no more than once every 3 years.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.
Hearing Aids for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: MEDICARE/BENEFIT PLAN pays 100%. Maximum BENEFIT PLAN payment of \$1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.

State of Wisconsin			
Benefits	PARTICIPANTS who do <u>not</u> have MEDICARE as the primary payor ³	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP) ³
Dental Implants	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.
Prescription Drugs	See below.	See below.	After medical DEDUCTIBLE above, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

¹ Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP.

²Federally required preventive services are covered at 100%.

³ State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime PARTICIPANTS Uniform Benefits SCHEDULE OF BENEFITS.

Local / Wisconsin Public Employers (WPE):

DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) <u>2/12</u> & those enrolled in <u>MEDICARE</u> and <u>PO6/16</u> or <u>PO7/17</u>	PARTICIPANTS enrolled in <u>PO6/16</u> who are not enrolled in <u>MEDICARE</u> ³	PARTICIPANTS enrolled in <u>PO4/14</u> including those enrolled in <u>MEDICARE</u>	PARTICIPANTS enrolled in <u>PO7/17</u> - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in <u>MEDICARE</u>³
Annual Medical DEDUCTIBLE	None.	\$250 individual / \$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). The family DEDUCTIBLE is EMBEDDED. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	\$500 individual / \$1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). The family DEDUCTIBLE is EMBEDDED. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	\$1,500 per individual plan / \$3,000 per family plan. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). The family DEDUCTIBLE is NON-EMBEDDED and applies to prescription drugs. Medical DEDUCTIBLE does not apply to preventive services*.
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE³	PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE³
		except as described below.		
Annual Medical OUT-OF-POCKET LIMIT (OOP)	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOP. ¹	\$1,250 individual / \$2,500 family limit except as described below. ¹ The OOP is EMBEDDED. Does not apply to prescription drugs. See separate prescription drug benefits for details.	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOP. ¹	After DEDUCTIBLE: \$2,500 per individual plan / \$5,000 per family plan. The OOP is NON-EMBEDDED. Applies to prescription drugs.
Annual MAXIMUM OUT OF POCKET (MOOP)	\$6,850 PARTICIPANT / \$13,700 family limit. The MOOP is EMBEDDED	\$6,850 PARTICIPANT / \$13,700 family limit. The MOOP is EMBEDDED	\$6,850 PARTICIPANT / \$13,700 family limit. The MOOP is EMBEDDED	Not applicable
*Routine, Preventive Services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) <u>2/12</u> & those enrolled in MEDICARE and <u>PO6/16</u> or <u>PO7/17</u>	PARTICIPANTS enrolled in <u>PO6/16</u> who are not enrolled in MEDICARE ³	PARTICIPANTS enrolled in <u>PO4/14</u> including those enrolled in MEDICARE	PARTICIPANTS enrolled in <u>PO7/17</u> - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE ³
Primary Care Office Visit COPAYMENT applies to: <ul style="list-style-type: none"> • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives (if BENEFIT PLAN offers) • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy 	BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays \$15 COPAYMENT per visit. DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOP, but not the DEDUCTIBLE.	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays \$15 COPAYMENT per visit. COPAYMENT applies towards meeting the annual OOP.
Specialist COPAYMENT applies to: <ul style="list-style-type: none"> • Specialists • URGENT CARE 	BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays \$25 COPAYMENT per visit. DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the OOP, but not the DEDUCTIBLE.	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays \$25 per visit. COPAYMENT applies towards meeting the annual OOP.

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) <u>2/12</u> & those enrolled in <u>MEDICARE</u> and <u>PO6/16</u> or <u>PO7/17</u>	PARTICIPANTS enrolled in <u>PO6/16</u> who are not enrolled in <u>MEDICARE</u> ³	PARTICIPANTS enrolled in <u>PO4/14</u> including those enrolled in <u>MEDICARE</u>	PARTICIPANTS enrolled in <u>PO7/17</u> - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in <u>MEDICARE</u>³
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS .	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE : BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	After DEDUCTIBLE : BENEFIT PLAN/MEDICARE pays 100%; no medical COPAYMENTS .	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE : BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays \$60 COPAYMENT .	PARTICIPANT pays \$75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE : BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays \$60 COPAYMENT . After COPAYMENT : DEDUCTIBLE applies.	After DEDUCTIBLE : PARTICIPANT pays \$75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/MEDICARE pays 80% (20% PARTICIPANT cost to \$500 OOPL per PARTICIPANT; no family limit. ²	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE : BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). ²	After DEDUCTIBLE : BENEFIT PLAN/MEDICARE pays 80% (20% PARTICIPANT cost to \$500 OOPL per PARTICIPANT; no family limit. ²	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE : BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). ²

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) <u>2/12</u> & those enrolled in MEDICARE and <u>PO6/16</u> or <u>PO7/17</u>	PARTICIPANTS enrolled in <u>PO6/16</u> who are not enrolled in MEDICARE ³	PARTICIPANTS enrolled in <u>PO4/14</u> including those enrolled in MEDICARE	PARTICIPANTS enrolled in <u>PO7/17</u> - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE ³
Cochlear Implants for PARTICIPANTS age 18 and older	BENEFIT PLAN/MEDICARE pays 100% HOSPITAL CHARGES. BENEFIT PLAN/MEDICARE pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100% HOSPITAL CHARGES. BENEFIT PLAN/MEDICARE pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16) , BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Local / Wisconsin Public Employers (WPE)

Benefits	PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE³	PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE³
Hearing Aids for PARTICIPANTS age 18 and older. One aid per ear no more than once every 3 years.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,000 per hearing aid.
Hearing Aids for PARTICIPANTS under age 18	As required by Wis. Stat. § 632.895 (16) , BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16) , BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16) , BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16) , BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	BENEFIT PLAN/MEDICARE pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN/MEDICARE pays 100%. Maximum BENEFIT PLAN payment of \$1,250 for diagnostic procedures and	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,250	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN/MEDICARE pays 100%. Maximum BENEFIT PLAN payment of \$1,250	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of \$1,250

Local / Wisconsin Public Employers (WPE)				
Benefits	PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE³	PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE³
	nonsurgical treatment per PARTICIPANT per calendar year.	for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of \$1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After medical DEDUCTIBLE above, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

¹ Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP.

² Federally required preventive services are covered at 100%.

³ Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2/12 Uniform Benefits SCHEDULE OF BENEFITS.

- 1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE
- 2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.
- 3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.
- 4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): 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.
- 5) 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 OOP. 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.
- 6) 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 OOP. 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.
- 7) 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.
- 8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the HEALTH PLAN.
- 9) Transplants: Limited to transplants listed in [Benefits and Services](#) Section.
- 10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.
- 11) 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.
- 12) 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.)
- 13) Oral Surgery: Limited to procedures listed in [Benefits and Services](#) Section.

14) 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.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in [Benefits and Services](#) Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

- a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.
- b) Preventive Prescription Drugs:
 - i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.
 - ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.
 - iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:

Level 1 COPAYMENT: \$5.00

The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:

Level 2 COINSURANCE: 20% (\$50 max)

The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% (\$150 max)

The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOP:

Level 1/Level 2 out-of-pocket costs accumulate toward OOPs as follows:

- a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): \$600 per individual or \$1,200 per family for all PARTICIPANTS.
- b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOP of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOP is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

Level 3 Annual OOP:

Level 3 out-of-pocket costs accumulate toward OOPs as follows:

- a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOP.
- b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOP of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOP is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS**Specialty Drug Cost Share:****Level 4 COPAYMENT: \$50**

The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% (\$200 max)

The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOP:

There is no OOP for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of \$6,850 individual / \$13,700 family.

The maximum annual amount YOU pay for YOUR Level 4 Preferred SPECIALTY MEDICATIONS.

Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPLs as follows:

- a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): \$1,200 per individual or \$2,400 per family.
- b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of \$2,500 for single coverage, or \$5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

- 3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE (\$200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.
- 4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.
- 5) **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.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description in [Section 400](#), are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

- 1) Understanding YOUR health care treatment options.
- 2) Clarifying YOUR health care goals.
- 3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.
- 4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.
- 5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

ALLOWED AMOUNT: Means the maximum amount on which payment is based for covered health care services. Generally this is composed of the PROVIDER'S CHARGE, less any discount negotiated by the HEALTH PLAN.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the HEALTH PLAN. The HEALTH PLAN considers, as part of determination of CHARGE:

- 1) Amounts charged for similar health care services in the same general area under comparable circumstances,
- 2) the HEALTH PLAN'S methodology guidelines,
- 3) pricing guidelines of any third party responsible for pricing a claim,

- 4) the negotiated rate determined between the HEALTH PLAN and an IN-NETWORK PROVIDER, and
- 5) other factors.

The term “area” means a county or other geographical area which the HEALTH PLAN determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the HEALTH PLAN determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent 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. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is \$1,500, YOUR BENEFIT 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 the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

- 1) Spouse.¹
- 2) Child.^{2, 3, 4}
- 3) Legal ward who becomes a permanent legal ward of the SUBSCRIBER or SUBSCRIBER'S spouse prior to age 19.^{2, 3, 4}
- 4) Adopted child when placed in the custody of the parent as provided by [Wis. Stat. § 632.896](#).^{2, 3, 4}
- 5) Stepchild.^{1, 2, 3, 4}
- 6) Grandchild if the parent is a DEPENDENT child.^{2, 3, 4, 5}

¹ 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.

² All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except when:

- 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. If the SUBSCRIBER should die, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The CONTRACTOR 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 CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR 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.

³ 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 acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

⁴ A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

⁵ A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DURABLE MEDICAL EQUIPMENT: See MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under [Wis. Stat. § 40.02 \(25\)](#) or [40.02 \(46\)](#) or [Wis. Stat. § 40.19 \(4\) \(a\)](#), of an employer as defined under [Wis. Stat. § 40.02 \(28\)](#). Employers, other than the State, must also have acted under [Wis. Stat. § 40.51 \(7\)](#), to make health care coverage available to its employees.

EMBEDDED: Means the individual portion of PARTICIPANT financial responsibility (DEDUCTIBLE, OOP, MOOP) within the family's total financial responsibility. For example, when a PARTICIPANT within a family plan meets the individual DEDUCTIBLE, that PARTICIPANT is no longer responsible for any further DEDUCTIBLE. The remaining family DEDUCTIBLE will still apply to other family PARTICIPANTS.

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

- 1) Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
- 2) Serious impairment to the PARTICIPANT'S bodily functions.
- 3) Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

Examples of EMERGENCIES are listed in [Section III, A, 1, d](#). EMERGENCY services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

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-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY 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 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: Means the health plan that is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOP set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

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) 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) 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 an IN-NETWORK 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.

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

IN-NETWORK 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.

LEVEL "M" DRUG: 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 but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

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

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the HEALTH PLAN:

- 1) Used primarily to treat an ILLNESS or INJURY, and
- 2) generally not useful to a person in the absence of an ILLNESS or INJURY, and
- 3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and
- 4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the HEALTH PLAN and/or PBM:

- 1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and
- 2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and
- 3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and
- 4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

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

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered 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 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-EMBEDDED: Means that families must meet the full family amount before benefits are paid.

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 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.

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.

MAXIMUM OUT-OF-POCKET LIMIT (MOOP): Means the most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care that YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: 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 providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the HEALTH PLAN unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOP): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit. The most YOU pay during a policy period (usually a calendar year) for benefits considered essential health benefits under federal law. This limit never includes YOUR premium, balance-billed charges, charges for health care YOUR BENEFIT PLAN does not cover, or services that are not considered essential health benefits.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: 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. 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.

PHARMACY BENEFIT MANAGER (PBM): The 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.

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 (PCP): Means an IN-NETWORK PROVIDER who is named as a PARTICIPANT'S primary health care contact. He/She provides entry into the health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

YOU must name YOUR PCP on YOUR enrollment application. Each family PARTICIPANT may have a different PCP.

PRIOR AUTHORIZATION: Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the HEALTH PLAN and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the HEALTH PLAN PRIOR AUTHORIZATION form and approved by the HEALTH PLAN in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each HEALTH PLAN and are described in the It's Your Choice materials. The authorization from the HEALTH PLAN will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the HEALTH PLAN before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED INJECTABLE: Means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.

SERVICE AREA: Specific zip codes in those counties in which the IN-NETWORK PROVIDERS are approved by the HEALTH PLAN to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a HEALTH PLAN or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The HEALTH PLAN or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is 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, 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 CARE.

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.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant 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 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 SERVICE

AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT 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 an OUT-OF-NETWORK 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 OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the HEALTH PLAN reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see [item A, 1](#) and [item A, 2](#) below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the HEALTH PLAN'S written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The HEALTH PLAN may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable HEALTH PLAN and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the HEALTH PLAN and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

- a) Medical care for an EMERGENCY, as defined in [Section II](#). Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.
- b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the HEALTH PLAN by the next business day or as soon as possible and tell the HEALTH PLAN where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.
- c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the HEALTH PLAN of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission

or as soon as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in [Section II](#). URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR HEALTH PLAN by the next business day or as soon as possible and tell the HEALTH PLAN where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN.

c) Some examples of URGENT CARE cases are:

- i) Most broken bones,
- ii) Minor cuts,
- iii) Sprains,
- iv) Most drug reactions,
- v) Non-severe bleeding, and
- vi) Minor burns.

3) Surgical Services

Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

- a) PREOPERATIVE and POSTOPERATIVE CARE, and
- b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under [item 16](#) of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the HEALTH PLAN for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the HEALTH PLAN or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives

The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the HEALTH PLAN may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

- a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.
- b) Elective sterilization.
- c) Contraceptives as required by [Wis. Stat. § 632.895 \(17\)](#), including, but not limited to:
 - i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit in [Section III, D](#).
 - ii) IUDs and diaphragms, as described under the DURABLE MEDICAL EQUIPMENT provision in [item C, 3](#).
 - iii) Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the PARTICIPANT is in her second or third trimester of pregnancy when the PROVIDER'S participation in the BENEFIT PLAN offered by the HEALTH PLAN terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the HEALTH PLAN may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services

MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR HEALTH PLAN).

- a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b) Well-baby care, including lead screening as required by [Wis. Stat. § 632.895 \(10\)](#), and childhood immunizations.

- c) Routine patient care administered in a cancer clinical trial as required by [Wis. Stat. § 632.87 \(6\)](#).
 - d) Colorectal cancer examinations and laboratory tests as required by [Wis. Stat. § 632.895 \(16m\)](#).
 - e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the HEALTH PLAN. It does not apply to travel required for work. (See [Exclusions, Section IV, A, 2, e.](#))
 - f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.
 - g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.
 - h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the HEALTH PLAN.
 - i) Preventive services as required by the federal Patient Protection and Affordable Care Act.
- 6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under [item B, 1, c](#) of this section.
- 7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.
- 8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.
- 9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the HEALTH PLAN) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the HEALTH PLAN'S SERVICE AREA, the HEALTH PLAN or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services

MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS 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 AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy

MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the HEALTH PLAN if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits

Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

- a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
- b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
- c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)
- d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.
- e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

- f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

- a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.
- b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.
- c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the HEALTH PLAN if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the HEALTH PLAN. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the HEALTH PLAN.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a HEALTH PLAN-approved or MEDICARE-certified HOSPICE CARE facility.

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

14) Phase II Cardiac Rehabilitation

Services must be approved by the HEALTH PLAN and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

- a) A heart attack (myocardial infarction),
- b) Coronary bypass surgery,
- c) Onset of angina pectoris,
- d) Heart valve surgery,
- e) Onset of decubital angina,
- f) Onset of unstable angina,
- g) Percutaneous transluminal angioplasty, or
- h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the HEALTH PLAN before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to \$1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the HEALTH PLAN prior to any oral surgery to determine if PRIOR AUTHORIZATION by the HEALTH PLAN is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

- a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

- b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
- c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)
- d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.
- e) Apicoectomy. (Excision of apex of tooth root.)
- f) Excision of exostoses of the jaws and hard palate.
- g) Intraoral and extraoral incision and drainage of cellulitis.
- h) Incision of accessory sinuses, salivary glands or ducts.
- i) Reduction of dislocations of, and excision of, the temporomandibular joints.
- j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.
- k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders

As required by [Wis. Stat. § 632.895 \(11\)](#), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

- a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.
- b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

- c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to \$1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the HEALTH PLAN in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

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

- a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
 - i) Aplastic anemia
 - ii) Acute leukemia
 - iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
 - iv) Wiskott-Aldrich syndrome
 - v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
 - vi) Hodgkins and non-Hodgkins lymphoma
 - vii) Combined immunodeficiency
 - viii) Chronic myelogenous leukemia
 - ix) Pediatric tumors based upon individual consideration
 - x) Neuroblastoma
 - xi) Myelodysplastic syndrome
 - xii) Homozygous Beta-Thalassemia

- xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
 - xiv) Multiple Myeloma, Stage II or Stage III
 - xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
- b) Parathyroid transplantation
 - c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.
 - d) Corneal transplantation (keratoplasty) limited to:
 - i) Corneal opacity
 - ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens
 - iii) Corneal ulcer
 - iv) Repair of severe lacerations
 - e) Heart transplants will be limited to the treatment of:
 - i) Congestive Cardiomyopathy
 - ii) End-Stage Ischemic Heart Disease
 - iii) Hypertrophic Cardiomyopathy
 - iv) Terminal Valvular Disease
 - v) CONGENITAL Heart Disease, based upon individual consideration
 - vi) Cardiac Tumors, based upon individual consideration
 - vii) Myocarditis
 - viii) Coronary Embolization
 - ix) Post-traumatic Aneurysm
 - f) Liver transplants will be limited to the treatment of:

- i) Extrahepatic Biliary Atresia
 - ii) Inborn Error of Metabolism
 - (1) Alpha -1- Antitrypsin Deficiency
 - (2) Wilson's Disease
 - (3) Glycogen Storage Disease
 - (4) Tyrosinemia
 - iii) Hemochromatosis
 - iv) Primary Biliary Cirrhosis
 - v) Hepatic Vein Thrombosis
 - vi) Sclerosing Cholangitis
 - vii) Post-necrotic Cirrhosis, Hbe Ag Negative
 - viii) Chronic Active Hepatitis, Hbe Ag Negative
 - ix) Alcoholic Cirrhosis, abstinence for six or more months
 - x) Epithelioid Hemangioepithelioma
 - xi) Poisoning
 - xii) Polycystic Disease
- g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the HEALTH PLAN.
- h) In addition to the above-listed diagnoses for covered transplants, the HEALTH PLAN may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the HEALTH PLAN determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.
- i) Kidney Transplants. See [item 19](#) below.

19) Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants in [Section III, A, 18](#)), donor-related services, and related physician CHARGES.

20) Chiropractic Services

When performed by an IN-NETWORK PROVIDER. Benefits are not available for MAINTENANCE CARE.

21) Women's Health and Cancer Act of 1998

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

- a) Reconstruction of the breast on which a mastectomy was performed,
- b) Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- c) Prosthesis (see DURABLE MEDICAL EQUIPMENT in [Section III, C, 3](#)) and physical complications of all stages of mastectomy, including lymphedemas,
- d) Breast implants.

22) Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the prescription drug benefits in [Section III, D, 1, e](#). Coverage also includes 1 office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require PRIOR AUTHORIZATION by the HEALTH PLAN.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The HEALTH PLAN may require that the hospitalization be PRIOR AUTHORIZED.

23) Inpatient Care

- a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the HEALTH PLAN.
- b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

- c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under [Wis. Stat. § 230.04 \(9r\) \(a\) 2.](#) a., b., and c.

24) Outpatient Care

EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

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 an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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](#) and the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

This benefit also includes services for a full-time student attending school in Wisconsin but out of the SERVICE AREA as required by [Wis. Stat. § 609.655](#).

b) Transitional Services

Covers MEDICALLY NECESSARY services provided by an IN-NETWORK 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](#) and as required by MHPAEA.

c) Inpatient Services

Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by [Wis. Stat. §632.89](#), [Wis. Adm. Code § INS 3.37](#) and MHPAEA. Covers court-ordered services for the mentally ill as required by [Wis. Stat. § 609.65](#). Such services are covered if performed by an OUT-OF-NETWORK 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 III, D, 1](#).

2) Durable Diabetic Equipment and Related Supplies

When prescribed by an IN-NETWORK PROVIDER for treatment of diabetes and purchased from an IN-NETWORK 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 OOP. Durable diabetic equipment includes:

- a) Automated injection devices.
- b) Continuing glucose monitoring devices.
- c) Insulin infusion pumps, limited to one pump in a calendar year and YOU must use the pump for 30 days before purchase.

All DURABLE MEDICAL EQUIPMENT purchases or monthly rentals must be PRIOR AUTHORIZED as determined by the HEALTH PLAN.

(Glucometers are available through the PBM. Refer to [Section III, D, 2](#) for benefit information.)

3) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT

When prescribed by an IN-NETWORK PROVIDER for treatment of a diagnosed ILLNESS or INJURY and purchased from an IN-NETWORK PROVIDER, MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**.

The following MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered only when PRIOR AUTHORIZED as determined by the HEALTH PLAN:

- a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.
- b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- c) Rental or, at the option of the HEALTH PLAN, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.
- d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

- e) IUDs and diaphragms.
- f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.
- g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.
- h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
- i) Ostomy and catheter supplies.
- j) Oxygen and respiratory equipment for home use when authorized by the HEALTH PLAN.
- k) Other medical equipment and supplies as approved by the HEALTH PLAN. Rental or purchase of equipment/supplies is at the option of the HEALTH PLAN.
- l) When PRIOR AUTHORIZED as determined by the HEALTH PLAN, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the HEALTH PLAN will consider whether:
 - i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or
 - ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students

If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

- a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and
- b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by [Wis. Stat. § 609.655](#). In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the HEALTH PLAN. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the HEALTH PLAN. Additional visits may be approved by the HEALTH PLAN. If the student

is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

- 5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by [Wis. Stat. §632.895 \(5\)](#) and [Wis. Adm. Code § INS 3.38 \(2\) \(d\)](#), if a DEPENDENT is continuously covered under any HEALTH PLAN under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.
- 6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by [Wis. Stat. §632.895 \(12m\)](#). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to \$50,000 per year for intensive-level and up to \$25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.

D. Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

If YOU do not show YOUR PBM identification card at the pharmacy at the time YOU are obtaining benefits, YOU may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the HEALTH PLAN.

1) Prescription Drugs

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPPL, all family PARTICIPANTS will have satisfied the annual OOPPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPPL for Level 1 and Level 2 Preferred prescription drugs.

The HEALTH PLAN, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTABLE).

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

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM ALLOWED AMOUNT. The ALLOWED AMOUNT is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted PROVIDER administers the injection. If the HEALTH PLAN or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

- a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.
- b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).
- c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.
- e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOP. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.
- f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.
- g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.
- h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTABLES and narcotics are among those for which a 90-day supply is not available.
- i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.
- j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.
- k) 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 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 include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The PARTICIPANT'S COINSURANCE will be applied to the annual OOP 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 OOP for prescription drugs are as follows:

a) Diaphragms

b) Syringes/Needles

c) Spacers/Peak Flow Meters

IV. Exclusions and Limitations

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under Uniform Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by HEALTH PLANS and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that [Subsection 10](#) applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be MEDICALLY NECESSARY, but still are not covered under this program, while others may be examples of services which are not MEDICALLY NECESSARY or not medical in nature, as determined by the HEALTH PLAN and/or PBM.

1) Surgical Services

- a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
- b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.
- c) Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

2) Medical Services

- a) Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the [Benefits and Services](#) Section.
- b) Expenses for medical reports, including preparation and presentation.
- c) Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by an IN-NETWORK PROVIDER to treat a metabolic or peripheral disease or a skin or tissue infection.
- d) Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include NUTRITIONAL COUNSELING as provided in the [Benefits and Services](#) Section.
- e) Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

- f) Services of a blood donor. MEDICALLY NECESSARY autologous blood donations are not considered to be services of a blood donor.
 - g) Genetic testing and/or genetic counseling services, unless MEDICALLY NECESSARY to diagnose or treat an existing ILLNESS.
- 3) Ambulance Services
- a) Ambulance service, except as outlined in the [Benefits and Services](#) Section, unless authorized by the HEALTH PLAN.
 - b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the [Benefits and Services](#) Section.
- 4) Therapies
- a) Vocational rehabilitation including work hardening programs.
 - b) Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under [Wis. Stat. § 632.895 \(12m\)](#) therapies.
 - c) Physical fitness or exercise programs.
 - d) Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.
 - e) Massage therapy.
- 5) Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental INJURY
- a) All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the [Benefits and Services](#) Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the [Benefits and Services](#) Section. (Note: Mandated TMJ benefits under [Wis. Stat. § 632.895 \(11\)](#) may limit this exclusion.)
 - b) All periodontic procedures, except gingivectomy surgery as listed in the [Benefits and Services](#) Section.
 - c) All oral surgical procedures not specifically listed in the [Benefits and Services](#) Section.

6) Transplants

- a) Transplants and all related services, except those listed as covered procedures.
- b) Services in connection with covered transplants unless PRIOR AUTHORIZED by the HEALTH PLAN.
- 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 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.
- 9) Durable Medical or Diabetic Equipment and Supplies
- a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the HEALTH PLAN.
 - b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the HEALTH PLAN.
 - c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.
 - d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the HEALTH PLAN.
 - e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the HEALTH PLAN. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.
 - f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.
 - g) Customization of buildings for accommodation (for example, wheelchair ramps).

- h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

- a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.
- b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.
- c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.
- d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).
- e) Anorexic agents.
- f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.
- g) All over-the-counter drug items, except those designated as covered by the PBM.
- h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- i) Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.
- j) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.
- k) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM'S Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l) Infertility and fertility medications.
- m) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.
- n) Charges to replace expired, spilled, stolen or lost prescription drugs.

11) General

- a) Any additional exclusion as described in the SCHEDULE OF BENEFITS.

- b) Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.
- c) Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.
- d) INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
- e) Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.
- f) Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the HEALTH PLAN and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.
- g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- h) Treatment, services or supplies used in educational or vocational training.
- i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j) MAINTENANCE CARE.
- k) Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).
- l) Personal comfort or convenience items or services such as in-HOSPITAL television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

- m) Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the BENEFIT PLAN.
- n) Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
- o) Expenses incurred prior to the EFFECTIVE DATE of coverage by the HEALTH PLAN and/or PBM, or services received after the HEALTH PLAN and/or PBM coverage or eligibility terminates. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under HEALTH PLANS during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding HEALTH PLAN will be the responsibility of the succeeding HEALTH PLAN unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding HEALTH PLAN'S network. In this instance, the liability will remain with the previous HEALTH PLAN.
- p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.
- q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.
- r) Charges for any missed appointment.
- s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by [Wis. Stat. § 632.895 \(9\)](#) and routine care administered in a cancer clinical trial as required by [Wis. Stat. § 632.87 \(6\)](#).
- t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

- u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:
 - i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the HEALTH PLAN.
 - ii. EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.
 - iii. EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the HEALTH PLAN.
- v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the HEALTH PLAN. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the HEALTH PLAN.
- w) Coma stimulation programs.
- x) Orthoptics (Eye exercise training) except for two sessions as MEDICALLY NECESSARY per lifetime. The first session for training, the second for follow-up.
- y) Any diet control program, treatment, or supply for weight reduction.
- z) Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.
- aa) Services to the extent a PARTICIPANT receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means YOU are actually insured under Worker's Compensation.
- ab) Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.
- ac) Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by an IN-NETWORK 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 HEALTH PLAN as part of this 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.
- 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.
- ai) Hypnotherapy.
- aj) Marriage/couples/family counseling.
- ak) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by [Wis. Stat. § 632.89](#) and [Wis. Admin Code § INS 3.37](#) and as required by the federal Mental Health Parity and Addiction Equity Act.
- al) Biofeedback.

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 OUT-OF-NETWORK 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 IN-NETWORK PROVIDERS.

- 4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must 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 OUT-OF-NETWORK 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, IN-NETWORK 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 OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.
- 6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.
- 7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which 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.

V. Coordination of Benefits and Services

A. Applicability

- 1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.
- 2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:
 - a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but
 - b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in [Section D](#) below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this [Section V](#), the following words are defined as follows:

ALLOWABLE EXPENSE: means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more PLANS covering the person for whom the claim is made. The difference between the cost of a private HOSPITAL room and the cost of a semi-private HOSPITAL room is not considered an ALLOWABLE EXPENSE unless the patient's stay in a private HOSPITAL room is MEDICALLY NECESSARY either in terms of generally accepted medical practice or as specifically defined by the PLAN. When a PLAN provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an ALLOWABLE EXPENSE and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the SECONDARY PLAN will also be responsible for paying up to the maximum benefit allowed for its PLAN. This will not duplicate benefits paid by the PRIMARY PLAN.

CLAIM DETERMINATION PERIOD: means a calendar year. However, it does not include any part of a year during which a person has no coverage under THIS PLAN or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN: means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

- 1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- 2) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does

not include any PLAN whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate PLAN. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate PLAN.

PRIMARY PLAN / SECONDARY PLAN: The order of benefit determination rules state whether THIS PLAN is a PRIMARY PLAN or SECONDARY PLAN as to another PLAN covering the person.

When THIS PLAN is a SECONDARY PLAN, its benefits are determined after those of the other PLAN and may be reduced because of the other PLAN'S benefits.

When THIS PLAN is a PRIMARY PLAN, its benefits are determined before those of the other PLAN and without considering the other PLAN'S benefits.

When there are more than two PLANS covering the person, THIS PLAN may be a PRIMARY PLAN as to one or more other PLANS and may be a SECONDARY PLAN as to a different PLAN or PLANS.

THIS PLAN: means the part of YOUR Summary Plan Description (group contract) that provides benefits for health care and pharmaceutical expenses.

C. Order of Benefit Determination Rules

1) General

When there is a basis for a claim under THIS PLAN and another PLAN, THIS PLAN is a SECONDARY PLAN that has its benefits determined after those of the other PLAN, unless:

- a) The other PLAN has rules coordinating its benefits with those of THIS PLAN, and
- b) Both those rules and THIS PLAN'S rules described in subparagraph 2 require that THIS PLAN'S benefits be determined before those of the other PLAN.

2) Rules

THIS PLAN determines its order of benefits using the first of the following rules which applies:

a) Non-Dependent/DEPENDENT

The benefits of the PLAN which covers the person as an employee or PARTICIPANT are determined before those of the PLAN which covers the person as a DEPENDENT of an employee or PARTICIPANT.

b) DEPENDENT Child/Parents Not Separated or Divorced

Except as stated in subparagraph 2, c below, when THIS PLAN and another PLAN cover the same child as a DEPENDENT of different persons, called "parents":

- i) The benefits of the PLAN of the parent whose birthday falls earlier in the calendar year are determined before those of the PLAN of the parent whose birthday falls later in that calendar year, but

- ii) If both parents have the same birthday, the benefits of the PLAN which covered the parent longer are determined before those of the PLAN which covered the other parent for a shorter period of time.

However, if the other PLAN does not have the rule described in i) above but instead has a rule based upon the gender of the parent, and if, as a result, the PLANS do not agree on the order of benefits, the rule in the other PLAN shall determine the order of benefits.

c) **DEPENDENT Child/Separated or Divorced Parents**

If two or more PLANS cover a person as a DEPENDENT child of divorced or separated parents, benefits for the child are determined in this order:

- i) First, the PLAN of the parent with custody of the child,
- ii) Then, the PLAN of the spouse of the parent with the custody of the child, and
- iii) Finally, the PLAN of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' PLANS have actual knowledge of those terms, benefits for the DEPENDENT child shall be determined according to C, 2, b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the PLAN of that parent has actual knowledge of those terms, the benefits of that PLAN are determined first. This paragraph does not apply with respect to any CLAIM DETERMINATION PERIOD or PLAN year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d) **Active/Inactive Employee**

The benefits of a PLAN which covers a person as an employee who is neither laid off nor retired or as that employee's DEPENDENT are determined before those of a PLAN which covers that person as a laid off or retired employee or as that employee's DEPENDENT. If the other PLAN does not have this rule and if, as a result, the PLANS do not agree on the order of benefits, this paragraph d is ignored.

e) **Continuation Coverage**

- i) If a person has continuation coverage under federal or state law and is also covered under another PLAN, the following shall determine the order of benefits:

- (1) First, the benefits of a PLAN covering the person as an employee, member, or SUBSCRIBER or as a DEPENDENT of an employee, member, or SUBSCRIBER.

(2) Second, the benefits under the continuation coverage.

ii) If the other PLAN does not have the rule described in subparagraph 1, and if, as a result, the PLANS do not agree on the order of benefits, this paragraph e is ignored.

f) Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the PLAN which covered an employee, member or SUBSCRIBER longer are determined before those of the PLAN which covered that person for the shorter time.

D. Effect on the Benefits of THIS PLAN

1) When This Section Applies

This section applies when, in accordance with [Section C](#), Order of Benefit Determination Rules, THIS PLAN is a SECONDARY PLAN as to one or more other PLANS. In that event, the benefits of THIS PLAN may be reduced under this section. Such other PLAN or PLANS are referred to as "the other PLANS" in subparagraph 2 below.

2) Reduction in THIS PLAN'S Benefits

The benefits of THIS PLAN will be reduced when the sum of the following exceeds the ALLOWABLE EXPENSES in a CLAIM DETERMINATION PERIOD:

a) The benefits that would be payable for the ALLOWABLE EXPENSES under THIS PLAN in the absence of this COB provision, and

b) The benefits that would be payable for the ALLOWABLE EXPENSES under the other PLANS, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of THIS PLAN will be reduced so that they and the benefits payable under the other PLANS do not total more than those ALLOWABLE EXPENSES.

When the benefits of THIS PLAN are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of THIS PLAN.

E. Right to Receive and Release Needed Information

The HEALTH PLAN has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the HEALTH PLAN any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the HEALTH PLAN may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The HEALTH PLAN will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the HEALTH PLAN is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- 1) The persons it has paid or for whom it has paid,
- 2) Insurance companies, or
- 3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

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 external 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 the Health Benefit Program (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:

- 1) The recommended treatment offers at least equal medical therapeutic value, and
- 2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and
- 3) 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 recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

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

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The HEALTH PLAN and/or PBM might pay more than the HEALTH PLAN and/or PBM owes under the policy. If so, the HEALTH PLAN and/or PBM can recover the excess from YOU. The HEALTH PLAN and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the HEALTH PLAN and/or PBM.

Each PARTICIPANT agrees to reimburse the HEALTH PLAN and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the HEALTH PLAN and/or PBM. At the option of the HEALTH PLAN and/or PBM, benefits for future CHARGES may be reduced by the HEALTH PLAN and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a HEALTH PLAN or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the HEALTH PLAN provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The HEALTH PLAN'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

- 1) The third party or any liability or other insurance covering the third party.
- 2) The PARTICIPANT'S own uninsured motorist insurance coverage.
- 3) Under-insured motorist insurance coverage.
- 4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the HEALTH PLAN or DEPARTMENT to such extent.

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

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the HEALTH PLAN or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the

PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the HEALTH PLAN and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the HEALTH PLAN, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

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

J. Grievance Process

All participating HEALTH PLANS and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the HEALTH PLAN and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT

complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. YOU may request an external review. In this event, YOU must notify the TPA and/or PBM of YOUR request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.