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Correspondence Memorandum

Date: January 10, 2020

To: Group Insurance Board

From: Jeff Bogardus, Pharmacy Program Manager
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Subject: 2021 Preliminary Program Agreement & Uniform Benefit Changes

This memo is for informational purposes and Board feedback only. No Board action is required.

Background

The Department of Employee Trust Funds (ETF) reviews contracts and benefit offerings for health, pharmacy, dental, and wellness programs annually in order to promote continuous improvement, ensure regulatory compliance, and improve vendors' ability to administer contracts.

ETF collects ideas for improvements throughout the year through communications to the Board, member concerns reported to ombudsperson services, and other internal questions or requests. ETF then makes a formal request for vendor change submissions in November of each year. ETF then aggregates the proposed changes for review at the January ETF Council on Health Program Improvement (CHPI) meeting, a gathering of all vendors who provide health, pharmacy, dental, and wellness services. CHPI is an opportunity for ETF to clarify change requests and for vendors to better understand the change concepts to be presented to the Group Insurance Board (Board). This memo summarizes those change concepts.

Health Program Agreement Changes

Many health program agreement changes recommended for 2021 are related to process improvement or clarify requirements as requested by health plans. Some plans asked for clarity around expectations of ID card delivery timing, citing challenges in adhering to turn-around time depending upon when eligibility information is received. Plans also requested clarity around when they can promote pilot programs to

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy

Eileen K Mallow Electronically Signed 1/21/20

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membership, data quality standards, and the methodology ETF uses to calculate the quality credit during the rate setting process.

ETF proposes the addition of a new subsection to the service agreement for 2021, related to independent review organization (IRO) determinations. If a health plan denies a member's service based upon medical necessity, the member has a right to independent review by a third-party IRO. The health plan is required to pay for that independent review. Currently, health plans are required to inform ETF's Ombudsperson Services whether the service denial was overturned or upheld by the IRO. ETF would further like the health plans to provide details of the IRO determination to ETF within 30 days of the determination. ETF will review this information to ensure the contract as currently written allows for the current standard of care. ETF would require health plans redact member-identifying information from the IRO document before providing to ETF.

Health Benefit Changes
Health plans offered minimal changes to health benefits coverage language for 2021. Ideas included requests to update formatting of the schedules of benefits, clarify language around coverage at the emergency room and preventive services, and clarify coverage intent for certain exclusions. The most substantial change proposed was the addition of out of area coverage for dependents, a concept brought to the Board in prior years.

Current Population Statistics[1]

Enrollment (Change)

- Total Enrollment = 260,691 (-1%)
- Active Employees = 216,513 (-1.4%)
- Early Retirees = 12,840 (-2.4%)
- Medicare-Eligible Retirees = 35,657 (+1%)
- Other = 1,680 (+6.1%)

Population Demographics

- 52% Female, 48% Male
- Average Age = 39.5
- Average Family Size = 2.2

Health Risk

- Healthy = 34% of members
- Stable = 23% of members
- At Risk = 22% of members
- Struggling =16% of members
- In Crisis =5% of members

[1]IBM Watson Health Dashboard, GIB Item10B, Reporting Period = Aug 2018 – Jul 2019 Incurred

A document containing all proposed benefit and contract changes for 2021 is included in Attachment A of this memo.

Pharmacy Benefit Program Changes
ETF is also considering several proposed additions to services provided by the Board's pharmacy benefit manager, Navitus Health Solutions, LLC (Navitus). The following four items will continue to be investigated by staff:

- Medical Pharmacy Solutions can leverage pharmacy benefit tools and processes to help manage the medical specialty drug spend and improve member care. Navitus provides channel management tools and services to determine whether certain drugs are covered under the medical benefit can be shifted to the

pharmacy benefit for greater utilization management and cost control, with minimal member disruption. Aligned with channel management are site-of-care management tools available from Navitus that aid in selecting more cost-effective sites where drugs are administered and establishing medical prior authorization criteria based on the pharmacy benefit to ensure appropriate use and more cost-effective care. In addition, a medical rebate program can create opportunities for more overall cost savings to the Group Health Insurance Program (GHIP) by generating rebates on drugs normally submitted through the medical benefit.

- Pharmacogenomics Testing uses an individual's genetic make-up and ability to metabolize medications to provide personalized drug recommendations. This program has the potential to optimize a member's drug therapy, avoid adverse drug events reduce overall costs by avoiding trial-and-error prescribing. This is the same program proposed for addition in 2020; at that time, the program was in pilot form at Navitus, but it is now included in their regular benefit offerings.

- eHealth Solutions is a suite of tools that members and their doctors can use at a clinic visit to access a member's benefit information. Electronic prescribing tools provide physicians with an electronic way to submit prescriptions and immediate access to a member's medication history and benefit information. Electronic prior authorization (PA) tools give the doctor immediate access to PA requirements. This can allow the doctor to discuss prescribing options with the member at the point of care, to change the prescription if PA requirements are not met and reduce the amount of time for a PA to be approved. Also, within the eHealth suite is a tool that allows doctors to submit an inquiry or trial adjudication that provides up-to-the-minute feedback through the doctor's electronic health or medical record system. This gives the doctor insight into the member's benefit, which can help identify the cost the member will pay, alternative drugs that are covered by the formulary, and lower cost pharmacy channels.

- The Copay-Max program takes advantage of drug manufacturer coupons and copay assistance programs applied to many high cost drugs in order to maximize the amount of savings for the member and the GHIP.

Staff will also be reviewing the Uniform Pharmacy Benefits certificate of coverage document in order to make minor technical changes and benefit clarifications. Detailed, recommended changes will be presented to the Board for approval at the May 2020 Group Insurance Board meeting.

Wellness Program Changes
2021 will mark the eighth year of the Board offering a $150 wellness incentive to members who complete a health screening, health assessment, and well-being activity. Due to the cost of the onsite health screenings ($57/each; total of approximately $1.7M spent in 2019) and the U.S. Preventive Task Force recommendation that most people do not need to get cholesterol or glucose screenings on an annual basis, ETF proposes

making health screenings an optional program activity for a member to earn the incentive, beginning in 2021. If a member chooses not to complete a screening, they would instead be asked to complete two well-being activities. The health assessment (questionnaire) would remain a core incentive activity requirement, as it provides valuable data for risk stratification and progress measurements.

Secondly, the Board's current policy allows health plans to offer their members wellness incentives, like gym membership or Community Supported Agriculture share reimbursements. This has been a complicated policy to administer because there is often confusion amongst plans on what types of incentives are allowable, if the incentives are considered taxable income, who to withhold FICA taxes from, and what to report to ETF. There is also confusion by members because not all health plans administer wellness incentives.

Members misunderstand the incentive is considered taxable income and the timing for the tax filing process. The health plan-issued incentives also create administrative burden for ETF, who must process incentive tax files, respond to member inquiries, send employer reports, and issue W-2s. Passing along these reports to employers also creates a security risk to ETF, since it includes members' personally identifiable information. Employers then must process the incentive as taxable income and answer employees' questions regarding what or why they are being taxed. ETF proposes the Board adopt a policy discontinuing non-Medicare Advantage health plan issued incentives for 2021 and streamline all wellness incentives through StayWell. Medicare Advantage plan(s) would still be allowed to offer incentives, since those incentives are considered in the plans' star rankings.

These two modifications to the wellness program policy will create a better experience for members, employers, health plans, and ETF, will result in cost savings, and contribute to improved member well-being. However, removing the health plan issued incentives may be viewed as a takeaway by some members.

Next Steps

ETF will review the changes noted above in the context of the contract and the Board's strategic initiatives and make recommendations for revision at the May Board meeting. For any changes that will materially affect a member's experience of the Board's programs, ETF staff will provide a review of those changes in the context of the Triple Aim.

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

Attachment: Proposed Health Program Agreement and Benefit Changes Detail

Contract Section	Contract Sub-Section	Contract Sub-Section Reference	Description of Change Requested	Proposed Contract Language	Notes
Section 000		(none)	Include list of State of Wisconsin holidays		Upon review with health plans, ETF recommends providing this detail either in the Account Manager Manual or the Key Dates Memo
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 1) Data Submission Requirements, b)	Submission requirements clarification	TBD - further clarification on what specific information ETF expecting, information not expected to be called out as an exclusion.	Additional discussion will be held at the February Data Submitting Entity Meeting convened by ETF and IBM Watson Health
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 3) Submission Timeline, a)	Clarify data submission timeline	All claims paid shall be submitted to the DEPARTMENT'S data warehouse in the correct file layout basd on the CONTRACTORS claim payment submission schedule approved by the DEPARTMENT.	Additional discussion will be held at the February Data Submitting Entity Meeting convened by ETF and IBM Watson Health
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 4) Data Dictionary	Clarify data dictionary requirement	TBD - further clarification on what specific information ETF expecting to be included in this document. Or, include this part of the feed rather than a one-off process and call that out within this section.	Additional discussion will be held at the February Data Submitting Entity Meeting convened by ETF and IBM Watson Health
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 6) Data Quality	Clarify data quality requirement	TBD - clearly defined thresholds for the data quality standards the health plan will be held too should be documented within the contract.	Additional discussion will be held at the February Data Submitting Entity Meeting convened by ETF and IBM Watson Health
Section 100	155 Miscellaneous General Requirements	155A Reporting Requirements and Deliverables, 3)	Due date to comply with changes	"...The CONTRACTOR must comply with such changes within forty-five (45) BUSINESS DAYS, or an agreed upon timeframe reasonable to the change being requested."	ETF will review the provision in which this item is included and the impact of adjusting the language
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, f)	Provider NPI requirement clarification	"...National Plan and Provider Enumeration System (NPPES), if applicable."	ETF sees no issue with this change.
Section 100	155 Miscellaneous General Requirements	155D Information Systems Security Audit	Maintain language		As presented to the Board previously, it is ETF's intent to maintain this language as-is.
Section 100	130 Premiums	130B Rate-Setting Process	Ensure contracts are finalized before rates are finalized		This is current practice, barring extraordinary circumstances.
Section 100	135 Financial Administration	135B Included Services, 3) Pilot Programs	Modification and application of contract	Clarify requirements around promoting pilot programs during It's Your Choice and otherwise.	ETF will work with health plans to clarify requirements related to pilot program promotion.

Section 200	205 Enrollment	205C Over-Age Disabled Child Eligibility	Only require families of members the Health Plan deems permanently disabled to confirm support and marriage questions on an annual basis. Drop the requirement to file a physician's review.		ETF will update the applicable guidance document for health plans on the dependent verification process to allow plans to update the physician review less frequently.
Section 200	205 Enrollment	205A Identification (ID) Cards	Clarify language within section to specify how days are determined.	"...The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file contactining the addition or enrollment change, or at least ten (10) BUSINESS DAYS prior to the ...."	ETF will review the requested change for impact.
Section 200	215 Medical Management	215B Department Initiatives, 3) Low Back Surgery and 4) Shared Decision Making	Modify administrative requirement for low back surgery	Remove Language 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. This paragraph does not apply to the MEDICARE ADVANTAGE CONTRACTOR. 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. This paragraph does not apply to the MEDICARE ADVANTAGE CONTRACTOR.	ETF will review the current list of Department Initiatives, but is hesitant to remove requirements. ETF will work with plans to determine whether there are options for improving administration.
Section 200	225 Quality	4)	Modify rate setting process and modify quality incentives program for transparency, alignment and consistency		ETF will host a discussion of the quality credit and proposed adjustments with health plans at their March CHPI meeting, and will bring options to the Board in May.
Section 200	240 Grievances	240G	Add requirement to pass through detailed clinical results from Independent Medical Review	Within thirty (30) days of the CONTRACTOR's receipt of the external review determination, CONTRACTOR will return a copy of the decision language to the DEPARTMENT with member personally-identifying information redacted.	ETF would like to monitor IRO decision content to ensure that current contract language supports best practices
Section 300	325 Data Warehouse	325A Data Warehouse Deliverable Requirements, 1) & 2)	Data Warehouse Deliverable Requirement timeline	TBD - explicit timeline for file change implementation and expectations should be outlined and referenced within these deliverables.	Additional discussion will be held at the February Data Submitting Entity Meeting convened by ETF and IBM Watson Health

Section 300	305 General Deliverable Standards	305A Deliverable Requirements	Notification to health plans regarding discontinuation of deliverables due throughout the contract year	Instructions on submitting individual deliverables and specific due dates will be provided by the DEPARTMENT annually	This is current practice, barring extraordinary circumstances.
Section 300	310 Administrative Deliverables	2d	Request to modify ID card processing timeline	ID Card Issuance for Elections 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 5. (See Section 205A.) Any enrollments received after December 5th will be mailed within 14 calendar days of receipt of the enrollment file.	ETF will review the requested change for impact.
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 10) Ambulance Services	Modify language for Ambulance Services to define when professional air ambulances are allowed	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 the PARTICIPANT'S health, AND only in an EMERGENCY situation. EMERGENCY Air Ambulance services are limited to those performed entirely within the United States. EMERGENCY Air Ambulance services are also limited to only those services necessary for transport to the nearest medical facility equipped to handle the EMERGENCY. 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.	ETF will review the requested change for impact.

Section 400	I. Definitions	(none)	Modify language for Usual and Customary Charge	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 where services were provided by an in-network provider, 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 19ET-2107cc (rev. 11/5/2018) 14 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. PARTICIPANT may be responsible for the USUAL AND CUSTOMARY CHARGES for services obtained from OUT-OF-NETWORK PROVIDERS for services that were neither EMERGENCY or URGENT in nature.	ETF will review the requested change for impact.
Section 400	IV. Exclusions and Limitations	A. Exclusions	Add language for alopecia treatment	Drugs or medications for the treatment of alopecia or hair loss. Examples include, but are not limited to, minoxidil or Rogaine.	ETF will review the requested change for impact.
Section 400	IV. Exclusions and Limitations	B. Limitations	Modify language related to bariatric surgery for treatment of GERD	Weight loss services including but not limited to surgeries for the treatment of gastroesophageal reflux disease (GERD)	ETF will review the requested change for impact.
Section 400	III. Benefits and Services	A. Medical /Surgical Services, 12) Outpatient Rehabilitation, Physical, Speech, and Occupational Therapy	Modify language as it relates to rehabilitation (ST, PT, OT)	As determined by the health plan, those services deemed medically necessary for 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. For those services deemed medically necessary by the payor, members are allowed up to 50 vists per Participant for all therapies combined per calendar year. Health Plans may review utilization and clinical information during the initial 50 visits to verify medical necessity. Additional medically necesasry visits may be authorized when prior authorized by the health plan, up to a maximum of 50 addtional visits per therapy per participant per cal year.	ETF will review the requested change for impact.
Section 400	IV. Exclusions and Limitations	A. Exclusions	Add language for Continuous Passive Motion (CPM) machine and cold therapy machine	Continuous passive motion (CPM) machine.	ETF will review the requested change for impact.

Section 400	VI. Miscellaneous Provisions	C. Case Management/Alternate Treatment	Modify administrative requireemnt for Case Management / Alternative Treatment	Remove Language 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.	ETF does not recommend removing or altering the Alternate Treatment provision. This provision is long-standing and allows plans the flexibility to cover services that are clinically appropriate in particular cases.
Section 400	IV. Exclusions and Limitations	A. Exclusions, 10) General, aj)	Modification of marriage and family therapy exclusion	aj) Marriage/couples/family counseling. Participant may invite family or significant other into their individual therapy session to address relationship issues.	ETF does not recommend altering this exclusion, as the proposed language would likely result in a change to visit coding that would effectively nullify the exclusion.
Section 400	II. Schedule of Benefits	(none)	Consolidate Schedules of Benefits	Consolidate the Schedule of Benefits (SOBs) for State and Local. We have identified several inconsistencies in the 2018 and 2019 contracts between the SOBs between State and Locals that have carried forward to the 2020 contract. This would allow for consolidated group member certificates as well.	ETF will review the requested change for impact.
Section 400	II. Schedule of Benefits	(none)	Emergency Room Visit cost sharing	Add additional note to the schedule of benefits "Emergency Room Visit" box such as: "You may be responsible for other charges in addition to the facility copay. See Illness/Injury related services below."	ETF will review the requested change for impact.

Section 400	II. Schedule of Benefits	(none)	Preventive Care vs. Diagnostic Care clarity	Laboratory and diagnostic studies may be subject to other plan benefits (diagnostic or treatment benefits) if determined not to be part of a preventive visit. When a Member has symptoms or a history of an illness or injury, laboratory and diagnostic studies relating to that illness or injury are no longer considered part of a preventive visit. Please refer to the "Diagnostic Services" subsection for non-preventive services. You may be responsible for paying out-of-pocket costs for any services We do not deem preventive. We would even go as far as recommending listing out covered preventive services (see attached example from our commercial certificate).	ETF will review the requested change for impact.
Section 400	II. Schedule of Benefits	(none)	Vision Services - Provide greater clarity of covered benefit	Currently listed under Section 400 - Uniform Benefits - Benefits and Services. Members are overlooking this and trying to find the benefit coverage in the SOB. The contract itself provides greater detail than the member group certificate.	ETF will review and reconcile the two sections of the agreement.
Section 400	II. Schedule of Benefits	(none)	Definition of telemedicine	Currently, documentation lumps "Telemedicine, telehealth or e-visit services" into one category. These services are really very different. Telehealth/Telemedicine: This is broadly defined as the provision of healthcare remotely by means of telecommunications technology. Examples of this service are as follows: - Patient goes to their local clinic/hospital and sit in a room with a tv monitor/videocamera and have a consultation or exam with a specialist. - Patient is inpatient and a doctor from another facility is consulted via a tv monitor/videocamera. - Patient is at home and has their weekly counseling visit with their mental health professional. *It is not common for an insurer to reduce or eliminate a copay or other liability for telemedicine/telehealth services.* E-visits are a bit different. An e-Visit is defined by Quartz as a visit using an electronic message and a patient's medical records to facilitate communication between the patient and a Provider. There is typically a list of possible conditions or symptoms that can be treated via this method and a patient may answer a list of questions to aid the provider in making a diagnosis. *It is common for an insurer to reduce or eliminate a copay or other liability for evisits.*	ETF has in the past recommended that the Board maintain a broad definition of telehealth in order not to limit coverage for a swiftly-developing area of coverage. ETF will review the suggested change for impact.
Section 400	II. Schedule of Benefits	(none)	DME when Medicare is Primary: - If Medicare covers, plan pays Medicare patient portion - if Medicare does not cover, patient pays 20% coinsurance toward $500 DME OOPL		ETF will review the requested change for impact.

Section 400	IV. Exclusions and Limitations	A. Exclusions, 10) General, x) Orthoptics	Benefit modification to Orthoptics	A. 2020 Agreement, 400 Uniform Benefits, IV. Exclusion and Limitations, 10. General, x. Orthoptics B. 2020 Agreement 400 Uniform Benefits IV. Exclusion and Limitations 10.) General Orthoptics (Eye exercise training) except for two sessions per lifetime. The first session for training, the second for follow-up.	ETF will review the requested change for impact.
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 3) Urgent Care	Urgent Care Services	Align provisions to match the information and application as described in Section 220C (see column D) 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) PARTICIPANTS must receive URGENT CARE from an IN-NETWORK PROVIDER if the PARTICIPANT is in the SERVICE AREA, unless it is not reasonably possible. If a PARTICIPANT is out of the SERVICE AREA, the PARTICIPANT go to the nearest appropriate medical facility unless they can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If the PARTICIPANT must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that they contact the HEALTH PLAN by the next BUSINESS DAY or as soon as possible and tell the HEALTH PLAN where the PARTICIPANT 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.	ETF will review and reconcile the two sections of the agreement.
Section 400	IV. Exclusions and Limitations		Clarification of extraction responsibility for wisdom teeth		ETF will review the section requested and clarify if appropriate.
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 2) EMERGENCY Care, c)	Out of area dependent coverage	Based on contract language, almost all follow up care is denied; as it is not considered "urgent". We would recommend one of two things: 1) Adopt a policy similar/identical to our commercial OOA dependent coverage; 2) Update language to clarify when OOA follow up care could be approved and/or add specific number of visits.	ETF will review the requested change for impact.