2026 Program Agreement Reference *(Select from drop down menu)*	**Description of Requested Change** *(Provide a brief narrative of intended change)*	**Proposed Language** *(Provide language from Program Agreement with changes highlighted in red text)*	**ETF Comments** (Additional justification for changes)
III. Program Administration E. Communications 3. Contractor Web Content and Web-Portal g.	The (GHIP) Agreement contains the following provision, requiring health plans to have a minimum of SHA2-256 bit EV certificates to provide the latest encryption and cryptography for web-portals. We propose to remove the Extended Validation (EV) requirement from the provision for the following reasons: 1. the domain validation (DV) certificates and extended validation (EV) certificates and encryption are the same. The difference is in the process to complete the certificate acquisition - more resource intensive and costly for the EV. 2. All recent versions of Microsoft Edge, Mozilla Firefox, Google Chrome, and Apple Safari have removed the EV certificate indicator (typically a green address bar), making it difficult for the average user to discern if an EV certificate is being used. 3. Other health plans that participate in the GHIP do not have the EV certificates on their web-portals 4. Web browsers in near future will require certificates that aren't older than 90 days. This means that every 90 days a new request process to acquire the certificate for extended validation would need to occur, increasing resource utilization and cost.	Propose language to remove: Web Content and Web-Portal g. The CONTRACTOR'S web-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.	Request from **Network Health**
Exhibit B - Department Terms and Conditions Section 24.0 Confidential Information, Privacy and HIPAA Business Associate Agreement Subsection (e).	ETF Participants' Confidential Information is of the utmost importance to Dean Health Plan (DHP). So that DHP can provide superior claims processing and other administrative services to ETF Participants, DHP respectfully requests that ETF incorporate terms which allow DHP to leverage offshore resources in provision of those services, provided no PHI or PII is stored offshore and extensive security protocol is applied to access the information by offshore resources. Additionally, the Contractor's ability to leverage offshore resources would be contingent on Contractor maintaining a SOC2.	**Propose to Add Language:** **REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES:** The Contractor's transmission, transportation or storage of Confidential Information outside the contiguous United States, or access of Confidential Information from outside the contiguous United States, is prohibited except (a) on prior written authorization by the Department or (b) when all of the following conditions are satisfied: (i) storage of Confidential Information remains within the United States, (ii) Contractor utilizes a secure virtual desktop for offshore resources access, (iii) Contractor employs industry-standard secure network monitoring, data breach safeguards and reporting, (iv) Contractor utilizes multi-factor authentication systems regarding access to Confidential Information by offshore resources, and (v) Contractor maintains a SOC2 and any applicable bridge letters during the Contract Period.	**Request from DEAN Health**
IV. I. 2. d. Quarterly Performance Standards & Penalties, Customer Service, Electronic Written Inquiry Response	Looking to remove or adjust penalty for smaller health plans	**Performance Standard.** 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 III.H.3. Customer Service.) **Penalty:** Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter. In no event shall any penalty imposed for failure to meet a performance standard exceed $500 per affected member.	**Request from MercyCare**: Feedback for ETF on Certain Performance Standards Penalties IV. I. 2. d. Quarterly Performance Standards & Penalties, Customer Service, Electronic Written Inquiry Response We request that the ETF modify the performance standards and penalties to address: - Certain penalties that are unrelated to impacted members and unrelated to plan revenue - Certain penalty thresholds that are unrelated to error rates Background Certain administrative performance standards in the ETF contract assess penalties that are unrelated to the number of impacted members (or number of member cases) or the percentage of covered members impacted. As a result, certain customer abrasion is not disincentivized and the financial penalty assessed is less related to the number of members impacted and to the plan revenue that must be used to pay those penalties. A fixed penalty structure – because it is unrelated to plan revenue – is inconsistent with the fact that total penalties are limited as a percentage of total premium in the ETF contract. Based on how the penalty provision works in the existing contract: - The penalty assessed per impacted member (or member case) is far higher for 1) a smaller plan or 2) a plan with a lower written inquiry rate. - While revenue is related to members covered, certain financial penalties are not even though the maximum total penalty is related to revenue. - Paradoxically, more missed member inquiries are afforded if there are more member inquiries (regardless of plan size) to begin with. The assumption is having fewer written inquiries is a good attribute. In the above example, the plan with the lowest written inquiry rate and the lowest miss rate / 1000 would have the highest penalty per impacted member and thus the highest penalty as a percentage of revenue. We ask that the ETF reconsider how it structures performance penalties for certain standards to make the financial penalty more equitable by plan size and for the error triggers to be based on the number of negatively impacted members as a percentage of the plan size. We would like to see the following language added to the penalty provision: In no event shall any penalty imposed for failure to meet a performance standard exceed $500 per affected member. This amount represents the forfeiture of a substantial portion of the member's quarterly premium, far in excess of the contractual limitation of 3% of premium for all penalties.

2026 Program Agreement Reference *(Select from drop down menu)*	**Description of Requested Change** *(Provide a brief narrative of intended change)*	**Proposed Language** *(Provide language from Program Agreement with changes highlighted in red text)*	**ETF Comments** (Additional justification for changes)
ETF Employer Insurance: PCP language requirement.	Question about how to handle requests from members to change health plans when they learn they've selected a PCP in a plan that doesn't include them. An example is someone who selected Quartz UW but wants to see docs in Community. I shared the Agreement & CoC language with John. His reaction is good for us to note. Do we know how well the plans are managing the PCP requirement? We may want to consider this for 2026. Arlene	Looking to add language to Program Agreement.	Request from Internal ETF Department
D. 4.e.ii. Data and Information Security, Data Integration and Use, Wellness and Chronic Condition Management Data	Update language so that data sharing is occurring between WebMD and only health plans who use the data.	ii. Wellness and Chronic Condition Management Data _ ~~The~~ CONTRACTORS who can ~~must be able to~~ accept and accommodate a monthly file from the DEPARTMENT'S wellness and chronic condition management vendor that includes data for the CONTRACTOR'S PARTICIPANTS should work with DEPARTMENT'S wellness and chronic condition management vendor to identify the most recent Wellness Data Specifications for biometrics, health assessments, and health coaching and chronic condition management, and integrate that data into the CONTRACTOR'S medical management program. ~~This data may include results from biometric screenings, health assessments, and unique PARTICIPANT information regarding enrollment in health coaching and/or chronic condition management programs. The file format must comply with the most recent Wellness Data Specifications as provided by the DEPARTMENT.~~	Request from Internal ETF Department: Suggesting this edit because some health plans do not use the data and likely will not due to their size and tech abilities. Instead of WebMD sending data to these health plans, we could limit to only those who use it, better protecting member data.
E. 3.b. Communications, Contractor Web Content and Web-Portal	Add requirement to refer to wellness and chronic condition management program and pharmacy benefit	b. The CONTRACTOR must include a link to other DEPARTMENT's wellness and chronic condition management program and pharmacy benefit web portal and/or public facing ETF/PBM vendor website within their customized website and/or web-portal dedicated to PARTICIPANTS.	Request from Internal ETF Department: Helps members find other benefits included in their GHIP coverage
G. 1. a. i. and ii. Care Management, Department Initiatives	Add diabetes management and prevention	i. ~~The current DEPARTMENT Initiative is limited to~~ Care Coordination.... ii. Diabetes Management and Prevention. The CONTRACTOR must provide PARTICIPANTS with diabetes management and prevention programming and/or refer PARTICIPANTS to the DEPARTMENT'S wellness and chronic condition management program administrator's diabetes management and prevention services. The CONTRACTOR must work collaboratively with other GHIP CONTRACTORS to identify additional deliverables.	Request from Internal ETF Department: Stepping stone to add more details and expectations/PGs/etc. in the future when we can focus more on this, and after IAS is implemented.
G. 3. a. iii. and iv. Care Management, Population Health	Align to other data sharing edits and refer to wellness and condition management vendor benefits	iii. As applicable, coordinating programming with the DEPARTMENT'S wellness and chronic condition management vendor(s) by:... iv. Referring PARTICIPANTS to the appropriate resources provided by the DEPARTMENT'S wellness and chronic condition management vendor(s). The CONTRACTOR must provide the DEPARTMENT documentation, annually via the Population Health Management Report, that demonstrates their efforts in actively promoting the services available to PARTICIPANTS through the wellness and chronic condition management program. This includes, but is not limited to general and targeted communications and referrals.	Request from Internal ETF Department: iii. To align with only those health plans who are getting and using data from wellness and CM vendor. iv. Expectation that they are referring and that they can document something that they are doing so in some way.

Description of Requested Change ***(Provide a brief narrative of intended change)***	**Proposed Language** ***(Provide language from Program Agreement with changes highlighted in red text)***	**ETF Comments** ***(Additional justification for changes)***
IAS Language to Add: Due to IAS, if a member wants to change plans due to gaining Medicare, they need to file an app before their Medicare effective date to have the change occur at the same time as Medicare begins. If late, the plan will change the first of the month after receipt of the app.	You should submit your application prior to your Medicare effective date. This can be sent up to three months in advance. Coverage with your new plan will be effective on the same date as Medicare. You may also submit the application up to 30 days after your Medicare effective date, but then coverage will be effective the first of the month after ETF receives your application.	Inserts language from other ETF documents, like the ET-4307, ET-2331 & FAQs.
IAS Language to Add: Due to IAS, Employer will no longer provide COBRA paperwork. That will come from Voya.		ETF needs to get language on how this will work from the IAS team.
Member request to permit members to change health plans following a death of a subscriber or dependent.		ETF to review with Segal and get plan feedback. Will look into DAISI- on what is impact of claims/premium?
State employer requests policy change to allow employees on layoff or LOA to reenroll upon return to work regardless of if their coverage is lapsed due to non payment or they canceled their coverage.		ETF will review. Concern about changing a policy with the implementation of IAS imminent.
4. **Benefits and Coverages** B. Exceptions to In-Network Care Requirement 4. Out-of-Network Coverage for Full-Time Students	**Update language to clarify that the student must be attending school within the state of Wisconsin and outside of the plan's service area.**	**Request from Network Health**: If your Dependent is a full-time student attending school within the State of Wisconsin but outside of your Health Plan's Service Area, certain outpatient mental health services and treatment of alcohol or drug abuse will be covered Out-of-Network, as required by Wis. Stat. § 609.655. See Mental Health and Substance Use Disorder Services below for more information. Your Dependent may have a clinical assessment by an Out-of-Network Provider with Prior Authorization in writing from your Health Plan. If outpatient services are recommended, your Dependent will be allowed coverage for five (5) visits outside of the Service Area with Prior Authorization from your Health Plan. Your Health Plan may approve additional visits. If your student Dependent is unable to maintain full-time student status, they must obtain services from an In-Network Provider for treatment to be covered unless you are enrolled in the Access Plan or other PPO Plan.
Schedule of Benefits, Decision Guide book: **Under Covered Services -** Emergency Care	**Quartz is requesting removing the language stating the ER copay is waived if admitted for observation for 24 hours or more:** The Quartz Commercial line of business waives ER copay if a member is admitted to inpatient but doesn't waive it for observation. The language forces Quartz to stop and manually remove the ER copay. This situation can't be automated.	**Request from QUARTZ:** The copayment is waived if you are admitted as an inpatient ~~or for observation for 24 hours or more~~.
5.Exclusions and Limitations A.4. Durable Medical Equipment, Durable Diabetic Equipment and Medical Supplies b.xiv. "Cold therapy and continuous passive motion devices "	**Quartz is requesting removing continuous passive motion devices from the Durable Medical Equipment and Medical Supplies exclusion example.** The Quartz Commercial line of business prior authorizes CPM devices for specific conditions/surgery. CPMs are commonly used when meeting medical criteria for the following procedures: total knee arthroplasty (TKA), ACL knee repair, surgical release after for adhesive capsulitis (operative manipulation), periacetabular osteotomy (PAO) or if non weight bearing after: OATS, microfracture, cartilage defects/fractures, or tibia plateau fracture all to be started within 3 days of the procedures.	**Request from QUARTZ**: Durable Medical Equipment and Medical Supplies that are provided solely for comfort, personal hygiene and convenience items. Examples of these items include, but are not limited to: xiv.Cold therapy ~~and continuous passive motion devices~~
4. **Covered Services** B.2 Urgent or Emergency Room Care	**Quartz is requesting adding an annual benefit limit of $20,000 for emergency services provided outside the continental United States and territories.** The Quartz Commercial line of business limits the benefit and enforcing a dollar limit would allow health plans to manage the risk presented by foreign claims not required under the No Surprise Act (NSA).	**Request from QUARTZ**: If you require **Urgent Care** or **Emergency Room** services, and you are not able to return to your network for services (e.g., you are traveling out of state or out of country), your **Out-of-Network** services will be covered by your **Health Plan**. Please note that only services that require immediate or **Urgent Care** will be covered; services that might safely be delayed in order for you to return to your **Health Plan's Service Area** may be denied by your **Health Plan**. Foreign claims for emergency services are subject to an annual maximum benefit limit of $20,000. Foreign claims are defined as Items or services obtained or provided outside of the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Non-emergency services obtained or provided outside of the country remain non-covered services.
5.Exclusion and Limitations A.22 Travel and Transportation	**Quartz is requesting adding medical evacuation to the exclusions under Travel and Transportation.** Quartz UM staff noted that we are only obligated to bring the patient to the closest facility that can care for the member appropriately. Quartz is not responsible for transporting the member home for care. The addition of the language would provide clarification to benefit exclusion.	**Request from QUARTZ:** a. Charges for, or in connection with, travel, except for ambulance transportation as outlined in Section 4.F. Covered Services. This includes but is not limited to meals, lodging and transportation (e.g. medical evacuation).
4.Covered Services F.17. Durable Diabetic Equipment and Related Supplies.	**Quartz and GHC-EC is requesting that Continuous Glucose Monitoring Devices be covered solely under the pharmacy benefit.** The Quartz Customer Success department has expressed that CGM's covered under both the pharmacy and medical benefit is very confusing to members. In addition, Quartz staff reviewing a CGM on the medical side makes it difficult to get the entire picture as we aren't privy to the pharmacy side of the house. The group also noted that it may be more cost effective to completely administer under the pharmacy benefit. Quartz Clinical staff noted that at least 75% of these are now on the pharmacy benefit.	**Request from QUARTZ**: Durable diabetic equipment includes automated injection devices, ~~continuous glucose monitoring devices,~~ and insulin infusion pumps.
Continuous Glucose Monitor (CGM)	**See Above:** We would like to have the CGM's be provided through the pharmacy benefit.	**Request from GHC-EC…**duplicate to line 11.
5. Exclusions and Limitations A.13. Other Non-Covered Services	**Quartz is requesting adding penile implants for treatment of erectile dysfunction to the exclusions under Other Non-Covered Services** Quartz would like clarification on how the Sexual Dysfunction Coverage benefit should be administered. Quartz is not in favor of the broad term of "Sexual Dysfunction." Quartz currently covers a pump because no exclusion language is present in the CoC. Quartz has coverage for penile implants at lower volume because exclusions are not clear. Quartz does not cover penile implants or other erection devices in other commercial products.	**Request from QUARTZ**: g. Penile implants for treatment of erectile dysfunction.
4.F.**Covered Services** 32 Physical, Speech and Occupational Therapy	**Quartz is requesting a maximum benefit of 50 visits for all therapies combined under Physical, Speech, and Occupational Therapy. This would remove the language that up to 50 additional visits may be available with Prior Authorization** Quartz requests 50 visits combined where the number of visits be across all disciplines permitting member voice, choice and need. The additional 50 visit benefit is far more generous than Quartz Commercial LOB. Quartz Medical Management staff note that pediatric outpatient therapy has the highest utilization compared to any of our other plans.	**Request from QUARTZ**: Up to 50 visits per Participant for all therapies combined are covered per calendar year. Your Health Plan may review utilization and clinical information during the initial 50 visits to verify medical necessity (See Section 4. E. Disease Management, Prior Authorizations, and Utilization Review for additional information). ~~Additional visits may be available with Prior Authorization from your Health Plan, up to a maximum of 50 additional visits per therapy, per Participant, per calendar year.~~

Description of Requested Change ***(Provide a brief narrative of intended change)***	**Proposed Language** ***(Provide language from Program Agreement with changes highlighted in red text)***	**ETF Comments** ***(Additional justification for changes)***
4. Covered Services F.8 Biofeedback	**Quartz is requesting adding specific conditions (fecal continence, chronic constipation, and refractory severe tinnitus related to mental health parity) under Biofeedback.** Expand eligible conditions for biofeedback to align with evolving evidence and member need.	**Request from QUARTZ**: Biofeedback is covered when provided to treat the following conditions: a. Headaches b. Spastic torticollis c. Urinary incontinence d. Fecal continence e. Chronic constipation f. Refractory severe tinnitus related to mental health parity Biofeedback is not covered for treatment of any other conditions; see Section 5. Exclusions, for additional information.
Compulsive gambling	**Quartz is requesting specifying and naming Pathological Gambling under Covered Services**. Quartz would like clarification if Pathological Gambling is covered under routine Behavioral Health benefits. Quartz covers behavioral health care for this diagnosis within all other Commercial products.	**Request from QUARTZ**
4. Covered Services F.23 Home Care Benefits	**Quartz is requesting clarification regarding coverage of INR Anti-Coagulation Home Monitoring**. Quartz requests clarification on as to whether INR Anti-Coagulation Home Monitoring is a covered benefit. Currently, home INR monitoring is not covered by Quartz Commercial products.	**Request from QUARTZ**
4. Covered Services F.30 Oral Surgery and Other Dental Services	**Quartz is requesting adding sleep apnea as an eligible diagnosis to Orthognathic Surgery under Oral Surgery and Other Dental Services.** Quartz requests that sleep apnea be added as an eligible diagnosis for orthognathic surgery with prior authorization.	**Request from QUARTZ**: I. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30 and sleep apnea.
4. Covered Services F.46 Transplants	**Quartz is requesting adding uterus and hair to the exclusions under Transplants.** Quartz requests clarification on what is not covered for transplantation, including uterus and hair as not covered benefits.	**Request from QUARTZ**
Acupuncture….adding benefit.	**Quartz is requesting adding 12 acupuncture visits per year by a licensed acupuncture provider or licensed physician for the treatment of nausea/vomiting during pregnancy or chemotherapy and chronic pain only under Covered Service**s Quartz requests to add acupuncture as a covered benefit for the following eligible diagnoses: treatment of nausea/vomiting when associated with pregnancy, chemotherapy, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Acupuncture is not covered for the treatment of any other conditions; and, Obtained from licensed acupuncture providers or licensed physicians. Coverage is limited to 12 visits per benefit year. This will provide equity of access among Quartz commercial products.	**Request from QUARTZ**: Acupuncture services are covered only when: ▪ Provided for the treatment of nausea/vomiting when associated with pregnancy, chemotherapy, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Acupuncture is not covered for the treatment of any other conditions; and, ▪ Obtained from licensed acupuncture providers or licensed physicians. Coverage is limited to 12 visits per benefit period.
5. Exclusions and Limitations A.4 Durable Medical Equipment, Durable Diabetic Equipment and Medical Supplies	**Quartz is requesting adding speech generation devices for persons with a permanent severe expressive speech disability to Covered Services with prior authorization.** Quartz requests speech generation devices as a covered benefit under durable medical equipment for persons with a permanent severe expressive speech disability with prior authorization.	**Request from QUARTZ**
4. Covered Services B.4 Out-of-Network Coverage for Full-Time Students	Quartz requests clarification to align with state statute and Mental Health and Substance Use Disorder language.	**Request from QUARTZ**: If your Dependent is a full-time student attending school in Wisconsin but outside of your Health Plan's Service Area, certain outpatient mental health services and treatment of alcohol or drug abuse will be covered Out-of-Network, as required by Wis. Stat. § 609.655. See Mental Health and Substance Use Disorder Services below for more information.
ALL Schedule of Benefits (SoBs)	**Dean is requesting an increase to cost sharing for both medical and pharmacy benefits.** Increase cost shares to address medical and Rx inflationary pressures.	**Request from DEAN**
Deductible/Coinsurance (All Plans)	**Line 24-36. Dean is requesting increasing to deductibles, out-of-pocket limits, and coinsurance on all plans.**	**Request from DEAN**
IYC Health Plan Deductible $250/$500	Increase deductible by a minimum of $250 (i.e., range from $500 to $1,000)	DEAN: Example: $500/$1,000
IYC OOPL $1,250/$2,500	Increase OOPL a minimum of $500/$1,000	DEAN: Example: $1,750/$3,500
IYC 10% Coinsurance	Increase to 20% coinsurance	DEAN: Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible ~~except for Durable Medical Equipment and Medical Supplies~~. You pay: ~~10~~ 20% after deductible is met Plan pays: ~~90~~ 80% after deductible is met
HDHP 10% Coinsurance	Increase to 20% coinsurance	DEAN: Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible ~~except for Durable Medical Equipment and Medical Supplies~~. You pay: ~~10~~ 20% after deductible is met Plan pays: ~~90~~ 80% after deductible is met
HDHP OOPL/MOOP $2,500/$5,000	Increase a minimum of $500	DEAN: Example: $3,000/$6,000
Access Plan OON OOPLs (non-HDHP State and PO6.16)	Current OOPL is $500/$1,000 deductible, 70%/30% coinsurance to $2,000/$4,000 maximum OOPL. If the in-network OOPLs increase how much should the OON OOPLs go up?	ETF: If we are increasing the in-network OOPLs, how much should we increase the Access Plan's OON OOPLs?
Access Plan OON OOPLs (HDHP State and PO7.17)	Current OOPL is $2,000/$4,000 deductible, 70%/30% coinsurance to $3,800/$7,600 maximum OOPL. If the in-network OOPLs increase how much should the OON OOPLs go up?	ETF: If we are increasing the in-network OOPLs, how much should we increase the Access Plan's OON OOPLs?

Description of Requested Change ***(Provide a brief narrative of intended change)***	**Proposed Language** ***(Provide language from Program Agreement with changes highlighted in red text)***	**ETF Comments** ***(Additional justification for changes)***
For Local Employer Groups:		DEAN**:**
HDHP	Offer a higher deductible HDHP with a higher OOPL/MOOP	DEAN:
PO2/PO12 (Traditional Full Pay)	Mirror State offering eligibility - Medicare Prime only; eliminate ability to offer as primary plan election for all active employees	DEAN:
PO4/PO14 ($500 Deductible)	Add 20% coinsurance after deductible; increase deductible to $750	DEAN:
Access Plan OON OOPLs (Traditional PO2.12)	Current OOPL is $500/$1,000 deductible, 80%/20% coinsurance to $2,000/$4,000 maximum OOPL. If the in-network OOPLs increase how much should the OON OOPLs go up?	ETF: If we are increasing the in-network OOPLs, how much should we increase the Access Plan's OON OOPLs?
Access Plan OON OOPLs (Deductible PO4.14)	Current OOPL is $1,000/$2,000 deductible, 70%/30% coinsurance to $4,000/$8,000 maximum OOPL. If the in-network OOPLs increase how much should the OON OOPLs go up?	ETF: If we are increasing the in-network OOPLs, how much should we increase the Access Plan's OON OOPLs?
Copay Increases (all plans)	**38-40. Dean is requesting increasing copays on all plans.**	**Request from DEAN**
$15 PCP	Increase to $20 or $25 copay	DEAN:
$25 Specialist	Increase to $35 or $40 copay	DEAN:
4. Covered Services F-17: Durable Diabetic Equipment and Related Supplies	**HealthPartners is requesting moving coverage of diabetic supplies to the pharmacy benefits.** Remove coverage for diabetic supplies from the medical plan.	**HealthPartners**: NA Removing coverage for diabetic supplies on the medical plan would align with market trend, reduce confusion for members, and could reduce plan costs due to favorable pricing and rebates for diabetic supplies via the PBM.
4. Covered Services F-38a: Reproductive Services and Contraceptives	**HealthPartners is requesting adding language to specifically name prenatal and postnatal care to Reproductive Services and Contraceptives.** Clarify coverage language for prenatal and postnatal care.	**Request from HealthPartners**: We recommend adding language to the COC F 38a: Routine prenatal care and exams, and routine postnatal care are covered. This includes health exams, assessments, education and counseling relating to the period immediately after childbirth. Maternity services for prenatal and postnatal care are covered, including services such as normal deliveries, ectopic pregnancies, cesarean sections, abortions allowable under Wis. Stat. §40.03 (6) (m), and miscarriages.
4. Covered Services F-18: Durable Medical Equipment and Medical Supplies	**HealthPartners is requesting adjusting the language in Durable Medical Equipment and Medical Supplies to state that all purchases or monthly rentals may need Prior Authorization.** Language change to better clarify existing benefit.	**Request from HealthPartners**: Language clarification: All Durable Medical Equipment purchases, or monthly rentals may have Prior Authorization as determined by your Health Plan.
4F-48: Vision Services	**HealthPartners is requesting removing the age differential regarding what is considered preventive for children within Vision Services.** Remove benefit differential for eye exams based on age. Offering a better benefit for eye exams for certain members based on their age may be considered a presumptive discriminatory benefit design, unless the health plan is able to justify the benefit differential by citing clinical evidence that supports imposing a benefit differential based on age. We don't have any clinical evidence that supports administering a better benefit for younger members and a worse benefit for older members (for eye exams).	**Request from HealthPartners**: Remove benefit differential: Vision screenings for Participants aged 5 and younger are considered preventive and are not subject to Deductible or office visit Copayments when provided by an In-Network Provider. Vision screenings for Participants aged 6 and older are not considered preventive and are subject to Deductible and specialty Provider office visit Copayment as applicable.
All Schedule of Benefits (SoBs) - under Emergency and Urgent Care	**HealthPartners is requesting clarifying member cost share for Emergency Care within the Schedule of Benefits.** Clarify member cost share for Emergency Care	**Request from HealthPartners**: Align Schedule of Benefits with SBC SBC: $75 copayment, then deductible, then 90% Schedule: $75 Copayment, then deductible, then 90%
ETF internal Department: Pages 68/69 F. Proof of Claim—Last paragraph	**Ombuds looking to get clarity in CoC language.** 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 twelve (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.	Proposed Language: Claims for services must be submitted to the Health Plan/and or PBM within 12 months, or later, as determined by the Department. If the Health Plan/and or PBM does not receive the claims within 12 months, the Health Plan/and or PBM may deny coverage of the claims. OR Current Language-reworked for clarity: Claims for services must be submitted to the Health Plan/and or PBM as soon as reasonably possible after date services were received. The Health Plan/and or PBM may deny coverage of a claim if not received within 12 months of the date of service. If later than 12 months, as soon as reasonably possible.
Add Benefit: **OMBUDS, this was also a Member request**: Specialized Contact Lenses Addition to Uniform Benefits-Durable Medical Equipment Member Request-Eric Hanson • GIB Control Correspondence Requesting Coverage • Understands that benefit additions must be costed out by actuaries.	**Ombuds looking to get clarity in CoC language.** Proposed Benefit Addition: Specialized Contact Lenses for the treatment of degenerative eye diseases in patients 18 years and younger. Benefit: 20% Coinsurance with Benefit Maximum of $500 per eye every two years or as medically necessary.	**ETF internal Department**
OMBUDS: Pay and Educate-Administrative Services Contract Provision-Addition Cost Benefit Analysis on cases with low dollar amounts-less than $200.00.	**Ombuds looking to get clarity in CoC language.** Proposal: Incorporate contract language in ASO that allows ETF to request that a Vendor "pay and educate" a member regarding their claim(s) or prior authorization denial. Member is educated on the one-time exception and notified that there will not be any further exceptions made on the same claim for services, regardless of which GHIP Vendor the member is enrolled in the future.	**ETF internal Department**
Member Request coverage of couples and marriage counseling.	I have recently found out that couples/marriage counseling is not covered in our medical coverage. Coverage for our spouses and ourselves is though. I humbly ask that staff looks into adding this since divorce rates are high with our jobs. I am a peer supporter and a large number of the discussions I have involve trouble at homes with significant others. I believe the state has a golden opportunity to help retain staff and help reduce mental anguish.	**Member** looking to add benefit.
Member Request to revisit eligibility for tummy tuck after Bariatric Surgery.	Looking to add benefit	**Member** looking to add benefit.
Line 51-59...Punted for 2026 from last year:		

Description of Requested Change ***(Provide a brief narrative of intended change)***	**Proposed Language** ***(Provide language from Program Agreement with changes highlighted in red text)***	**ETF Comments** ***(Additional justification for changes)***
Durable Medical Equipment and Medical Supplies (**Network Health**)	align Schedule of Benefits (SoBs) and CoC cost sharing to follow Durable Medical Equipment benefit for hearing aids (limit of 1 per ear every 3 years). What Network is trying to do is **avoid** the unique cost share set-up on hearing aids, as each claim is a manual process. - Member is responsible for deductible, - Then member pays 20% coinsurance, plan pays 80% up to $1,000 - Then the member is responsible for 100% of the remaining total	**Request by Network Health in 2025**
Physical, Speech, and Occupational Therapy (***Network Health***)	looking to limit 25 visits per discipline (Physical, Speech, and Occupational Therapy) since this is another manual process for Network and would like to track usage per discipline. Currently the CoC has up to 50 visits per Participants for all therapies combined.	**Request by Network Health in 2025**
Travel and Transportation (**Quartz**)	adding "medical evacuation" to specifically call it out in the Exclusions and Limitations section. Quartz didn't give any examples to help understand the specific callout of this request except they would like to align it to their commercial exclusions and limitations. My thinking is that Quartz had some issue come up via their commercial plan and would like to avoid that ramification with the GHIP.	**Request by QUARTZ in 2025**
Reproductive Services (**Dean**)	looking to add or exclude services related to the diagnosis of sexual dysfunction. Currently the CoC is silent. - Segal cost analysis: According to Merative Data, there were around 550 office visits dealing with Sexual Dysfunction totaling about $95K in 2022. Each visit was on average about $170. Since sexual dysfunction claims are already in the data, it seems that at least some of the plans are covering this benefit. National statistics show that around 30% of adults suffer from sexual dysfunction, with only about 25% of those adults seeking treatment. The cost would be no more than $3M if ETF's utilization followed the national statistics. However, it's unclear what proportion of these would be treated through emerging online companies (HIMS, Roman, etc.) instead of a doctor.	**Request by DEAN Health in 2025**
Weight Loss, Diet Programs, and Food or Supplements (**Member Request**)	asking to permit coverage for medical food (enteral feeding) which is formulated to be consumed or administered enterally under the supervision of a physician. This is intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.	**Member** looking to add benefit**.**
Durable Medical Equipment in the Local Deductible Health Plan - P04/14 (**Dean**)	looking to remove the separate Durable Medical Equipment (DME) $500 Out-of-Pocket Limits (OOPL). Dean would like DME to apply to Deductible/Coinsurance OOPL. The main concern is the amount of calls Dean receives regarding this. Members are confused with the separate $500 OOPL and how the deductible applies first, then they pay 20% coinsurance up to an additional $500 OOP.	**Request by DEAN Health in 2025**
ETF: review CoC	Review language related to home care benefits. Current language indicates 50 visits with possible 50 more. Security's benefit through Contessa is for a 30 day or 60 day episode. There may be multiple visits per day though. It will be good to understand what other health plans are doing and what their benefit includes. Do they offer home care as a number of days? Number of visits? How does it compare to our Certificate language?	**ETF Language review**
Durable Medical Equipment and Medical Supplies (**Dean**)	Currently we cover these items under Durable Medical Equipment and Medical Supplies with this caveat: "Elastic support hose, for example, JOBST, when prescribed by an in0network provider (for Access Plan or other PPO Plan Participants, an Out-of-Network Provider may prescribe and provide covered services). Limited to two pairs per calendar year." Starting 1/1/24 CMS has pulled the compression garments to treat Lymphedema out of their general coverage and given them it's own coverage because the garments comes in pieces so I person could wear more than one piece and some pieces are worn during the day and others can be worn at night. Whereas ETF pays for 2 pairs a year. CMS now for Medicare pays for: - Daytime: 3 garments per affected body part every 6 months - Nighttime: 2 garments per affected body part every 2 years. Maybe for 2026 we should pull this coverage and give it its own designation using terminology like "affected body parts" and "garments"	**Request by DEAN Health in 2025**
Well Wisconsin Changes for Medicare Advantage members	Revisit the availability of the Well Wi Program for Medicare Advantage members	**ETF to Review:** Dependent upon the Medicare Advantage RFP recommendation and contract award and IAS capabilities

Pilot Program Name	Description of program, including goals, relevant diagnosis, procedure, or other claims-related codes.	What date do you propose starting the program (no sooner than January 1, 2026)?
Dean: Acupuncture	10 visits/member/year	Propose to end the acupuncture pilot program 01/01/2026. The utilization/adoption rate is very low comparatively and it is not widely accepted by our medical system partners. 2024 utilization through August reflects 88 unique State members and 6 unique Local members.