

2027 Program Agreement Reference	Description of Requested Change	Proposed Language
III. Program Administration, A. Enrollment and Eligibility Maintenance, 4. Identification (ID) Cards	Remove "the emergency room and office visit copayment amounts, if applicable." Add: "No Surprises Act (NSA) requirements." The NSA requires deductible and out-of-pocket maximums; but does not require copays and/or coinsurance. ID cards have limited space to display all this information and have it be legible.	a. The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage and No Surprises Act (NSA) requirements. Or, alternately: a. The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage.
III.G.2. Primary Care Provider/Primary Care Clinic Designation.	Remove requirements related to PCP/PCC data passed to health plans via the files provided by ETF. PCP/PCC data will no longer be send to plans on enrollment files from My Insurance Benefits once it goes live.	
III. D. Data and Information Security	Clarify language related to subservice organization reporting and what constitutes a "major" system change that triggers the 180-day notification requirement.	TBD
New Section	Incorporate language that vendor "pay and educate" members 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.	TBD

2027 Health Plan Certificate of Coverage Reference	Description of Requested Change	Proposed Language
4. Benefits and Coverages, F. Covered Services, 18. Durable Medical Equipment and Medical Supplies, g.	Change limitations on coverage of compression garments to allow for instances where multiple garment pieces may be required to address a body part (e.g., upper and lower leg). The current policy is read to limit to only one piece per body part. CMS updated coverage in January 2024; this would align with CMS coverage requirements	Elastic support hose, for example, JOBST, when prescribed by an in-network provider (for Access Plan or other PPO Plan Participants, an Out-of-Network Provider may prescribe and provide covered services). Limited to three daytime garments per affected body part every 6 months, and 1 nighttime garment per affected body part per plan year.
5. Exclusions and Limitations, A. Excluded Services, 9. Informational Medical Exams and Testing, b.	Typo correction	9.b. Genetic testing and/or genetic counseling services not medically necessary to diagnose and treat illness.
4. Benefits and Coverages, F. Covered Services, 18. Durable Medical Equipment and Medical Supplies, h.	Clarify that benefit maximum includes the fitting and dispensing fees for hearing aids.	h. One hearing aid per ear, 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, and fitting and dispensing fee.
4. Benefits and Coverages, F. Covered Services, 40. Skilled Nursing Facilities	Remove "24 hours of discharge".	40. Skilled Nursing Facilities Confinement in a licensed Skilled Nursing Facility is covered as long as medically necessary. Prior authorization may be required. Only Skilled Care is covered; Custodial Care is excluded.
4. Benefits and Coverages, F. Covered Services, 30. Oral Surgery and Other Dental Services	Add "or other approved scoring methodology".	I. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30 or other approved scoring methodology.
4. Benefits and Coverages, F. Covered Services, 45. Temporomandibular Disorders	Align prior auth language to "may require prior auth" as stated throughout certificate of coverage.	45. Temporomandibular Disorders May require prior authorization, as required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures involving a bone, joint, muscle, or tissue, and for any medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

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4. Benefits and Coverages, F. Covered Services, 32. Physical, Speech, and Occupational Therapy	Have entire benefit be combined or per therapy. Change additional visits with prior auth to medical necessity.	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 when medically necessary, up to a maximum of 50 additional visits combined for all therapies, per participant, per calendar year.
5. Exclusions and Limitations, A. Excluded Services, 4. Durable Medical Equipment, Durable Diabetic Equipment, and Medical Supplies, a.	Align prior auth language to "may require prior auth" as stated throughout certificate of coverage.	a. Durable Medical Equipment, Durable Diabetic Equipment, or Medical Supplies that have not received prior authorization when required by your Health Plan.
4. Benefits and Coverages, F. Covered Services, 17. Durable Diabetic Equipment and Related Supplies	Move coverage continuous glucose monitor supplies to the pharmacy benefit	Durable diabetic equipment includes automated injection devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year. Glucometers and continuous glucose monitoring (CGM) devices and supplies that are required for use are available through the PBM except for Annuitants and their covered Dependents who are eligible for Medicare Part A and Medicare Part B. CGMs are covered for these Participants under Medicare Part B and the Health Plan. Refer to the Uniform Pharmacy Benefits document for more information.
1. Glossary of Terms / 5. Exclusions and Limitations, A. Excluded Services, 1. Administrative and Clerical Charges	Remove plan coverage of sales and other taxes	Charge: means an amount for a health care service from a Provider that is reasonable, as determined by the Health Plan. Charges include all taxes for which the Participant can legally be billed. 5.A.1. Administrative and Clerical Charges a. Charges for any missed appointment. b. Expenses for medical reports, including preparation and presentation. c. Charges for sales tax and value added tax (GST, IVA or VAT)

2027 Health Plan Certificate of Coverage	Description of Requested Change	Proposed Language
Reference		
4. Benefits and Coverages, B. Exceptions to In-Network Care Requirement, 2. Urgent or Emergency Room Care	Add a dollar limit to foreign claims coverage.	2. Urgent or Emergency Room Care 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.
6. Coordination of Benefits	Add provision to make travel insurance primary payor over health insurance on foreign claims.	Travel Insurance 1.Travel Insurance is primary to this policy. Participant needs to submit medical and/or pharmacy claim reimbursements to the travel insurance for coverage. Upon receipt of the travel insurance remit/EOB/documentation, any remaining amount can be submitted to the health plan for consideration of coverage – include the travel insurance claim payment documentation (EOB/remit) that shows remaining unpaid balance, itemized bill, proof of purchase and health plan reimbursement form
4. Benefits and Coverages, F. Covered Services, 17. Durable Diabetic Equipment and Related Supplies	Remove durable diabetic equipment (automated injection devices and insulin infusion pumps) coverage from the medical plan, to the pharmacy benefit.	Remove section.

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1. Glossary of Terms	Clarify e-visit as an asynchronous service.	E-Visit: means an asynchronous evaluation and treatment by a Provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An EVisit is also called a digital visit.
4. Benefits and Coverages, F. Covered Services, 44. Telemedicine and Remote Care, a. E-Visits	Clarify e-visit as an asynchronous service.	a. E-Visits E-Visits are covered by your plan. An E-Visit must be initiated by the Participant seeking services, not the Provider, to be covered. E-Visits are covered when the same service would be covered if provided in person when performed by: i. A doctor ii. A nurse practitioner iii. A physician assistant iv. Licensed clinical social workers v. Clinical psychologists or psychiatrists vi. Physical therapists vii. Occupational therapists viii. Speech language pathologists Because E-Visits are asynchronous, and can be completed via messaging services, they may happen over several hours or even days.
5. Exclusions and Limitations, A. Excluded Services, 20. Therapies Not Covered, b.	UW Health has a Pediatric Fitness Clinic that helps kids between 5-18 with health, fitness, nutrition, and weight gain. Because there is some physical activity involved plans have denied coverage under the therapies not covered, physical fitness and exercise exclusion	20. Therapies Not Covered b. Physical fitness or exercise programs (except for services administered Doctors of Medicine for members under 18 years old).

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5. Exclusions and Limitations, A. Excluded Services, 3. Cosmetic Treatments and Services, a.	Hidradenitis suppurative is a medical condition that if left untreated is very painful and could lead to other conditions including cancer. Laser hair removal surgery has been shown through multiple reports to treat the condition	3. Cosmetic Treatments and Services a. 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, 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), and hidradenitis suppurative. Psychological reasons do not represent a medical/surgical necessity.
4. Benefits and Coverages, F. Covered Services, 48. Vision Services / 5. Exclusions and Limitations, A. Excluded Services, 24. Vision Correction	Add coverage for specialized contact lenses in limited circumstances.	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.
4. Benefits and Coverages, F., Covered Services, 18. Durable Medical Equipment and Medical Supplies	Align Schedule of Benefits (SoBs) and Certificate of Coverage cost sharing to follow Durable Medical Equipment benefit for hearing aids (limit of 1 per ear every 3 years). Health plans would like to 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	TBD
4. Benefits and Coverages, F. Covered Services, 23. Home Care Benefits	Adjust maximums on home care benefits.	TBD
4. Benefits and Coverages, F. Covered Services, 30. Oral Surgery and Other Dental Services, I.	Add sleep apnea as an eligible diagnosis to Orthognathic Surgery under Oral Surgery and Other Dental Services.	I. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30 or sleep apnea.

2027 Schedules of Benefits Reference	Description of Requested Change	Proposed Language
Mental Health Counseling Visits	Add language to SOB's Under "Mental Health Counseling Visits" list out Autism Treatment as a covered service.	These services include behavioral health, autism treatment, psychiatric counseling, and substance use disorder services
Cost-sharing	Increase member cost shares to address medical and Rx inflationary pressures. Recommendations follow below.	
	IYC Health Plan Deductible (\$250/\$500)	Increase deductible by a minimum of \$250 (i.e., range from \$500 to \$1000) Example: \$500 Individual / \$1000 Family
	IYC Health Plan OOPL (\$1250/\$2500)	Increase OOPL a minimum of \$500/\$1000 Example: \$1750 Individual / \$3500 Family
	IYC Health Plan Coinsurance (10%)	Increase from 10% to 20% (and apply consistently to all benefits that take a coinsurance) Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible. You pay: 20% after deductible is met Plan pays: 80% after deductible is met
	HDHP Coinsurance (10%)	Increase from 10% to 20% (and apply consistently to all benefits that take a coinsurance) Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible. You pay: 20% after deductible is met Plan pays: 80% after deductible is met
	HDHP OOPL (\$2500/\$5000)	Increase a minimum of \$500 Example: \$3000 Individual / \$6000 Family
	PCP Copay (\$15)	Increase from \$15 to \$20 or \$25
	Specialist Copay (\$25)	Increase from \$25 to \$35 or \$40
	ER Copay (\$75 / \$60)	Increase to \$150 - \$200
	Local Employer HDHP	Offer a higher deductible HDHP with a higher OOPL
	Local P02/P12 (Traditional Full Pay)	Mirror State offering eligibility - Medicare Prime only; eliminate ability to offer as primary plan election for all active employees
	Local P04/P14 (\$500 Deductible)	Add 20% coinsurance after deductible, increase deductible from \$500 Individual / \$1000 Family to \$750 Individual / \$1500 Family. OOPL \$1500 Individual / \$3000 Family.
	Separate DME OOPL (\$500)	Remove separate OOPL for DME on the Traditional Full Pay and \$500 Deductible plan Follow deductible/coinsurance (same as IYC Health Plan)
	Out-of-Pocket Limits (OOPL)	Have all services apply to the OOPL (i.e., include non-essential health benefits)

2027 Uniform Dental Benefit Certificate of Coverage Reference	Description of Requested Change	Proposed Language
New Section	Special Health Care Needs Benefit Addition	Members with special health care needs will have access to additional services to help improve their oral health and minimize the risks for future, more costly procedures. Some of the enhanced benefits include: •Additional visits or exams prior to the first treatment for patients to learn what to expect and what is needed for a successful dental appointment. •Up to four cleanings in a year to minimize plaque build-up and maintain oral health. •Extra chair time to help patients with sensory processing differences, behavioral challenges, or other barriers to treatment. •Anesthesia and/or nitrous oxide (when necessary)
2027 Uniform Pharmacy Benefit Reference	Description of Requested Change	Proposed Language
New Section	Request that GLP-1 cost analysis be updated to account for any changes in pricing of GLP-1s	TBD