AGENDA AND NOTICE OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD MEETING

Tuesday, April 14, 2009
9:00 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

Documents for this meeting are available on-line at:
http://etf.wi.gov/boards/board_gib.htm
To request a printed copy of the agenda items, please contact
Cindy Gilles, at (608) 261-0736.

Times shown are estimates only.
⬅ *Denotes action item.*

9:00 a.m. **1. Call to Order**

9:05 a.m. ⬅ **2. Consideration of Minutes of February 17, 2009, Meeting**

9:10 a.m. ⬅ ***3. Appeals**
- 2008-006-GIB and 2008-027-GIB

9:25 a.m. **4. Announcement of Action Taken on Business Deliberated During Closed Session**

9:30 a.m. ⬅ **5. Health Insurance Program**
- Establish Dual-Choice Enrollment Dates
- 2010 Guidelines and Uniform Benefits

10:15 a.m. ⬅ **6. Long-Term Care Insurance Program**
- John Hancock Replacement Policy

10:30 a.m. **7. Income Continuation Insurance/Long-Term Disability Insurance Programs**
- Aetna Annual Update

11:00 a.m. **8. Miscellaneous**
- Enrollment Validation Payment (EVP) Project Update
- Budget/Legislative Update
- Correspondence/Complaint Summary
- 2010 Meeting Dates
- Pending Appeals Status Report
- Surviving Insured Dependent Rule Update-CR 08-079
- Announcements
- Future Agenda Items

11:15 a.m. **9. Adjournment**

At the conclusion of the meeting, the Board will host a reception to honor outgoing Chair Steve Frankel. No Board business will be discussed. The public is invited.

***The Board may be required to meet in closed session pursuant to the exemptions contained in Wis. Stats. § 19.85(1)(a) for quasi-judicial deliberations. If a closed session is held, the Board will reconvene into open session for further actions on these and subsequent agenda items.**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Cindy Gilles, Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931. Telephone number: (608) 261-0736. Wisconsin Relay Service 7-1-1. e-mail: cindy.gilles@etf.state.wi.us.

MINUTES OF MEETING

DRAFT

STATE OF WISCONSIN
GROUP INSURANCE BOARD

Tuesday, February 17, 2009

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

BOARD PRESENT:
Steve Frankel, Chair
Cindy O'Donnell, Vice-Chair
Esther Olson, Secretary
Robert Baird
Martin Beil
Eileen Mallow
Paul Ostrowski (representing Jennifer Donnelly)

BOARD NOT PRESENT:
Janis Doleschal
David Schmiedicke
Gary Sherman

PARTICIPATING ETF STAFF:
Dave Stella, Secretary
Bob Conlin, Deputy Secretary
Tom Korpady, Administrator, Division of Insurance Services
Bill Kox, Director, Health Benefits and Insurance Plans Bureau
Michelle Baxter, Director, Insurance Administration Bureau
Diane Poole, Director, Disability Programs Bureau
Cindy Gilles, Group Insurance Board Liaison

OTHERS PRESENT:
Janine Anderson, Wisconsin Physicians Service Insurance Corporation
Brian Bellford, Legislative Audit Bureau
Barb Belling, Office of the Commissioner of Insurance
Marcia Blumer, Division of Insurance Services
Jeff Bogardus, Division of Insurance Services
Penny Bound, Dean Health Plan
Andrea Darling, United Health Care
Jess Domnick, Navitus
Phil Dougherty, Wisconsin Association of Health Plans
Rhonda Dunn, Office of the Secretary
Elizabeth Dye, Group Health Cooperative
Lisa Ellinger, Division of Insurance Services
Kjirsten Eisner, Minnesota Life Insurance Company
Colleen Evans-Carter, Anthem
Caitlin Frederick, Department of Administration
Becky Gorst, Security Health Plan
David Grunke, Wisconsin Physicians Service Insurance Corporation

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Emily Halter, Group Health Cooperative South Central
Ross Hampton, Wisconsin Education Association Trust
Sue Hill, Navitus
Steve Hurley, Office of Policy, Privacy and Compliance
Kathy Ikeman, Unity Health Insurance
Joy Kaiser, Medical Associates Health Plans
Jon Kranz, Office of Budget and Trust Finance
Arlene Larson, Division of Insurance Services
Teri Malsch, Wisconsin Physicians Service Insurance Corporation
Michelle Mazola, Anthem
Peg Narloch, Division of Insurance Services
Greg Nelson, Wisconsin Physicians Service Insurance Corporation
Connie O'Connell, Gateway Ventures
Tom Pabich, Navitus
Ryan Pelz, Mercy Care
Roxanne Perille, Humana
Paul Perkins, Group Health Cooperative
Kathy Pinsen, Gateway Ventures
Gail Reckner, Security Health Plan
Beth Ritchie, University of Wisconsin System Administration
Deb Roemer, Division of Insurance Services
Bob Schaefer, State Engineers Association
Chris Schmelzer, Minnesota Life Insurance Company
Ron Sebranek, Physicians Plus Insurance Corporation
Peg Smelser, Wisconsin Education Association Trust
Joan Steele, Division of Insurance Services
Gary Steffen, Wisconsin Science Professionals
Matt Stohr, Office of Legislative Affairs, Communications, and Quality Assurance
Susana Vasquez-Jarcee, Group Health Cooperative
John Verberkmoes, American Federation of Teachers-Wisconsin
Sharon Walk, Office of the Secretary
Allan Wearing, Blue Cross Blue Shield of Wisconsin
Sharon Whitman, Wisconsin Physicians Service Insurance Corporation
Brandon Widell, United Health Care
Bob Willett, Office of Budget and Trust Finance
Betty Wittmann, Division of Insurance Services

Steve Frankel, Chair, Group Insurance Board (Board), called the meeting to order at 9:30 a.m.

ANNOUNCEMENTS

Welcome Back to Rhonda Dunn Dave Stella, Secretary, welcomed back Rhonda Dunn, Executive Assistant of the Department of Employee Trust Funds, from her leave. Ms. Dunn thanked everyone for their support.

Department Reorganization Tom Korpady, Administrator, Division of Insurance Services, announced that the Governor's Office and the Department of Administration approved the reorganization of the Department of Employee Trust Funds. Within the Division of Insurance Services, there is a new Bureau of Insurance Administration, headed by Michelle Baxter.

CONSIDERATION OF MINUTES OF NOVEMBER 11, 2008, MEETING

MOTION: Ms. Mallow moved approval of the minutes of the November 11, 2008, meeting as submitted by the Board Liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

ELECTION OF OFFICERS

Mr. Frankel shared that after 21 years as Board Chair, he will be retiring from the Board in April.

NOMINATION FOR CHAIR: Ms. Olson nominated Cindy O'Donnell for Chair. The nomination was seconded by Ms. Mallow.

MOTION: Mr. Beil moved to close the ballot and elect Ms. O'Donnell as Chair. Ms. Mallow seconded the motion. The vote passed without objection on a voice vote. Ms. O'Donnell abstained.

NOMINATION FOR VICE-CHAIR: Ms. O'Donnell nominated Eileen Mallow for Vice-Chair. The nomination was seconded by Ms. Olson.

MOTION: Mr. Beil moved to close the ballot and elect Ms. Mallow as Vice-Chair. Mr. Baird seconded the motion. The vote passed without objection on a voice vote. Ms. Mallow abstained.

NOMINATION FOR SECRETARY: Mr. Baird nominated Esther Olson for Secretary. The nomination was seconded by Ms. O'Donnell.

MOTION: Mr. Beil moved to close the ballot and elect Ms. Olson as Secretary. Ms. Mallow seconded the motion. The vote passed without objection on a voice vote. Ms. Olson abstained.

MOTION: Ms. Olson moved to have the newly elected officers take office after the April 14, 2009, meeting. Ms. Mallow seconded the motion, which passed without objection on a voice vote.

HEALTH INSURANCE PROGRAM

Guidelines/Uniform Benefits Timeline: Mr. Kox discussed the timeline for development of changes to the Guidelines and Uniform Benefits for contract year 2010. The staff discussion will begin on or about February 24, 2009. In the past, Board members and their staff have participated in the discussions. Final recommendations for changes will be presented to the Board at the April 14, 2009, meeting. Some of the changes that will be discussed include:

- **Administration:** Language modification describing the calculation of Medicare-reduction rate.
- **Eligibility/Enrollment:** Administrative Rule change for surviving dependents to continue coverage.
- **Local Government Contract:** The need to tighten the 65% participation waiver for new groups when in conflict with group underwriting requirements.
- **Benefits:** Federal Mental Health Parity, which goes into effect January 1, 2010. Additional coverage, including dental implants, bariatric surgery, and acupuncture. Changes to offset benefit additions, including increased co-payments of emergency room visits and prescriptions.

Cost and Quality Project Update: Mr. Korpady provided a brief update on Dr. John Hansen's project regarding the treatment for lower back pain.

2009 Dual-Choice Enrollment Results: Mr. Korpady shared that it was a slow year for member applications to switch health plans. The State Maintenance Plan increased by 168 contracts.

Report on Health Plan Employer Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (CAHPS®): Mr. Kox reported that the HEDIS® and CAHPS® performance measures are included in the report annually. Overall, Wisconsin health maintenance organizations are performing above the national average in most areas. Areas needing improvement include cancer screening, mental health services and antibiotic indicators.

Third Party Audit of WPS Health Insurance: Mr. Kox shared that Claim Technologies Incorporated (CTI) conducted an audit of WPS for calendar years 2006 and 2007. WPS is performing in the top half of approximately 100 plans that CTI has audited on 11 of the 12 measures. CTI noted improvements could be made with regard to claims paid after member termination. This typically happens after retroactive coverage terminations from employers.

Medicare Part D Prescription Drug Plan: Mr. Kox highlighted the investigation into contracting with the Centers for Medicare and Medicaid Services (CMS) in order to provide a Medicare Part D Prescription Drug Plan (PDP). The advantages include: additional savings to the State Group Health Insurance Program, depletion of the Governmental Accounting Standards Board liability, and employer group waivers. The disadvantages include: increased pharmacy benefit management administration costs as well as more complexity and staff time.

HEALTH INSURANCE ENROLLMENT, VALIDATION, AND PAYMENT (EVP) PROJECT

Ms. Baxter shared with the Board that in 2008 an internal planning team developed a plan to improve and update the Health Insurance and Complaint System. The main focus of the project is to provide online services, ensure participants eligible for medical and pharmacy benefits receive such benefits, eliminate duplication of work, and ensure continued compliance with the Health Insurance Portability and Accountability Act. The project will be completed in multiple phases during 2009 and 2010.

INCOME CONTINUATION INSURANCE (ICI) MONTHLY EARNINGS CALCULATION

Ms. Poole presented information on proposed language changes for the State ICI Plan to correct changes made in 2006 that negatively affected employees who worked overtime on a regular basis and forced employers to continually project salaries for premiums. Premiums will now remain the same upon return to employment from an authorized leave and are only changed after the employee has worked one full calendar year or has a permanent change in appointment. For benefits, earnings are determined at the time of disability. Earnings may be projected when only the rate of pay changes. For those who unsuccessfully attempt to return to work, earnings will be the same as the prior disability or prior calendar year's earnings.

Mr. Beil thanked Ms. Poole and the staff for the work they have done with this language.

MOTION: Mr. Beil moved to approve the State and Local ICI plan changes. Ms. O'Donnell seconded the motion, which passed without objection on a voice vote.

POST-RETIREMENT LIFE INSURANCE ACTUARIAL VALUATION

Bob Willett, Office of Budget and Trust Finance, reported that the Governmental Accounting Standards Board (GASB) established new accounting and financial reporting standards for benefits paid to employees after their working careers, commonly referred to as Other Post-Employment Benefits (OPEB). The new GASB rule requires that the full cost of retiree benefits must be accrued while they are employed and the benefit plan must account for any accrued unfunded liability. With these changes, retirees under age 65 will now be linked with "over age 65 retirees." The GASB requirements have necessitated changes to the Wisconsin Public Employers Group Life Insurance Program administrative agreement between the Group Insurance Board and Minnesota Life Insurance Company (MLIC).

MOTION: Mr. Beil moved to accept the recommendations of MLIC with regard to changes to the administrative agreement and annual reporting to comply with GASB standards. Mr. Baird seconded the motion, which passed without objection on a voice vote.

CONSIDERATION OF PAYROLL DEDUCTION AUTHORIZATION FOR LEGAL SERVICES PLAN

Connie O'Connell and Kathy Pinson, Gateway Ventures, Inc., (Gateway Ventures) presented information to the Board regarding Gateway Ventures offering pre-paid legal insurance coverage through Pre-Paid Legal Casualty, Inc., as an optional employee benefit at a rate of $14.75/month without legal shield and $15.75/month with legal shield. Gateway Ventures has a 42% loss ratio of the full value of the benefits offered, when compared to other employee benefit plans.

MOTION: Mr. Beil moved to accept Gateway Ventures request to offer pre-paid legal services through Pre-Paid Legal Casualty. Ms. O'Donnell seconded the motion. The motion failed on the following roll call vote:

Members voting Aye: Beil and O'Donnell

Members voting Nay: Baird, Frankel, Mallow, Olson, Ostrowski (for Donnelly)

MISCELLANEOUS

Mr. Korpady referred the Board members to the various items included in the Board packets.

ADJOURNMENT

MOTION: Ms. Mallow moved to adjourn the meeting. Mr. Baird seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 10:55 a.m.

Dated Approved: _____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: March 30, 2009

TO: Group Insurance Board

FROM: Arlene Larson, Manager
Self-Insured Health Plans

SUBJECT: Establishment of Dual-Choice Enrollment Period

Staff recommends that the Group Insurance Board (Board) approve October 5-23, 2009, as the Dual-Choice Enrollment period for 2009.

The Board annually establishes the dates of the Dual-Choice Enrollment period. Staff recommends setting October 5-23, 2009, as the Dual-Choice Enrollment period for coverage effective on January 1, 2010.

Setting this date offers payroll representatives adequate time to enter application data in time for their payroll calendar deadlines. It also allows sufficient time to complete the printing and distribution of the *It's Your Choice* books prior to the start of Dual-Choice, and gives health plans enough time to print the provider directories for participants making enrollment decisions.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
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CORRESPONDENCE MEMORANDUM

DATE: April 2, 2009

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Joan Steele, Manager, Alternate Health Plans

SUBJECT: Guidelines and Uniform Benefits for the 2010 Benefit Year

The study group recommends that the Group Insurance Board (Board) adopt the Guidelines and Uniform Benefits changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.

Background

Annually, the Board reviews its *Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program*. As part of this review, necessary changes are made to the health insurance contract and the Uniform Benefits package. As in the past, there will be no net material change in the overall benefit level.

A study group met on February 24 and March 10, 2009, to establish recommendations contained in this memo for the Board's consideration. The attached tables also include other relevant clarifications that are not specifically discussed in this memo.

The study group meetings included: Barbara Belling, Office of Commissioner of Insurance (OCI); Caitlin Morgan Frederick, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Jim Pankratz, OSER; Beth Ritchie, University of Wisconsin (UW); and the following Department of Employee Trust Funds (Department) staff: Lisa Ellinger, Bill Kox, Joan Steele, Arlene Larson, Jeff Bogardus, Michelle Baxter, Brian Schroeder, Matt Stohr, Sari King, Liz Doss-Anderson, Christina Keeley, and Vickie Baker.

Please note that as staff continues to refine Uniform Benefits, further contract changes may be necessary. For example, we may need to revise the contract to reflect changes that may be required if other state mandates are passed before the bidding process is completed. Staff will bring any notable changes before the Board but is also requesting authority to proceed with any needed technical clarifications.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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Attached are the following:

- **Attachment A** – Explains the basis for any notable changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B** – Excerpts from the Guidelines, Addendum, and State and Local Contracts with recommended cost-neutral modifications for 2010.
- **Attachment C** – Explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** – Excerpts from Uniform Benefits, with recommended modifications for contract year 2010.

The impetus for these proposals comes from the Board, participants, health plans and staff. Health plans were informed of some proposed changes via e-mail on January 23, 2009. In response to comments from health plans, some minor revisions were considered and/or made when developing these recommendations. Specific health plan comments are available from staff upon request.

Some changes are clarifications or specific statements of existing practice; other revisions are more substantive. Changes under discussion are shown with shading of new language and ~~striking out~~ of language to be deleted. There are also a few changes shown in Attachments B (Guidelines/Addendum/Contracts) and D (Uniform Benefits) that are not described on the tables or discussed below. We consider these to be minor modifications or clarifications of current practice.

Where appropriate, the recommendations also apply to the Wisconsin Physicians Service (WPS) contracts for the Standard Plans and staff will make the necessary changes.

RECOMMENDED CHANGES TO ADMINISTRATION

1) **Non-Payment for Medical Errors:** The group discussed the Federal Centers for Medicare and Medicaid Services (CMS) policy effective in October 2008 in which payments are withheld from hospitals for care associated with treating certain infections and medical errors. The group recommended adding language stating that health plans are expected to incorporate the CMS policy into their contracts with network providers and hospitals.

2) **Medicare Rate Calculation:** The group discussed and recommended modifying the calculation of the Medicare-reduced rate, pending the recommendation of the Board's actuary. This will impact those health plans with Medicare-reduced rates within the acceptable range, but could be lower, based on participants' experience. Staff will report to the Board when the analysis is complete.

3) **Medicare Rate Categories:** The group discussed and recommended revising the Medicare-reduced family rate categories so that the Medicare Family 2 rate applies only after all insured family members are on Medicare. This is viewed as a fairness issue, as currently an insured family with one person over (i.e., on Medicare) and one person under (i.e., not on Medicare) pays more in premium than a family with two persons over and one or more family members under. Currently, there are approximately 40 contracts in the Medicare Family 2 rate category that do not have all family members on Medicare and the group recommends these contracts be grandfathered.

RECOMMENDED CHANGES TO ELIGIBILITY/ENROLLMENT

4) **Dependent Coverage:** The group discussed and recommended requiring subscribers to list on the application all family members that are eligible for coverage when applying for family coverage. This has been an issue in the past when a subscriber with family coverage does not list an eligible dependent on the application, such as a stepchild, and files an application at a later date, sometimes years later, to add the dependent. Current contract language states the newly-added dependent has coverage based on when family coverage went into effect, if the dependent was eligible at that time. This can cause significant administrative issues for the health plans to reprocess claims from past years. The group recommends that eligible dependents not listed on an application for family coverage can be added to the policy effective the first of the month following the employer's receipt of the application. Newborns and adopted children are exceptions, as state statute provides coverage from birth and placement for adoption.

5) **Retrospective Premium Adjustments:** The group feels that having a set time period for retrospective premium adjustments is a more equitable approach. Currently, the contract allows for premium adjustments to occur back to January 1 of the previous year. Due to enhanced system tracking capabilities, the group discussed and recommended modifying the provision to limit retrospective premium to six months.

6) **Rehired Annuitants at the University:** The group recommended adding the rehired annuitant language as requested by the University. The University, on behalf of the Board of Regents, requested the Board put into contract the University's current policy that rehired annuitants are not eligible for the graduate assistant plan offered under Wis. Stat. § 40.52 (3) (see attachment E). This plan is priced lower than the regular active plan because it is expected to cover graduate assistants who are typically younger and consequently a lower risk than the general population.

RECOMMENDED CHANGES TO THE LOCAL CONTRACT

7) **65% Participation Requirement:** The group discussed the potential risk to the program for participation waivers filed by new groups joining our health insurance program, which may allow for the new group to waive out those members with better risk. The Board's actuary supports a minimum 65% participation requirement before the new group is able to join the health insurance program. The group recommends adopting this change and allowing large employers with more than 50 employees to retain a second plan for up to four years due to the timing of collective bargaining, provided the employer meets the minimum 65% participation requirement.

8) **Allow Continuation Coverage for Participants Subsequently Found to be Ineligible:** Several situations arose in the past whereby a local employer joins our health insurance program and later discovers that some insured participants will not be eligible. The group recommended adding language to allow the participants who are subsequently found to be ineligible to elect continuation coverage for up to 36 months.

RECOMMENDED CHANGE TO BENEFITS

As described below, the group recommends the following benefit changes that are cost-neutral.

9) **Pharmacy Annual Out-of-Pocket (OOP) Maximum:** The group recommends increasing the OOP maximum for 1½ years, which is consistent with recent past practice. The annual OOP maximum is currently $385 per individual/$770 per family. Periodically, the Board revises the OOP maximum in accordance with the change in relative value of the original Uniform Benefits maintenance drug list. It was not increased from 2004 through 2006. For 2008 and 2009, it was increased in relative value for 1½ years to make up for some of the lag. The Board's actuary calculated the following OOP maximum amounts for various changes in its relative value:

   - $455/$910 for the two years during which it was not adjusted.
   - $410/$820 for the 1½ years adjustment.
   - $400/$800 for the one year adjustment.

10) **Breast Implant Coinsurance:** It has come to staff's attention that health plans are inconsistent in benefit administration of breast implants for reconstruction following mastectomy. Five health plans process claims for the breast implant under the medical supplies and durable medical equipment benefit that is payable at 80%. Ten health plans pay for the breast implants at 100%. The group discussed and recommended language to clarify the benefit administration so that the coinsurance is not applied to breast implants for reconstruction following mastectomy. According to the Board's actuary, the cost to specify that the coinsurance does not apply is $0.01 per member per month (PMPM), which has always been viewed as a rounding issue and not subject to a benefit offset.

11) **Case Management/Alternate Treatment:** This provision states the health plan must recommend the alternate treatment. The group discussed and recommended broadening the contract's case management/alternate treatment provision to allow the member's attending physician to make recommendations for the alternate treatment with the health plan coming to agreement with the course of treatment before the recommended alternate treatment is provided and covered under the contract. The Board's actuary states this change should not have an impact on cost.

Other potential changes affecting costs. As described below, the group acknowledges the following benefit changes that have a fiscal impact and are or may be required by law.

12) **Federal Mental Health Parity:** Pursuant to the recently passed Federal Mental Health Parity Act (FMHPA) as contained in the stimulus package, the group recommended language changes to remove the dollar and day maximums for mental health and alcohol and other drug abuse (AODA) treatment. As this is a federal mandate, no benefit offset is needed. FMHPA provides an exemption next year if the costs rise more than 2% in the first year. Department staff will work with the Board's actuary to monitor the cost impact.

13) **Other State Mandates:** As of today, the status of several mandates is unknown. The mandates have a fiscal impact and include providing autism benefits and coverage for domestic partners. The contract language will be updated as necessary to comply if the mandates are passed for 2010 before the premium bidding process is completed.

Summary of Cost Impact of Potential Changes

Benefit Increase	PMPM
Breast Implant Coinsurance	$0.01
Total	**$0.01**

Benefit Reduction	PMPM
Total	**$0.00**

DISCUSSION OF OTHER ISSUES

Other issues were considered by the study group but did not result in recommended changes. The most notable issues are summarized below. Staff will provide additional information upon request.

1) **Medicare Prescription Drug Plan (PDP):** After reviewing timelines and requirements, Department staff indicated the PDP is likely to be pursued for 2011 at the earliest. Therefore, no changes are needed at this time. For 2010, we will again seek the Retiree Drug Subsidy (RDS), if eligibility continues.

2) **Office Visit Copayment Option & Two-Person Rate (Local Program):** The group considered recommendations from a local employer that requested an option that included copayments for office visits and a two-person rate category. The group recommends pursuing a benefit option that includes office visit copayments at such time when there is sufficient interest expressed by local employers to justify the administration of a different benefit level. The two-person rate category would require a statutory change and is not warranted, based on past cost analysis that does not show enough cost difference between two-person contracts and family contracts that cover three or more individuals.

3) **Emergency Room (ER) Copayment:** The group discussed possible changes to the copayment assessed during ER visits when not admitted directly to the hospital as an inpatient. One possible change based on a participant recommendation is to waive the copayment when admitted for observation. The Board's actuary estimates a PMPM cost of $0.02 to make this change. The group does not recommend pursuing this benefit change because there are no benefit decreases to offset its cost.

   The group also considered the option of removing the waiver so the ER copayment is assessed even when the member is admitted directly from the ER as an inpatient. This may avoid complaints from members who were admitted from the ER for observation who believe their copayment should be waived. According to the Board's actuary, the PMPM savings for this benefit change is $0.25. However, a concern was expressed that if the copayment is not waived, it could deter some members from seeking care in the ER for emergency situations. The Board's actuary felt this was not an issue because the copayment currently applies to the benefit and members use the ER not knowing if they will be admitted and have the copayment waived. Health plans indicate that it is standard in commercial business to waive the ER copayment when the member is admitted as an inpatient directly from the ER. The group does not recommend pursuing a benefit decrease that is outside the industry norm.

   The group also discussed increasing the ER copayment from $60 to $70. According to an informal survey of health plans, the average ER copayment for commercial business ranges between $75 to $100. The Board's actuary indicates this benefit change would have an approximate PMPM savings of $0.17. The group does not recommend pursuing a benefit decrease that may be punitive in rural areas where there are limited choices due to fewer urgent care facilities or limited urgent care hours.

4) **Acute Inpatient Rehabilitation:** The group discussed a health plan's recommendation to limit the benefit for acute inpatient rehabilitation to 90 days so that it aligns more closely to its commercial business for ease of administration. Currently, the benefit is unlimited. The Board's actuary indicates this benefit decrease would generate a PMPM savings of $0.00 to $0.01. The group does not recommend this benefit change because it is cost neutral and would impact those rare situations when a member needed prolonged rehabilitation.

5) **Weight Loss Surgery (Gastric Bypass) Benefits:** The group again considered coverage for the surgical treatment of obesity (e.g., gastric bypass), which has been requested by numerous participants. The estimated PMPM cost to add the benefit is $7.02 initially, due to pent-up demand, and $4.68 thereafter. If benefits were added for 80% coverage, the estimated PMPM cost is $5.48 initially and $3.65 thereafter. Even though costs for the procedure are decreasing, the PMPM has risen due to increased utilization. The group concurred that adding gastric bypass to Uniform Benefits for the surgical treatment of obesity will require substantial benefit decreases in order to maintain the overall benefit level as required by statute. As the treatment may be covered under the Standard Plan if it meets WPS's medical necessity criteria, the group does not recommend adding this benefit for 2010.

6) **Dental Implants Following Accidental Injury:** The group considered allowing coverage for dental implants under the accidental loss of teeth provision, as dental implants are becoming the standard of care as well as a more cost-effective treatment option in some situations. If the benefit is capped at $1,000 per tooth, the cost impact is $0.18 PMPM. If the benefit is capped at $1,000 per year, the cost impact is $0.12 PMPM. The group does not recommend pursuing this benefit change because of its cost.

7) **Acupuncture:** The group discussed a request from several participants to add benefits for acupuncture. The PMPM estimated cost to add this benefit would be $0.50. If the benefit was capped at $1,000 per year, the estimated PMPM cost would be $0.45 PMPM. The group does not recommend pursuing this change because the contract currently has a provision for alternate treatment that would allow a health plan to extend coverage to acupuncture in limited situations when it is determined to be medically appropriate.

8) **Flexible Flat Feet:** The group discussed a participant's request to add coverage for the treatment of flexible flat feet, which is currently excluded. The Board's actuary indicates that almost half of children ages three through six have this condition and outgrow it. The PMPM cost to add this benefit is $0.05 to $0.10. The group does not recommend pursuing this benefit change because of its cost and that it may encourage treatment for a condition that often corrects itself with time.

9) **Orthognathic Surgery:** The group discussed a health plan's request to add coverage for orthognathic surgery, which is currently excluded. The Board's actuary estimates the PMPM cost of $0.35 to add this benefit. The group does not recommend pursuing this benefit change due to its high cost and because the benefits are available under the Standard Plan.

10) **Orthoptics (Eye Training or Vision Therapy):** The group discussed a participant's request to expand the benefits for orthoptics. Currently, two visits are covered per lifetime, one for training and the second for follow-up. The Board's actuary estimates the PMPM cost would be $0.10 to $0.15 to provide an unlimited benefit for orthoptics. The group does not recommend pursuing this benefit change due to its cost and because a limited benefit is currently available.

11) **Intrauterine Devices (IUD) Coinsurance:** The group discussed a participant's request to provide full benefits for IUDs. Currently, IUDs are covered under the medical supplies benefit, subject to 20% coinsurance. Removing the coinsurance from this benefit would cost approximately $0.04 PMPM. According to the health plans and the Board's actuary, the available medical information does not support the participant's claims on safety and cost. Hence, the group does not recommend pursuing this benefit change.

If the Board chooses to add any of the benefits listed in the section above, the pharmacy copayments could be increased to finance them. Currently, the pharmacy copayments are **$5/$15/$35**. The Board's actuary calculated the savings for the following pharmacy copayments, assuming an OOP maximum of $410/$820:

- $5/$16/$35 would generate $0.18 PMPM.
- $5/$16/$40 would generate $0.33 PMPM.
- $5/$18/$40 would generate $0.66 PMPM.

Staff will be available at the Board meeting to respond to any questions or concerns. We again thank the guidelines discussion group members for their participation in this process.

Notable Changes Under Consideration for the 2010 Guidelines, Addendum, and State and Local Contracts

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
Guidelines I. Pages 1 – 3			Rearranged language to better explain the local government program and added language to explain the surcharge assessment and underwriting process.	To reflect current processes.
Guidelines II., D., 4 .- 6. Page 4			Added language for the Department to request health plans to demonstrate their efforts in encouraging network providers to participate in various quality initiatives.	To replace requirements in Addendum 1C that has been eliminated.
Guidelines II., D., 8. Page 5			a) Added language specifying the utilization/disease management submission is in the format as determined by the Department. b) Added language specifying that health plans requiring a primary care provider or clinic selection must have processes to allow members to reasonably change their selection.	a) To provide flexibility to the Department to modify the submission as deemed necessary. b) To replace requirements in Addendum 1C that has been eliminated.
Guidelines II., E., 7. Page 6			Added language stating that health plans are expected to incorporate the CMS policy into their provider and hospital contracts to withhold payments for care associated with treating certain infections and medical errors.	Refer to discussion item #1 on page 2 of the memo.
Guidelines II., H. Page 7			a) Revised language as to further encourage health plans to separate higher cost providers into separate plans. b) Revised the requirements for the Medicare coordinated family rate categories.	a) To encourage health plans to pursue this, as it has been permissible under the contract. b) Refer to discussion item #3 on page 2 of the memo.
Guidelines II., J. Pages 8 - 10			Updated the time table for annual submissions.	• To delete the Addendum 1C submission • To add the health plan features comparison summary, • To clarify the group experience submission, • To require a PDF of the provider directory on health plans' web sites, • To specify contract attachments, and • To change the timing of the utilization/disease management report.

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
Addendum 1 Pages 11 - 13			a) Added language clarifying Table 8B requirements. b) Deleted Addendums 1B & 1C.	a) To replace requirements in Addendum 1B. b) No longer needed.
	Article 1.1 Page 14	Same	Updated the definition to include a person who is receiving a long-term disability.	To clarify current practice.
	Article 1.7 Pages 14 - 15	Same	a) Rearranged the language to flow with the Administrative Rule. b) Revised language to require an application to cover eligible dependents.	a) For consistency purposes. b) Refer to discussion item #4 on page 3 of the memo.
	Article 2.2 (5) Page 16	Same	Added language specifying health plans must comply with laws regarding patient privacy.	Recommended by staff to clarify current practice.
	Article 2.2 (6) Page 16	Same	Added language requiring health plans to maintain a written contingency plan and to submit it upon request.	Recommended by staff to ensure health plans can continue operation.
	Article 2.3 (4) Page 16	Same	Added language to limit retrospective premium adjustments to two months.	Refer to discussion item #5 on page 3 of the memo.
	Article 2.5 (2) Page 16	Same	Reduced the per member per month from health plans for the costs of informational materials.	Reviewed annually and updated as appropriate.
	Article 2.8 (2) Page 17	Same	Revised language describing processing of applications.	To update processes due to implementation of electronic enrollment data transmission.
	Article 2.10 (7) Page 17	Same	Added language specifying this provision complies with all laws regarding patient privacy.	Recommended by staff to clarify current practice.
	N/A	Article 3.1 (2) Page 18	Added language specifying that ineligible participants can elect continuation coverage for up to 36 months.	Refer to discussion item #8 on page 3 of the memo.
	N/A	Article 3.1 (3) Page 18	Added language requiring a local employer who is assessed a surcharge to participate in the program a minimum of three years.	To protect the risk pool of the local program.
	N/A	Article 3.1 (5) Page 19	Revised the waiver provision so that only large employers (>50) may retain a second plan for up to four years due to the timing of collective bargaining, provided the employer also meets the 65% participation requirement.	Refer to discussion item #7 on page 3 of the memo.

Section & Page Number (in Attachment B)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
	Article 3.3 (7)(a) Page 20	Same	Added language clarifying an enrollment opportunity exists for the employee who deferred coverage when an eligible dependent loses other coverage.	To articulate an enrollment opportunity that is available under federal law.
	Article 3.3 (7)(b) Page 20	Same	Added language describing the 60-day enrollment opportunity due to loss of eligibility for, or eligibility to participate in a premium assistance program.	To comply with the Children's Health Insurance Program Reauthorization Act of 2009.
	Article 3.4 (7) Page 20	Same	Added language clarifying that the addition of a dependent due to a National Medical Support Notice or establishment of paternity creates an opportunity to switch health plans.	To clarify current practice.
	Article 3.9 (2) Page 21	Same	a) Added language specifying rehired annuitants continue their same coverage by filing an application. b) Added language specifying rehired annuitants are not eligible for the graduate assistant program. (State contract only)	a) To clarify existing practice. b) Refer to discussion item #6 on page 3 of the memo.
	Article 3.12 (3) Page 21	Same	Added language specifying employees on a leave of absence have the same enrollment opportunities as described in section 3.3 (7).	To clarify existing practice.
	Article 3.12 (4) (c) Page 21	N/A	Updated language describing the timeframe for employees to apply for coverage after release from active duty.	Technical change.
	Article 3.14 (1) Page 22	Same	Updated language to explain eligibility for returning students and dependents born to covered spouse following the death of a subscriber.	To clarify coverage following an Administrative Rule change.
	Article 3.16 (2) Page 22	Same	Added language clarifying the Medicare-reduced premium rate applies when coverage is provided under a non-employer group number.	To account for existing practice of employer run out of premium after termination of employment.
	Article 3.16 (7) Page 22	Same	Added language clarifying that Medicare becomes the primary payor after the 30-month coordination period when the member is enrolled in Parts A and B.	To clarify existing practice.
	Article 3.18 (1) (d) Page 23	Same	Added language clarifying the sick leave escrow application can provide notice to cancel coverage.	To clarify existing practice.

The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objective stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board agree that these terms shall always be interpreted consistent with the objectives stated herein.

The Board's objective with alternate health care programming is: to encourage the growth of alternate health benefit plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board (Board) has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

~~Local governments seeking to participate in the health insurance program must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. This participation requirement may be waived by the Department on a case-by-case basis for employers for whom the timing of collective bargaining agreements prevents the minimum participation level at any given time. The Board also may offer an optional deductible benefit structure for local governments.~~

The Board is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the Board has developed these Guidelines by which alternate health delivery plans may be evaluated for possible inclusion under the State of Wisconsin's group health benefit program on a "dual-choice" basis.

"Dual-choice" refers to a program where employees (including retirees and continuants) who are currently insured have the opportunity to choose between at least two competing health benefit plans, the standard plan and one or more alternate plans. The mechanics of "dual-choice" are relatively simple. Once an alternate plan receives approval from the Board on the benefit structure, its proposed premium rate is submitted as a sealed bid. 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 proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health care plans to submit their premium rate quotations for the following calendar year. The Board reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

Guidelines
Section I.

The Board determines the premium rate for its self-insured Standard, fee-for-service, group health benefit plan. This premium is established after review of claims experience, secular trends, etc., and after consultation with the Board's actuary. ~~Once the Board has established the premium rates for the standard health plan, the Board opens the sealed "bids" for the alternate health benefit plans.~~ The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure. Under the tiered structure, the Office of State Employment Relations has determined the Standard Plan to be placed in Tier 2 for purpose of determining premium contribution share for those subscribers who are active employees ~~residing~~ assigned to work out of state. ~~Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation.~~

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~~Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.~~

The tiered premium structure is based on recommendations from the Board's appointed actuary whereby each alternate plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the Board's 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. Plans are determined to be qualified on a county by county basis. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or a Tier 2 plan available in any county. The Department may take such action as necessary to implement this intent.

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Effective January 1, 2009, local governments seeking to participate in the health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the health plan and prescription drug plan. Administration of the underwriting process is done by the Standard Plan administrator and actual assessment of the surcharge is determined by the Board's actuary.

Local governments must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. The Board also may offer an optional deductible benefit structure for local governments.

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Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

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In the event that the contribution is based on a percentage of the lowest cost qualified plan, if an alternate plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total alternate plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The Board is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health-care delivery system. A health care plan with efficient, highly qualified providers, who effectively practice peer-review and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health care plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the Board to participate under the State of Wisconsin's Group Health Benefit program. They have been developed to explain and clarify the general requirements set forth under Wis. Stats. Subchapter IV of Chapter 40, and Chapters ETF 10 and 40, Wisconsin Administrative Code, Rules of the Department of Employee Trust Funds. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stats. 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.

Participation in the program is not limited exclusively to organizations, which are considered "qualified" by the federal government as a health maintenance organization (HMO). The Board is interested in providing public employees with the opportunity to enroll in any comprehensive health benefit program, which is able to demonstrate financial responsibility, a successful operating experience, and meets the requirements outlined in these Guidelines.

D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

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

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

   b. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

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

4. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog, Checkpoint, Wisconsin Hospital Association quality accountability initiative and others as identified by the Department.

5. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network providers, large multi-specialty groups, small group practices and systems of care to participate in such quality standards as the Wisconsin Collaborative for Quality Healthcare and others as identified by the Department.

6. Plans must demonstrate, upon request by the Department, their support for the Department's initiatives in monitoring and improving quality of care, such as collecting HEDIS measures and submitting quality improvement plans as directed by the Department. This may include providing actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to provider reimbursement.

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7. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, information requested on the disease management survey and catastrophic claims data. Where appropriate, such as for the catastrophic claims data report, plans are expected to separate out pharmacy claims from the Department's pharmacy benefit manager from any pharmacy claims that are paid by the plan.

8. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians, such as Utilization Review (UR), chronic care/disease management and wellness/prevention. Each plan shall report annually to the Board its utilization and disease management capabilities and effectiveness, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the Department. Plans shall also include a report detailing the State of Wisconsin group experience by disease categories, place of services along with comparisons to aggregate benchmarks and any other measures the plan believes will be useful to Department staff and the Board in understanding the source of cost and utilization trends. The in a format may be as determined by each plan.

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

   - Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.
   - Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
   - Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
   - Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
   - Procedure to monitor emergency admissions to non-plan hospitals.
   - Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
   - If members are required to select a primary care provider or primary care clinic, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.

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   In its report, plans must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

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 plan and hospitals which would be involved under the group health benefit program. Each applicant must specify whether there is a contractual relationship between the plan 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 physicians and hospitals are compensated under the program including a description of any and all incentives involved. If physicians are salaried, a detailed explanation of how salaries are established, reviewed and changed, and who is the authorizing party for such action. The intent is to secure information on how a plan 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 plan. For those plans where medical specialists are used as referral physicians rather than primary care, the plans 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 enrollee to satisfy a deductible or be subject to co-payment, 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 plan as full payment for covered services. Each plan must certify that it will "hold harmless" the enrollee from any effort(s) by third parties to collect payments for medical/hospital services.

   This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee 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 co-payment basis; or in those instances where the individual 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 published plan requirements shall not be subject to the "hold-harmless" provision.

6. Provider agreements for transplants are expected to specify that retransplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered and is not subject to the Uniform Benefits exclusion on retransplantation.

7. Plans are expected to incorporate into hospital and provider agreements the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

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H. Rate-Making Process

Each plan must include in its proposal to the Board 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 which 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 confidential by the Board insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans ~~may~~ are encouraged to separate higher cost providers within geographic areas under the tiered structure into separate plans. 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. Plans shall provide rates for both the regular and deductible options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.

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The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The Department reserves the right to audit, at the expense of the plan, the addendum and the other data the plan 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.

Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)
- Family (Employee Plus Eligible Dependents)
- Medicare Coordinated

  - Individual
  - Family (~~2 Medicare Eligible~~all insureds under Medicare)
  - Family (at least 1 under Medicare, at least 1 other not under Medicare)

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- Graduate Assistants[1]:
  - Individual
  - Family
- Deductible Option for Local Program

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

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

J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds

(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by the Department the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by the Department the following Monday.)

Due Date (Receipt by Dept)	Information Due	Date Submitted
April 15, 20098	• New plans only. Proposal to participate in the program (Section II., I, page 1-18). Contract to be executed by plan/Board. (Section 3)	
May 12, 20098	• Estimated premium rate proposal for next calendar year.	
May 156, 20098	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June 12, 20098	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • Plan Utilization and Rate Review Information (Addendum 1A). This information is to be mailed directly to: Julie Maendel Deloitte Consulting 50 South Sixth Street Suite 2800 Minneapolis, MN 55402-1538 • ~~Addendum 1B and~~ Tables 8A and 8B describing catastrophic data. • ~~Addendum 1C – Utilization Review Worksheet, including actual contract language that specifies provider agreement or terms to participate in or report on Quality Improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.~~ • Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year.	
June 156, 20098	• HEDIS information is required for the prior calendar year in the format as determined by the Department.	
July 101, 20098	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit. • Information of the plan's features, including objective documentation as requested, for use in the health plan features comparison summary in the "It's Your Choice" brochure.	
July 178, 20098	• Premium rate quotations for next calendar year. (Annually, about July 17, each plan will be provided with a rate quotation form.) • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	

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Due Date (Receipt by Dept)	Information Due	Date Submitted
July 20, 2009	• Report ~~on utilization and disease management capabilities and effectiveness~~ detailing the State of Wisconsin group experience with comparisons to aggregate benchmarks. [Section II., D., 8.]	
July 2~~4~~5, 2009~~8~~	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1~~2~~ data submission was unacceptable.)	
July 31, 2009~~8~~	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August 7~~8~~, 2009~~8~~	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 1~~4~~5, 2009~~8~~	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period.	
August 2~~5~~6, 2009~~8~~	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals.	
August 2~~8~~9, 2009~~8~~	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period. • Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
September 1~~4~~5, 2009~~8~~	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September 21, is required. • For plans not participating in the group health insurance program in 201~~0~~7, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 201~~0~~7. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 2~~4~~5~~6~~.** • Draft of letter the plan will mail to current subscribers summarizing dental benefit and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September 21, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 2~~4~~5~~6~~, WITH FORWARDING REQUESTED.**	
September 21 – December 31, 2009	• Put a PDF copy of your plan's provider directory for the upcoming benefit year on your plan's web site and provide ETF with the URL of the location. The URL must remain the same through the end of the calendar year.	

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Guidelines
Section II., J.

Due Date (Receipt by Dept)	Information Due	Date Submitted
September 24, 20098 (TBD)	• Dual-Choice kick off meeting in Madison.	
September 30, 20098	• Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page and all applicable attachments. • Provide five (5) copies of all informational materials in final form to the Department. • Final dental benefit description that will be provided to members if the plan offers dental coverage.	
October 1, 2009	• Report on utilization and disease management capabilities and effectiveness. [Section II., D., 8.]	
October 23, 20098	• Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
October 6 – 24, 20098 (TBD)	• Dual-Choice Enrollment Period.	
October 30 – December 8, 20098 (TBD)	• Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of student and disabled dependent status. • Report the student status and disabled dependent status in the file format and frequency as determined by the Department.	
January 12, 20109	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of referral and grievance procedures must be included.	
January 15, 20109	• Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March 12, 20109	• Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights.	
April 1, 20109	• A Quality Improvement plan in the format set forth by the Department.	
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • Report direct pay terminations and reinstatements in the format as determined by the Department.	
Monthly	• Research and report proposed resolution to the Full File Compare discrepancies identified by the Department.	

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TABLE 8A - CLAIMS IN EXCESS OF $100,000

Line 1 - is the total amount of paid claims for individuals with paid claims of $100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of $150,000 each, you would enter the value of $150,000 X 5 = $750,000.

Line 2 - is the number of individuals with paid claims of $100,000 or greater.

Line 3 – is the total amount of claims of $100,000 or greater on an individual basis. For example, if you had five cases with paid claims of $150,000 each, this cell would calculate as follows: $150,000*5 - $100,000*5 = $250,000.

Line 4 - is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of 4/1/2007 – 3/31/2008. For example, if a plan includes experience for claims that were incurred from 4/1/2007 – 3/31/2008 and paid through 5/31/2008, the Runout Months would equal two.

Line 6 - will be calculated as (1 + Completion Factor) multiplied by the Paid Charges. This represents the total amount of claims of $100,000 or greater that have been incurred in the Reporting Period.

TABLE 8B - CLAIMS IN EXCESS OF $100,000 DETAIL

Table 8B requests ~~a detailed list~~ member level claims data by major cost category of large paid claims of $100,000 or greater during the defined report period. Table 8B is a separate data submission that is submitted to the Department only. Additional data may be requested on different subgroups throughout the year.

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TABLE 9A – QUESTIONS REGARDING SUBMITTED DATA

TABLE 9A requests responses to a few questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 9A. TABLE 9A is considered a part of the required data and must be provided at the same time as all other information.

TABLE 9B – SCHEDULE OF DENTAL BENEFITS

TABLE 9B requests plans submit their 2007 and 2008 schedule of dental benefits in the prescribed format. TABLE 9B is considered a part of the required data and must be provided at the same time as all other information.

~~**ADDENDUM 1B: CATASTROPHIC CASE DATA**~~

~~Catastrophic cases, (defined to be those members with paid charges in excess of $100,000 in a calendar year) will be reported in a predefined format showing in total for the group and for each member whose claims totals meets this definition. This information may include the following:~~

~~A. The age, sex, enrollment status (i.e., subscriber, dependent, active, graduate assistants, retiree, or continuation).~~

~~B. Hospital charges by:~~
~~1. Name and type of facility~~
~~2. Diagnosis code(s) and description~~
~~3. Procedure code(s) and description~~
~~4. Number of admissions~~
~~5. Days per admission~~
~~6. Severity of illness (if available).~~

~~C. Physician charges by:~~
~~1. Inpatient~~
- ~~Total~~
- ~~Surgical~~
- ~~Pathology~~
- ~~Radiology~~

~~2. Other than inpatient~~
- ~~Total~~
- ~~Pathology~~
- ~~Other~~

~~D. Others:~~
~~1. Prescription Drugs~~
~~2. All Others~~

Plan Name _____

ADDENDUM 1C: UTILIZATION REVIEW / QUALITY IMPROVEMENT WORKSHEET

Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians.

Check YES, if requirement is in place. Plans must certify that these (or equivalent) procedures are in place.

If "NO" is answered to any question, plans must provide, in writing, a description of the equivalent process.

YES	NO	
		UTILIZATION REVIEW
☐	☐	Written guidelines that physicians must follow to comply with the HMO's or PPP's UR program.
☐	☐	Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
☐	☐	Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
☐	☐	Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
☐	☐	Procedure to monitor emergency admissions to non-plan hospitals.
☐	☐	Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
☐	☐	If PCP or PCC is required, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make that change. The plan will assist in location of a provider and facilitate timely access, as necessary.
		QUALITY IMPROVEMENT
☐	☐	Send correspondence to network hospitals and large multi-specialty groups or systems of care requesting their participation AND increased performance results in the public reporting initiatives of Leapfrog (National), Checkpoint (Wisconsin) and Collaborative for Quality Healthcare (Wisconsin) by April of plan year.
☐	☐	Submit to the Department actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.
☐	☐	Complete and submit to the Department objective documentation (or participate in a Department requested survey/audit) to determine credible programs/processes specific to those used to compare health plan features in the "It's Your Choice" brochure.
☐	☐	Complete and submit a Quality Improvement plan to the Department as described in Section J of the Guidelines.

This CONTRACT sets forth the terms and conditions for the HEALTH PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered by the Group Insurance Board pursuant to Wis. Stat. § 40.51.

ARTICLE 1 DEFINITIONS

The following terms, when used and capitalized in this CONTRACT are defined and limited to that meaning only:

1.1 "ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a disability benefit under Wis. Stat. § 40.65; or a terminated EMPLOYEE with 20 years of creditable service ~~or a disability benefit under Wis. Stat. § 40.65~~.

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1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTINUANT" means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

1.5 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.6 "DEPARTMENT" means the Department of Employee Trust Funds.

1.7 "DEPENDENT" means the SUBSCRIBER'S:

- Spouse.
- Unmarried child.
- Legal ward who becomes a legal ward of the SUBSCRIBER prior to age 19 but not a temporary ward.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Grandchild if the parent is a DEPENDENT child. The DEPENDENT grandchild will be covered until the end of the month in which the DEPENDENT child turns age 18.

A DEPENDENT child must be 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.

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 and Family Services~~ Children and Families or equivalent if the birth was outside of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

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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. Other children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) A child age 19 or over who is a full-time student, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be a DEPENDENT:

- At the end of the calendar year in which the child ceases to be a full-time student or in which the child turns age 25, whichever occurs first.
- At the end of the month in which the child marries.

~~Student status includes any intervening vacation period if the child continues to be a full-time student.~~ As defined in Wis. Adm. Code § ETF 10.01 (5), student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled and includes any intervening vacation period if the child continues to be a full-time student. Per the Internal Revenue Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the DEPENDENT ceases to be a full-time student due to a medically necessary leave of absence.

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(2) A 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, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a DEPENDENT for federal income tax purposes and is not married). The HEALTH PLAN will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(3) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(4) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of ~~eligibility, not on the date of~~ notification ~~to the HEALTH PLAN and/or pharmacy benefit manager~~ with coverage effective the first of the month following receipt of the application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896.

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1.8 "EFFECTIVE DATE" means the date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

1.9 "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., 2m., or 8.

1.10 “EMPLOYER” means an eligible State of Wisconsin agency as defined in Wis. Stat. § 40.02 (54).

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(4) In cases where PREMIUM rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by the data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

(5) The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in the event of strike, disaster, etc., and shall submit it to the DEPARTMENT upon request.

2.3 CLERICAL AND ADMINISTRATIVE ERROR

(4) Except in cases of fraud, unreported death, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid~~not be made prior to January 1 of the previous calendar year~~. No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Five (5) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor, which shall provide the annual description of BENEFITS and such other information, or services it deems appropriate, including audit services. The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.0~~4~~6 per member per month. HEALTH PLANS will be advised of amount of this charge prior to the due date for PREMIUM bids. The HEALTH PLAN will be responsible for any costs assessed to the HEALTH PLAN even if the HEALTH PLAN is withdrawing from the program.

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2.8 DUE DATES

(2) The EMPLOYER shall immediately forward to the ~~HEALTH PLAN~~ DEPARTMENT the "~~carrier~~ ETF ~~a~~Advance ~~c~~Copy" of applications filed by newly eligible EMPLOYEES. ~~The HEALTH PLAN shall issue identification cards based upon the carrier advance registration copy of the applications.~~

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2.10 GRIEVANCE PROCEDURE

(7) Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy, when signed by the PARTICIPANT or PARTICIPANT'S representative, to give written authorization for release of information to the DEPARTMENT. 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 working days, or by an earlier date as requested by the DEPARTMENT.

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3.1 EFFECTIVE DATE

(2) The governing body of an EMPLOYER shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. The resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month, or the beginning of the quarter for EMPLOYERS receiving a rate differential as determined through underwriting, on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 30 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the EMPLOYER all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small EMPLOYERS as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void~~, unless the EMPLOYER is granted a waiver of the participation requirement by the DEPARTMENT~~. EMPLOYEES who are on a leave of absence and not insured under the EMPLOYER'S plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the EMPLOYER'S current group health plan. Eligible EMPLOYEES who are not insured under the EMPLOYER'S current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

(3) Notwithstanding section 3.2, any EMPLOYER for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months. ~~and a~~Any EMPLOYER who files a resolution after December 20, 1990, and who offers a non-participating plan pursuant to sub. (4) shall be required to remain in the program a minimum of three years. Any EMPLOYER who is assessed a surcharge as determined by the underwriting process shall be required to remain in the program a minimum of three years.

(4) The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to or on behalf of EMPLOYEES in lieu of coverage under this program. EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical. The BOARD reserves the right to assess a surcharge as determined by the BOARD's actuary if this is not done within three years. EMPLOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision. However, the DEPARTMENT may allow any EMPLOYER to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program;

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and (3) that the minimum number of all of the EMPLOYER'S Wisconsin Retirement System participating EMPLOYEES, including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in (2) above. The Plan Stabilization Contribution may be increased for that EMPLOYER if less than 50% of the participating EMPLOYEES elect the STANDARD PLAN coverage. The EMPLOYER cannot later have a bargaining unit drop from this health insurance program and carry other coverage.

(5) ~~The~~ A Large EMPLOYER (more than 50 employees in the Wisconsin Retirement System) may indefinitely retain a second plan, as described in (4) above, or temporarily retain a second plan for up to four years ~~waive the participation requirements~~ due to timing of collective bargaining or the merger or division of municipalities~~, as described in (2) above,~~ by executing the appropriate Resolution to Participate, provided the EMPLOYER also meets the 65% participation requirement as described in (2) above. The EMPLOYER may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the EMPLOYER'S initial enrollment period due to the EMPLOYER retaining a second plan or due to the timing of collective bargaining. The EMPLOYER must notify the DEPARTMENT, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

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(6) The EMPLOYER electing the deductible option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 of the Internal Revenue Code.

(7) If participation by an EMPLOYER is approved in accordance with Sub. (2) and the subsequent participation falls under the minimum requirement, the BOARD may terminate EMPLOYER participation at the end of the calendar year by notifying the EMPLOYER prior to October 1.

(8) The EMPLOYER is responsible for notifying ANNUITANTS of the availability of coverage.

(9) The EMPLOYER is responsible for notifying any CONTINUANTS of the prior group plan of the EMPLOYER'S change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.3 SELECTION OF COVERAGE

(7) (a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, ~~or under medical assistance (Medicaid),~~ or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, ~~he/she~~ the EMPLOYEE may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under another plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) As required by Federal law, an eligible EMPLOYEE may defer coverage if he/she is covered under medical assistance (Medicaid) or the Children's Health Insurance Program (CHIP). If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to the DEPARTMENT.

(~~b~~c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, or marriage provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage.

(~~c~~d) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) or (c) above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(7) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. ~~to~~ ANNUITANTS also have this enrollment opportunity, as if Federal law required it. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

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3.9 REHIRED OR TRANSFERRED EMPLOYEE COVERAGE

(2) Rehired ANNUITANTS who terminate their annuity and participate in the Wisconsin Retirement System may continue the same health insurance coverage by filing an application with the EMPLOYER within 30 days following the Wisconsin Retirement System participation begin date.

Rehired ANNUITANTS at the UW System are not eligible for the health insurance program under Wis. Stat. § 40.52 (3) for graduate assistants regardless of whether they are eligible to participate in the Wisconsin Retirement System.

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3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

(3) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days of return from leave. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. EMPLOYEES shall also have the enrollment opportunities as described in section 3.3 (7) (a) while on leave of absence. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

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(4) For the purpose of this provision and in accordance with Wis. Stat. §40.05 (4g), an eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving state contributions for health insurance on the date he or she is activated for duty. The thirty-six month limitation for continuing coverage, described in (1) above, does not apply.

The EMPLOYEE may elect to:

(a) Continue health insurance coverage and establish prepayment of PREMIUMS while on active duty; or

(b) Within 60 days of being activated for coverage, let his or her coverage lapse for nonpayment of PREMIUM after being activated for duty and reinstate coverage while on leave by filing a health insurance application; or

(c) Allow his or her coverage to lapse and reapply for coverage within 30 days of return to employment, provided the EMPLOYEE applies for re-employment within 90 days after release from active duty, and resumes employment ~~resumes~~ within 9180 days ~~after release from active duty~~.

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3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS

(1) As required by Wis. Adm. Code § ETF 40.01, the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family~~, if the DEPARTMENT receives an application for coverage from the surviving DEPENDENT within 90 days after the death of the insured EMPLOYEE or ANNUITANT or 30 days of the date the DEPARTMENT notifies the DEPENDENT of the right to continue, whichever is later~~. A DEPENDENT that regains eligibility and was previously insured under a contract of a deceased EMPLOYEE or ANNUITANT or a child of the EMPLOYEE or ANNUITANT who is born after the death of the EMPLOYEE or ANNUITANT will be eligible for coverage until such time that they are no longer eligible.

(2) Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

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

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

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month which begins on or after the date the Medicare hospital and medical insurance benefits (Parts A and B) become effective as the primary payor and coverage is provided under a non-employer group number.

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

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3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another HEALTH PLAN through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to 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 HEALTH PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period. HEALTH PLANS must notify the DEPARTMENT within one month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the HEALTH PLAN are limited to one month following the termination date.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF expires, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT or a later date as specified on the cancellation of coverage notice or sick leave escrow application. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

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(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph (4) as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under 3.18 (4) of this section.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows the EMPLOYEE to maintain coverage for 36 months instead of 18.

Notable Changes Under Consideration for the 2010 Uniform Benefits

Section Page Number (in Attachment D)	Description	Reason for Change
Schedule of Benefits I. Pages 1 - 3	a) Added a reminder that plan providers must be used except in emergent and urgent care situations. b) Clarified benefit limitations are per participant. c) Revised the mental health/alcohol/ drug abuse language benefits.	a) Change requested by a participant to clarify existing practice. b) Change requested by a health plan to clarify contract language. c) Refer to discussion item #12 on page 4 of the memo.
Definitions II. Pages 4 – 12	a) Updated the definition of DEPENDENT as described in Attachment A, Contract Article 1.7. b) Moved the definition of DURABLE MEDICAL EQUIPMENT to combine it with the newly added definition of MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT. c) Revised the definition of MAINTENANCE THERPAY to be MAINTENANCE CARE for clarification.	a) Refer to Attachment A, Contract Article 1.7. b) Change requested by staff to combine the definition to make it consistent with language describing the benefit. Added language to accomplish the desired result in the most economical manner. c) Change requested by a health plan to clarify contract language.
Benefits and Services III., A., 3. Page 14	Added language explaining that oral surgery procedures are not included in this section.	Change requested by a health plan to clarify contract language.
Benefits and Services III., A., 7. Page 16	Added language clarifying that chemotherapy is included in the benefit.	Change requested by a health plan to clarify contract language.
Benefits and Services III., A., 9. Page 16	Clarified language explaining benefits for air ambulance.	Change requested by staff and a health plan to clarify contract language.
Benefits and Services III., A., 10. Page 16	Updated language to use more inclusive terminology without expanding the benefit.	Change requested by a health plan to clarify contract language.
Benefits and Services III., A., 18. Page 19	Revised language to clarify the organ transplant benefit is limited to one transplant per health plan.	Change requested by a health plan to clarify contract language.
Benefits and Services III., A., 21. Page 21	Revised language to state that breast implants are not subject to coinsurance.	Refer to discussion item #10 on page 4 of the memo.

Section Page Number (in Attachment D)	Description	Reason for Change
Benefits and Services III., C., 3. Pages 23 - 24	a) Revised language to emphasize that prior authorization from the health plan may be required for coverage. b) Revised language describing coverage for oxygen and respiratory equipment to clarify the benefit and to use more modern terminology without expanding the benefit.	a) Change recommended by staff to clarify contract language. b) Change requested by staff to clarify existing practice and to ensure uniform administration by health plans.
Exclusions and Limitations IV., A., 2., a. Page 29	Clarified language excluding benefits for exams and other services requested by third parties.	Change requested by a health plan to clarify contract language.
Exclusions and Limitations IV., A., 2., c. Page 29	Revised language describing the benefits for foot care that are not excluded under this provision.	Change requested by staff to clarify existing practice and to ensure uniform administration by health plans.
Exclusions and Limitations IV., A., 4., b. Page 30	Moved the exclusion to the general category and changed it to “Maintenance Care” to be consistent with the change in the definition. (See item j. in the general category.)	Change requested by a health plan to clarify contract language.
Exclusions and Limitations IV., A., 7., h. Page 31	Clarified language describing the ninth month of pregnancy.	Change requested by staff to clarify contract language.
Exclusions and Limitations IV., A., 10., f. Page 32	Removed the exclusion stating that oxygen therapy was excluded except as authorized by the health plan because language was added in the benefit section as explained above. This clarifies the benefit without expanding it.	Change requested by staff to clarify existing practice and to ensure uniform administration by health plans.
Exclusions and Limitations IV., A., 12., b. Page 33	For consistency with Article 3.16 (3) of the contract, added language to clarify that the exclusion only applies if the participant is enrolled in the Medicare coordinated coverage and does not enroll in Medicare Part B or later cancels Medicare coverage.	Change requested by staff to clarify existing practice and to ensure uniform administration by health plans.
Exclusions and Limitations IV., A., 12., f. Page 34	Added language clarifying that benefits are not coordinated with the U.S. Veterans Administration.	Change requested by staff to clarify existing practice.
Miscellaneous Provisions VI., C. Page 38	Added language to allow the attending physician to recommend the alternate treatment.	Refer to discussion item #11 on page 4 of the memo.
Miscellaneous Provisions VI., J. Page 41	Reiterate the contract requirement to appeal plan grievance determinations within 60 days.	Change requested by staff to clarify existing practice.

I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at $0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits. This also does not include Your lifetime maximum benefit if You were previously covered by the Health Plan, as Your lifetime maximum benefit may include any benefits paid during all periods of coverage with the same Health Plan under this program.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin group health insurance program.

NOTE: - Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of $500 per individual / $1,000 per family, per calendar year. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.

- *For Participants enrolled in a Preferred Provider Plan (WPS ~~Patient~~ Metro Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.*

Except as specifically stated for Emergency and Urgent Care (see Sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless you get a Prior Authorization from your Health Plan. Prior Authorization requirements are described in the Plan Description section of the "It's Your Choice" book.

The benefits that are administered by the Health Plan are subject to the following:

- Policy Deductible: NONE
- Policy Coinsurance: 100% of charges, except as described below
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: $2,000,000 per Participant
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be

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available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.

- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed $500.00 annually per Participant.

- Hearing Aids: One hearing aid per ear no more than once every three years payable at 80%, up to a maximum payment of $1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.

- Cochlear Implants: Device, surgery for implantation of the device, and follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, payable at 80%. Hospital charges for the surgery are covered at 100%. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. Fifty additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.

- Hospice Care Benefits: Covered when the Participant's life expectancy is 6 months or less, as authorized by the Health Plan.

- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of $1,000,000 for transplants, including Preoperative and Postoperative Care.

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.

- Mental Health/Alcohol/Drug Abuse Services*:

  Outpatient Services: $1,800 maximum per Participant per calendar year
  Transitional Services: $2,700 maximum per Participant per calendar year
  Inpatient Services: 30 days or $6,300, whichever is less, per Participant per calendar year

  Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is $7,000 per Participant per calendar year.

  The maximum is determined using the average amount paid to the Providers by the Health Plan and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to Copayment.

  ***Note: Annual dollar and day limit maximums for mental health/alcohol/drug abuse only services are suspended pursuant to the Federal Mental Health Parity Act.**
  ~~**However, day limit maximums do apply, if applicable.**~~

  ~~**Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the**~~

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~~**annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.**~~

- 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.)

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- Oral Surgery: Limited to procedures listed in Benefits and Services Section.

- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.

- Hospital Emergency Room Copayment: $60 per visit; waived if admitted as an inpatient directly from the emergency room. (An inpatient stay is generally 24 hours or longer.)

The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

- Prescription Drugs and Insulin:
  Level 1* Copayment for Formulary Prescription Drugs: $ 5.00
  Level 2**Copayment for Formulary Prescription Drugs: $15.00
  Level 3 Copayment for Covered Non-Formulary Prescription Drugs: $35.00

  *Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.
  **Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.

  Annual Out-of-Pocket Maximum (The amount You pay for Your Level 1 and Level 2 Prescription Drugs and Insulin):
  $385 per individual or $770 per family for all Participants, except:
  $1,000 per individual or $2,000 per family for State Participants enrolled in the Standard Plan, and
  No annual out-of-pocket maximum for Wisconsin Public Employer Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

  NOTE: Level 3 Copayments do not apply to the out-of-pocket maximum and must continue to be paid after the annual out-of-pocket maximum has been met.

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.

- Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

II. DEFINITIONS

The terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this 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.

- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.

- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA 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 maximums 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 maximums 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 a Plan 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 Plan 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.

- **DEPENDENT:** Means the Subscriber's:
  - Spouse.
  - Unmarried child.
  - Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Grandchild if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

  A Dependent child must be 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.

  A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of ~~Health and Family Services~~ Children and Families or equivalent if the birth was outside of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

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  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. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

  1. A child age 19 or over who is a full-time student, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be a Dependent:
     - At the end of the calendar year in which the child ceases to be a full-time student or in which the child turns age 25, whichever occurs first.
     - At the end of the month in which the child marries.

     ~~Student status includes any intervening vacation period if the child continues to be a full-time student.~~ As defined in Wis. Adm. Code § ETF 10.01 (5), student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled and includes any intervening vacation period if the child continues to be a full-time student. Per the Internal Revenue Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the Dependent ceases to be a full-time student due to a medically necessary leave of absence.

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  2. A 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, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a Dependent for federal income tax purposes and is not married). The Health Plan will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the Dependent is no longer so disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.

4. Any Dependent eligible for benefits will be provided benefits based on the date of ~~eligibility, not on the date of~~ notification ~~to the Health Plan and/or PBM~~ with coverage effective the first of the month following receipt of the application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896.

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- ~~**DURABLE MEDICAL EQUIPMENT:** Means an item which can withstand repeated use and is, as determined by the Health Plan, primarily used to serve a medical purpose with respect to an Illness or Injury, generally not useful to a person in the absence of an Illness or Injury, appropriate for use in the Participant's home, and prescribed by a Plan Provider.~~

- **EFFECTIVE DATE:** The date, as certified by the Department of Employee Trust Funds 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.

- **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson 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., e. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

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

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

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies.

- **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.

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

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

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

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

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

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

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

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

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

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

- **MAINTENANCE ~~THERAPY~~ CARE:** Means ongoing ~~therapy~~ 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 ~~Therapy~~ 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

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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.

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- **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.

- **MEDICAID:** Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.

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

- **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.

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

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

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

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

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

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

4. Dietitian visit

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

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

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

- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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

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

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

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

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

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

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

  You must name Your Primary Care Provider on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **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 Non-Plan 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 Section G, Plan Descriptions, of the “It’s Your Choice” book. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.

- **PROVIDER:** Means 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 Plan 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 Section G, Plan Descriptions, of the “It’s Your Choice” book. 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.

- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health 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.

- **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.

- **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 require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.

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

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

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

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

- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

The benefits and services which the Health Plan and PBM agrees to provide to Participants, or make arrangements for, 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 plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a plan 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, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the Health Plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for Emergency and Urgent Care, You must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan 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 in this plan 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 plan. 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. Plan Hospital emergency rooms should be used whenever possible. Should You be unable to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You are receiving Emergency care. Non-urgent follow-up care must be received from a Plan 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 emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.

e. Some examples of Emergencies are:
- Acute allergic reactions
- Acute asthmatic attacks
- Convulsions
- Epileptic seizures
- Acute hemorrhage
- Acute appendicitis
- Coma
- Heart attack
- Attempted suicide
- Suffocation
- Stroke
- Drug overdoses
- Loss of consciousness
- 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 returns to the Plan Service Area to receive such care from a Plan Provider.

b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan 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:
- Most Broken Bones
- Minor Cuts
- Sprains
- Most Drug Reactions
- Non-Severe Bleeding
- 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 16. of this section.

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4. Reproductive Services

The following services do not require a Referral to a Plan 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 daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of 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. Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.

d. IUDs , as described under the Durable Medical Equipment provision.

e. 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 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 that it be notified 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 approved Provider.

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. 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 Exclusion A., 2., e.)

e. Injectable and infusible medications, except for Self-Administered Injectable medications.

f. Nutritional Counseling provided by a participating registered dietician or Plan Provider.

g. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

6. Anesthesia Services

Covered when provided in connection with other medical and surgical services covered under this plan. 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, ~~and~~ radioactive isotopes and chemotherapy drugs are administered and billed by an approved Provider.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved 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~~, as described in the Schedule of Benefits~~. 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 Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. ~~In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.~~

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, ~~x-rays~~, 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 a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

11. Outpatient Physical, Speech and Occupation Therapy

Medically Necessary services as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit maximum 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 Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

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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 ~~s~~Supplies, drugs and medicines prescribed by a Health Plan physician; 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:

1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.

2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.

3) 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 physician 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 (4) straight hours in a twenty-four (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 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, ~~m~~Medical ~~s~~Supplies and services, counseling, bereavement

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counseling for 1 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.

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 Replacement with Artificial Teeth Because of Accidental Injury

Total extraction or total replacement (limited to, bridge or denture) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within eighteen months of the accident. 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. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision.

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 Plan 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 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. All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the $1,000,000 maximum lifetime benefit for transplants.

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. ~~Organ retransplantation, which applies to items b., e., f., and g. as listed below, is not a covered benefit.~~

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a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
   - o Aplastic anemia
   - o Acute leukemia

- Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
- Wiskott-Aldrich syndrome
- Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
- Hodgkins and non-Hodgkins lymphoma
- Combined immunodeficiency
- Chronic myelogenous leukemia
- Pediatric tumors based upon individual consideration
- Neuroblastoma
- Myelodysplastic syndrome
- Homozygous Beta-Thalassemia
- Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
- Multiple Myeloma, Stage II or Stage III
- 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:
   - Corneal opacity
   - 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;
   - Corneal ulcer
   - Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - Congestive Cardiomyopathy
   - End-Stage Ischemic Heart Disease
   - Hypertrophic Cardiomyopathy
   - Terminal Valvular Disease
   - Congenital Heart Disease, based upon individual consideration
   - Cardiac Tumors, based upon individual consideration
   - Myocarditis
   - Coronary Embolization
   - Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - Extrahepatic Biliary Atresia
   - Inborn Error of Metabolism
     - Alpha -1- Antitrypsin Deficiency
     - Wilson's Disease
     - Glycogen Storage Disease
     - Tyrosinemia
   - Hemochromatosis
   - Primary Biliary Cirrhosis
   - Hepatic Vein Thrombosis

- o Sclerosing Cholangitis
- o Post-necrotic Cirrhosis, Hbe Ag Negative
- o Chronic Active Hepatitis, Hbe Ag Negative
- o Alcoholic Cirrhosis, abstinence for 12 or more months
- o Epithelioid Hemangioepithelioma
- o Poisoning
- o Polycystic Disease

g. Kidney/pancreas, heart/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 section A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan Provider. Benefits are not available for Maintenance ~~Therapy~~ Care.

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21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:

- o Reconstruction of the breast on which a mastectomy was performed;
- o Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- o Prostheses (see DME in section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;

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- o Breast implants, which are not subject to coinsurance.

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22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized 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 a Plan 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.

1. 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 twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits 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 five 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.

2. Outpatient Care

Emergency Care: First aid, accident or sudden Illness requiring immediate Hospital services. Subject to the Copayment described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the Copayment.

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 to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

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

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

b. Transitional Services

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

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided pursuant to 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

1) Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1. The charges for such drugs will not be applied to the maximum benefit available for any mental health, alcohol or drug abuse services.

2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the Provider by the Health Plan.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject to 20% Coinsurance as outlined in the Schedule of Benefits**. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for Durable Medical Equipment. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.
- Insulin infusion pumps, limited to one pump in a calendar year and You must use the pump for thirty (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 D. for benefit information.)

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, ~~m~~Medical ~~s~~Supplies and Durable Medical Equipment will be covered **subject to 20% Coinsurance as outlined in the Schedule of Benefits**. ~~All purchases or monthly rentals must be Prior Authorized as determined by the Health Plan.~~

The following supplies and equipment will be covered only when Prior Authorized as determined by the Health Plan:

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.

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- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

- Rental or, at the option of the Health Plan, purchase of equipment such as, but not limited to: wheelchairs~~,~~ and hospital-type beds~~, and artificial respiration equipment~~.

- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

- IUDs.

- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.

- Cochlear implants, which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit.

- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, covered at 80% up to a maximum payment of $1,000 per hearing aid. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.

- Ostomy and catheter supplies.

- Oxygen and respiratory equipment for home use when authorized by the Health Plan.

- 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.

- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, 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 20% Coinsurance as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids, the out-of-pocket costs will apply to the annual out-of-pocket maximum for Durable Medical Equipment.

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4. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO 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 Plan Service Area, pursuant to Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's 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 return to the Plan's Service Area 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

Pursuant to Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance 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.

D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM)

You must obtain benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, You may need to make 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 out-of-pocket maximum applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket maximum, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual out-of-pocket maximum as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket maximum, all family members will have satisfied the annual out-of-pocket maximum for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket maximum. 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 out-of-pocket maximum for Level 1 and Level 2 Formulary 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).

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.

Notwithstanding the exclusion in Section IV., 12., (b) for Participants in the Wisconsin Public Employers’ group, the PBM will pay prescription drug benefits for Medicare eligible members as secondary, regardless of whether or not the Participant is actually enrolled in a Medicare Part D prescription drug plan.

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).

c. Single packaged items are limited to 2 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 out-of-pocket

maximum. Coverage is limited to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.

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 Plan 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 Formulary 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 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.

j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.

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

l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or 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 on the Formulary approved products. Prior Authorization is required for anything not listed on the Formulary.

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

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

3. Other Devices and Supplies

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

- Diaphragms
- Syringes/Needles
- 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 the Plan 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 11 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 plan, 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. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.

b. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct 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.

c. 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.

d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

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 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~~; or (d) in connection with any of these except~~. This exclusion does not apply when services are performed ~~prescribed~~ by a Plan Provider ~~who is~~ to treat~~ing the Participant for~~ a metabolic or peripheral disease or a ~~if the~~ skin or tissue ~~is~~ infect~~ioned~~.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits section.

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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 Section.

4. Therapies

a. Vocational rehabilitation including work hardening programs.

~~b. Maintenance Therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.~~

~~c.~~b. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

~~d.~~c. Physical fitness or exercise programs.

~~e.~~d. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

~~f.~~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 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 Section.

c. All oral surgical procedures not specifically listed in the Benefits 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., ~~which~~ 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. Implantable birth control devices (for example, Norplant).

g. Surrogate mother services.

h. Maternity services received out of the Plan Service Area ~~in the ninth~~ one month ~~of pregnancy~~ 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).

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

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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. Mental Health Services/Alcohol and Drug Abuse

a. Hypnotherapy.

b. Marriage counseling.

c. Residential care except transitional care as required by Wis. Stat. § 632.89.

d. Biofeedback.

10. 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 authorized by the Health Plan.

c. Medical ~~s~~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 an hearing impairment); and self-help devices not Medically Necessary, as determined by the Health Plan, including, but not limited to, shower chairs and reaches.

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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. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Health Plan.~~

~~g.~~f. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

~~h.~~g. Customization of buildings for accommodation (for example, wheelchair ramps).

11. 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 for spilled, stolen or lost prescription drugs.

12. General

a. Any additional exclusion as described in the Schedule of Benefits.

b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other 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 ~~is~~ the primary payor or who subsequently cancels Medicare coverage.

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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 ~~U.S. ~~V~~eterans ~~A~~dministration~~ 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.

~~j.~~k. Care provided to assist with activities of daily living (ADL).

~~k.~~l. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.

~~l.~~m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

~~m.~~n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

~~n.~~o. Expenses incurred prior to the coverage Effective Date in 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 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

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succeeding Health Plan's network. In this instance, the liability will remain with the previous insurer.

~~o.~~p. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye following cataract surgery.

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~~p.~~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.

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~~q.~~r. Charges for any missed appointment.

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~~r.~~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 cancerclinical trial as required by Wis. Stat. § 632.87 (6).

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~~s.~~t. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

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~~t.~~u. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:

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1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.

2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.

3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.

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~~u.~~v. Services of a specialist without a Plan 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.

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~~v.~~w. Coma Stimulation programs.

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~~w.~~x. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.

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~~x.~~y. Any diet control program, treatment, or supply for weight reduction.

~~y.~~z. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.

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~~z.~~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.

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

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

a~~c~~d. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.

a~~d~~e. 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.

a~~e~~f. Sexual counseling services related to infertility and sexual transformation.

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

B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

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

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

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial

insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other Benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

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

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

8. Lifetime policy maximum for transplant benefits: $1,000,000.

   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.

9. Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: $2,000,000 (includes transplant benefits) per Health Plan.

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

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

B. Physical Examination

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

C. Case Management/Alternate Treatment

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

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

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

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

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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

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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 insurance benefits. The Subscriber's rights to group health insurance 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 the Standard Plan with a 180-day waiting period for preexisting conditions.

Change to an alternate Health Plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

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 may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent dual-choice enrollment periods. Reenrollment in the Health Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

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 insurer under these Uniform Benefits, whether that is a Health Plan or the Public Employee Trust Fund, shall be subrogated to a Participant's rights to damages, to the extent of the benefits the insurer 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 insurer's rights of full recovery may be from any source, including but not limited to:

- The third party or any liability or other insurance covering the third party
- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- 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 insurer to such extent.

The insurer subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the insurer's prior written consent shall be deemed to prejudice the insurer's rights. Each Participant shall promptly advise the insurer in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the insurer such additional information as is reasonably requested by the insurer. The Participant agrees to fully cooperate in protecting the insurer's rights against a third party. The insurer 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 insurer and the Participant over the question of whether or not the Participant has been "made whole", the insurer 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 insurer provides benefits, by initiating and processing a claim pursuant to 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 insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer 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 insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer 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 insurer 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 a Plan Provider of Your membership in the Health 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 receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Health Plan, clearly indicating the Health Plan'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 (twelve) 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 members' 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 an ETF 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.

You may also request an independent review per Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. You have no further right to administrative review once the Independent Review Organization 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 Independent Review Organization decision has been rendered. 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 or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
http://etf.wi.gov

CORRESPONDENCE MEMORANDUM

DATE: March 31, 2009

TO: Group Insurance Board

FROM: Betty Wittmann, Manager
Optional Insurance Plans and Audits

SUBJECT: Long-Term Care Insurance Rate Increase Proposal – John Hancock

Staff recommends the Group Insurance Board (Board) approve the Long-Term Care Insurance (LTC) replacement policy from John Hancock, submitted by SeniorCare Insurance Services, Inc. (SeniorCare) as provided in Wis. Stats. § 40.55 and Wis. Admin. Code Ch. ETF 41.

Background

John Hancock is one of two companies currently marketing LTC policies to state employees and annuitants. The Board has previously approved several John Hancock LTC policies under the Board's Optional Insurance Plan Guidelines. The proposal from SeniorCare intends to replace the current Custom Care II policy with its updated Custom Care II Enhanced (Enhanced) policy. The current policy is no longer available for sale in Wisconsin, effective April 1, 2009.

SeniorCare has been the marketing arm for John Hancock since 1999 and utilizes licensed insurance agents to sell the Board-approved John Hancock LTC policies to state employees, annuitants and eligible family members.

Discussion

All state employees, state annuitants and their eligible family members who purchased the Custom Care II policy will continue to hold those policies uninterrupted.

John Hancock is requesting a premium increase of approximately 10-15% (varies by age) for the new Enhanced policy. The proposal has been reviewed by the Board's consulting actuary, Deloitte Consulting, LLP (Deloitte). The Deloitte review (copy attached) indicates that the proposal, when sold with the 5% compound inflation rider plus Guaranteed Purchase Option (GPO), meets the requirements outlined in the Board's guidelines and Wis. Admin. Code. The policy has been approved by the State of Wisconsin Office of the Commissioner of Insurance.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	4/14/2009	6

Overall, the Enhanced policy offers additional flexibility in benefits that John Hancock refers to as "consumer protection enhancements," along with an inflation option that increases benefits based on the Consumer Price Index (CPI). Deloitte's analysis of these benefits begins on page 3 of their memo. However, it should be noted that the policies sold to our members will not include the "No Inflation" or the "CPI Inflation" options as they do not meet the standards specified in ETF 41.02.

Partnership Program

Effective January 1, 2009. the State of Wisconsin implemented the Wisconsin Partnership Program. This program allows individuals who purchase LTC policies to disregard assets from their estate in an amount equal to the benefits they were paid by the policy on behalf of the individual who has received medical assistance (Medicaid). The Partnership program requires LTC policies to be sold with an inflation rider for individuals under 76 years of age. In addition, licensed insurance agents will need to pass a certified training course to solicit all LTC policies.

John Hancock's Enhanced policy will be offered both as a Non-Partnership or Partnership policy, and our members can select either option. The proposal includes the marketing brochures for both the Partnership and Non-Partnership policies that SeniorCare intends to utilize in marketing this program to our members.

Conclusion

Based on staff review and the attached Deloitte evaluation, the staff recommends approval of John Hancock's Custom Care II Enhanced and Partnership LTC policies with the 5% compound inflation GPO for immediate offering.

Staff will be available at the meeting to answer any questions you may have regarding this proposal.

Attachment

Group Insurance Board

2008 ICI and LTDI Program

April 14, 2009

Board	Mtg Date	Item #
GIB	04/14/09	7

Agenda

- 2008 Projects and Approaches
- Executive Summary
- Performance
  - Customer Service
  - Administration
  - Claims Experience Overview
- Questions and Answers

2008 Projects and Approaches

Contract Renewal

- Aetna responded to the RFP and was selected by GIB
- 5-year contract is in place and an important relationship continues

Continue to Integrate ETF Program Within Aetna Post-Acquisition

- Keep Aetna management educated and informed of key aspects of ETF relationship
- Retain highest performing staff on WI account
- Maintain vital aspects of ETF program
  - While advocating program enhancement possibilities

Aetna Ombudsperson Activity

- Continues to be at a low level – less than one incident per month

Continue to Partner With ETF Team

- Adjustments, program evolution, shared expertise

Customer Service Remains Priority

- Improve on telephone timeliness (2008 Goal)

Executive Summary

- **Ombudsperson Activity**
  - Experienced staff has led to more resolution within general response process - reducing need for elevated Ombuds activity
- **Key Customer Service Measures**
  - Met or exceeded customer service levels for 2008
  - Specific areas of telephone service were improved from 2007
- **Claims Study- State ICI, Local ICI, LTDI**
  - Combined claims counts dropped slightly from 1691 in 2007 to 1678 in 2008
  - State ICI program is 85% of all claims volume (82% last year) - a small increase from 1388 claims in 2007 to 1419 claims in 2008. The Local ICI and LTDI programs had a decrease in claims from 2007 to 2008
  - Musculoskeletal is the most common diagnostic category for all programs
  - Mental Health claims become LTD claims about as often as Musculoskeletal and last much longer. Once a Mental Health claim is LTD, the claimant is not likely to return to work
  - Neoplasm and Injury, while less in number, have longer durations

Ombuds Activity

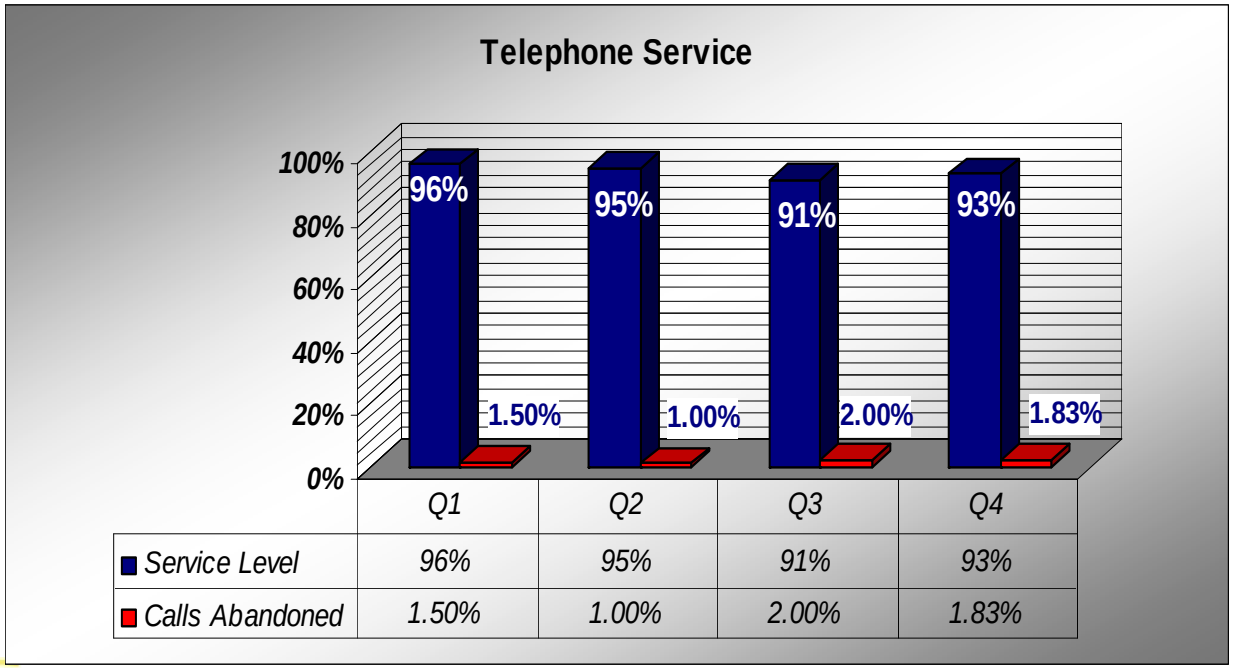
- **ETF Ombudspersons reported the following ICI and LTDI contacts:**
  - **2004 – 171 contacts**
  - **2005 – 61 contacts**
  - **2006 – 16 contacts**
  - **2007 – 19 contacts**
  - **2008 – 13 contacts**
- **Typically, ETF Ombudsperson contacts are educating members on processes (including administrative review rights) and facilitating communication between the member and Aetna**
- **Experienced Aetna claims staff generally are able to handle issues that in the past required Ombuds intervention**
- **In 2008, the Aetna Ombuds level issues fell into the categories of:**
  1. **Overpayments**
  2. **Duplication of benefits**
  3. **Benefit offset/deduction clarifications**

2008 Performance Measures

- **Phone Statistics**
  - **2008 Performance**
  - **5-Year Study**
- **Evidence of Insurability - EOI Processing**
  - **Number of Applications**
  - **Approvals and Denials**
- **Customer Service Measurements**
  - **Aetna met annual service levels in all key categories**
  - **General customer service has been very good**

2008 Telephone Performance

Quarter	Calls Received	Level of Service	Calls Abandoned
1st Quarter	3,085	96%	1.50%
2nd Quarter	3,031	95%	1.00%
3rd Quarter	2,625	91%	2.00%
4th Quarter	2,034	93%	1.83%
Annual	10,775	94%	1.58%



Performance Standards

1. 85% of calls answered within 30 seconds
2. 4.5% or less abandoned calls

Basic Customer Service has improved:

- 2007 84% answered in 30 seconds
- 2008 94% answered in 30 seconds
- 2007 4.85% calls abandoned
- 2008 1.58% calls abandoned

Phone Performance Study 2008

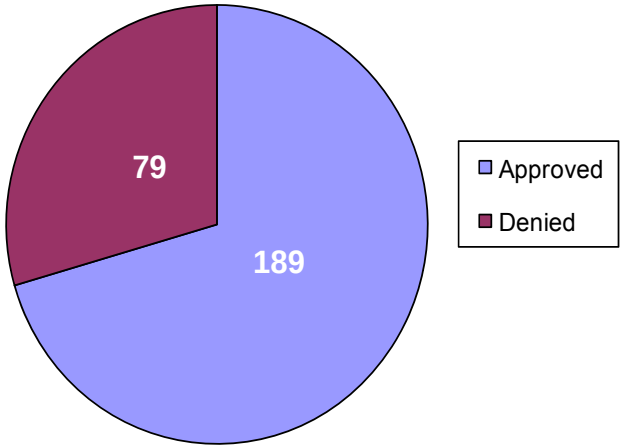
	2008	2007	2006	2005	2004
Number of phone calls	10,775	11,774	10,795	16,617	26,834
Answered-30 seconds	94%	84%	83%	91%	85%
Abandoned	1.58%	4.85%	4.17%	3.7%	3.6%

- **Aetna improved key measures for 2008 by adjusting staff allocation to expected call volumes as claim owner model matured, fewer errors are being made, and less calls are made through Ombuds position**
  - **Assigning a claim owner at intake decreased the call volume dramatically from 2004 - employees know their claim owner and call directly rather than calling into a customer service pool**
  - **The slight increase in 2007 calls required some staff adjustment that seems to have worked**

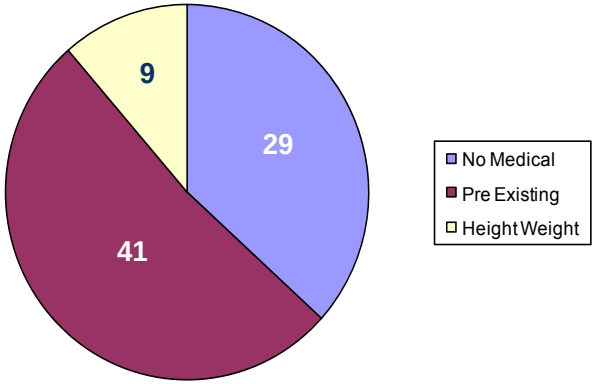
Comments last year "Aetna… intends to exceed (required) levels for the remainder of 2008."

2008 Evidence of Insurability

EOI Applications - 268



Denied EOI Applications - 79



- **Initiation within 5 days**:

  99%
  (98% in 2006, 2007)
  standard is 95%

- **Determination within 30 days:**

  99%
  (99% in 2006, 2007)
  standard is 98%

- **Determination communicated within 4 days:**

  100%
  (99% in 2006, 2007)
  standard is 100%

2008 Customer Service Measures

Telephone Performance - 85% of calls answered in 30 seconds

94% - Standard Met

Telephone Abandonment Rate - no more than 4.5% will be abandoned

1.58% - Standard Met

Silent Monitor Audit of Intake - 95% pass quality - polite, accurate and professional

100% - Standard Met

Silent Monitor Audit Clinical - 95% pass quality - polite, accurate and professional

98% - Standard Met

Customer Satisfaction Surveys - 90% respondents will give overall rating of excellent or good

98% - Standard Met

2008 Claims Experience Study

1. **Claims Counts by Product**

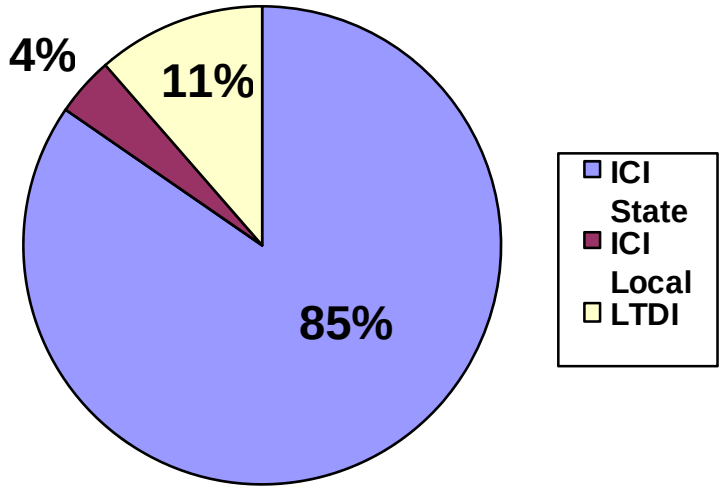
2. **Individual Program Utilization**

   a) **State ICI- STD/LTD**
      - **Claims, Agency, Gender, Diagnostic Categories**

   b) **Local ICI- STD/LTD**
      - **Claims, Agency, Gender, Diagnostic Categories**

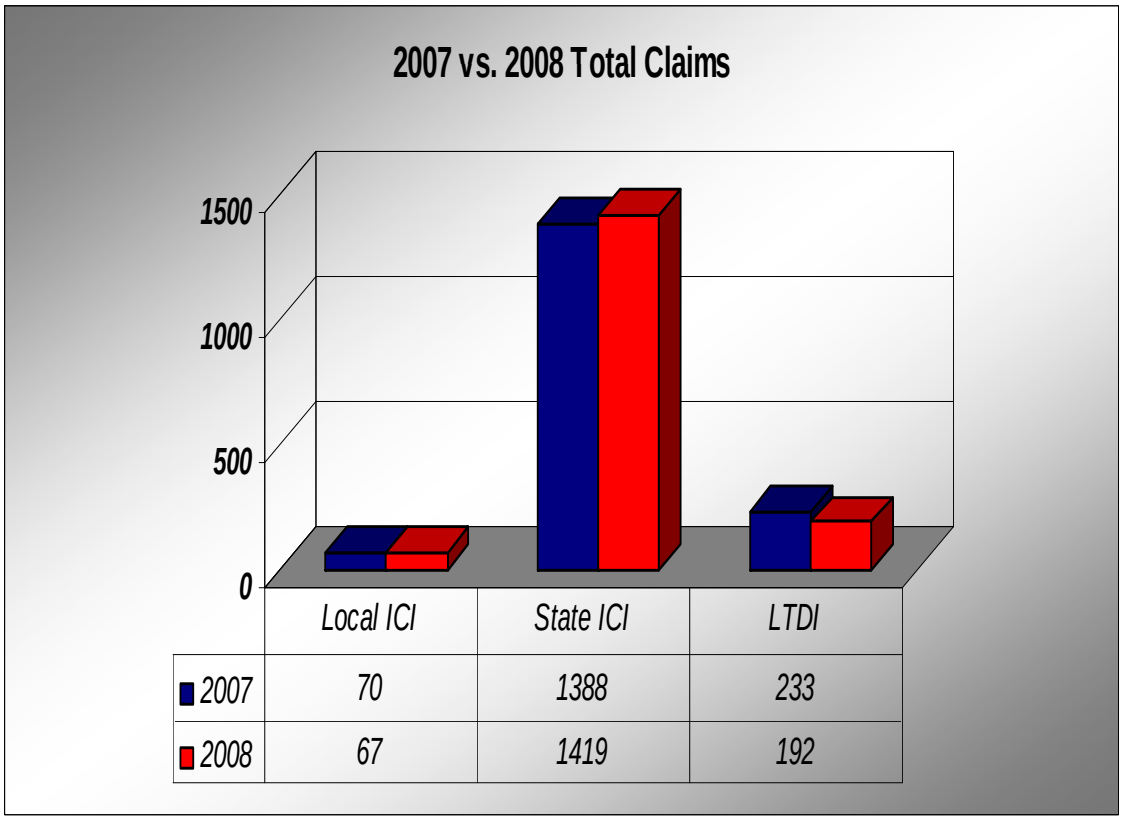
   c) **LTDI**
      - **Claims, Agency, Gender, Diagnostic Categories**

2008 Overall New Claims



- State ICI - 1419 claims
- Local ICI - 67 claims
- LTDI- 192 claims

Claim Numbers – 2007 to 2008

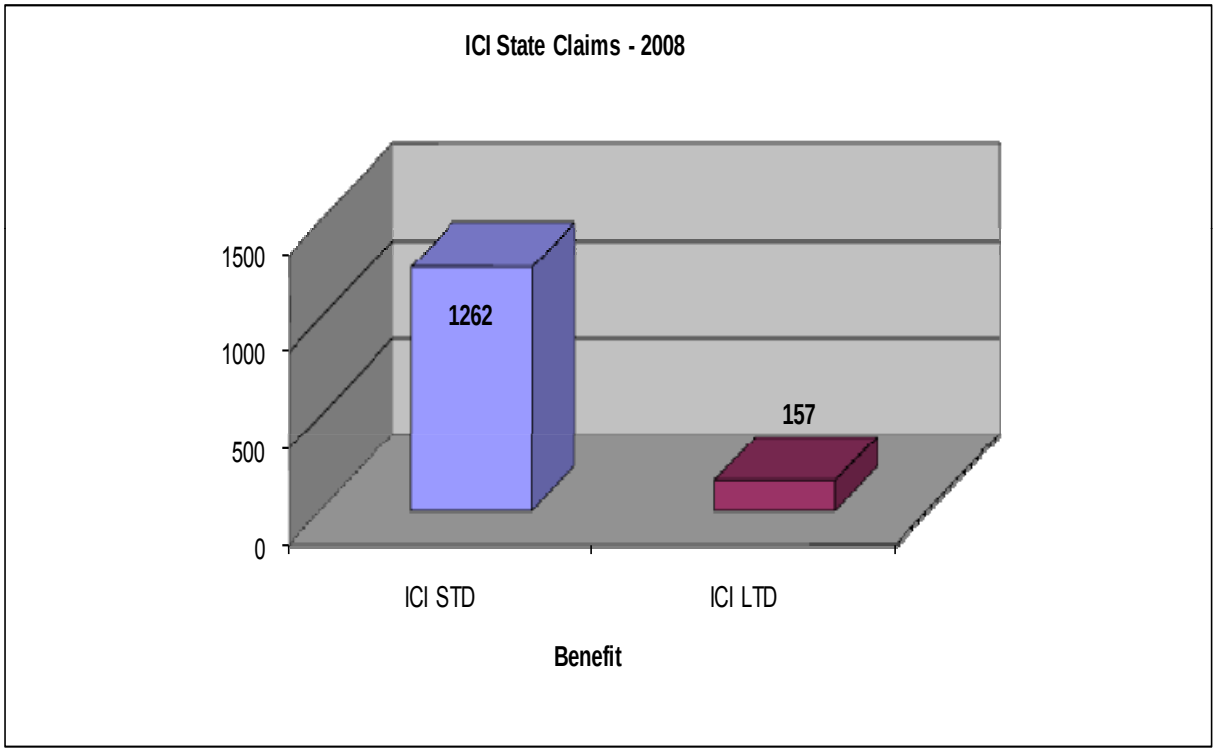


2007- 1691 Claims

2008 - 1678 Claims

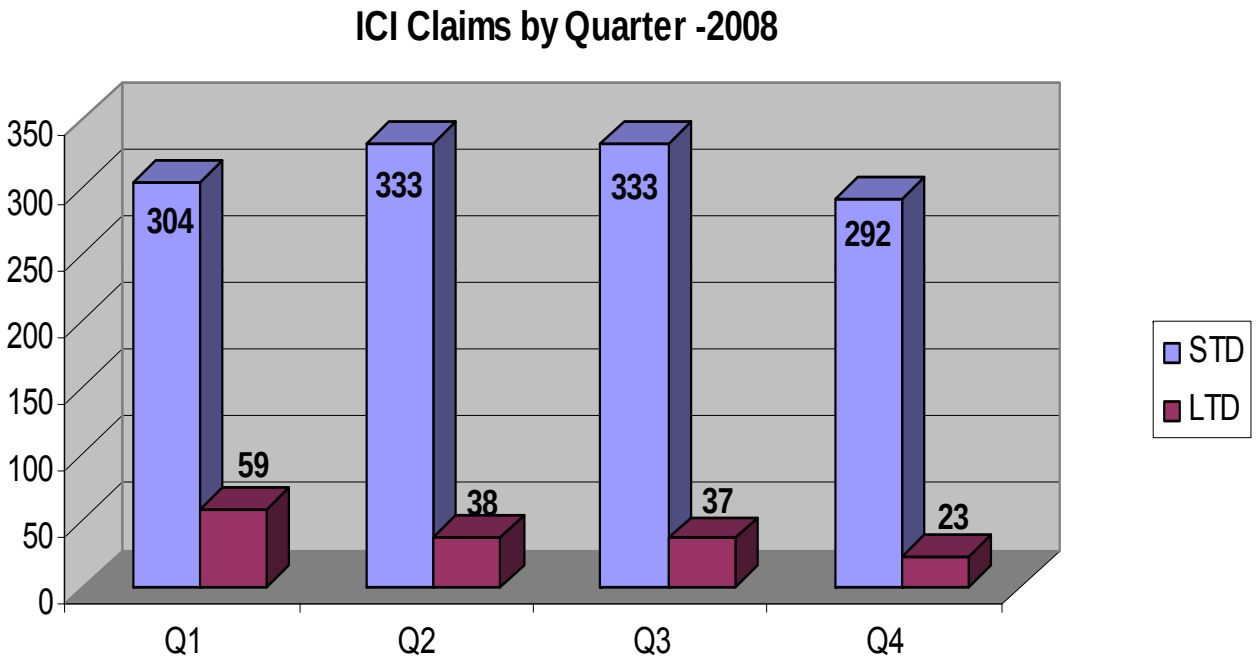
- **There were very slight decreases in the ICI Local Program and the LTDI Program and a slight increase in the ICI State Program**
- **ICI State continues to be the primary driver of claims experience**

2008 ICI State Program Claim Counts



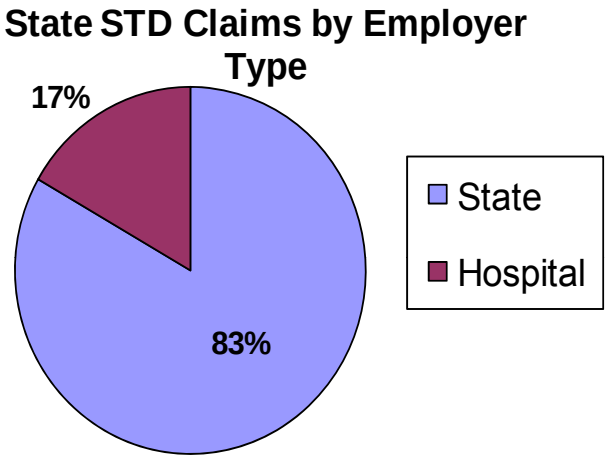
- 1262 New ICI State Short-Term Disability (STD) claims in 2008
- 157 State ICI claims moved into the Long-Term Disability (LTD) phase:
  - An ICI STD claim becomes LTD after one year of duration

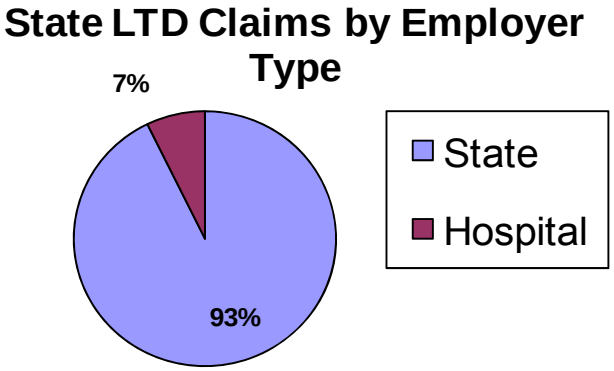
ICI State STD/LTD by Quarter- 2008



- As has been the case in prior years, there is a slight rise in STD claims in Q2 and Q3
- Just over 10% of STD claims will become an LTD claim
- A decrease in STD claims becoming LTD claims is evident with decreases for four quarters consecutively

2008 State ICI Claims by Employer Type

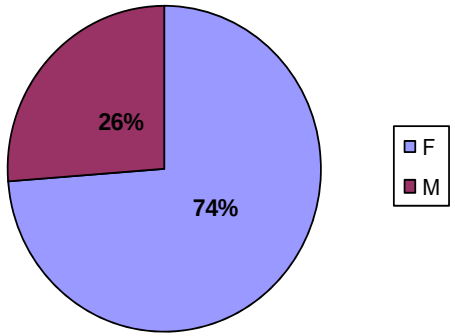




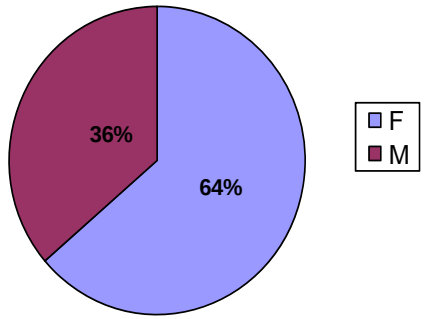
- All ICI State Claims are recorded as either
  - State or Hospital
- Of the 1262 STD Claims
  - 1051 were State
  - 211 were Hospital
- Of the 157 ICI LTD Claims
  - 146 were State
  - 11 were Hospital

2008 State ICI Claims by Gender

ICI STD by Gender



ICI State LTD by Gender



- **ICI STD**
  - **931 Claims - Female**
  - **331 Claims - Male**
  - **Maternity as an exclusive category for Female supports the ratio and is common as an STD statistic**
- **ICI LTD**
  - **100 Claims - Female**
  - **57 Claims - Male**

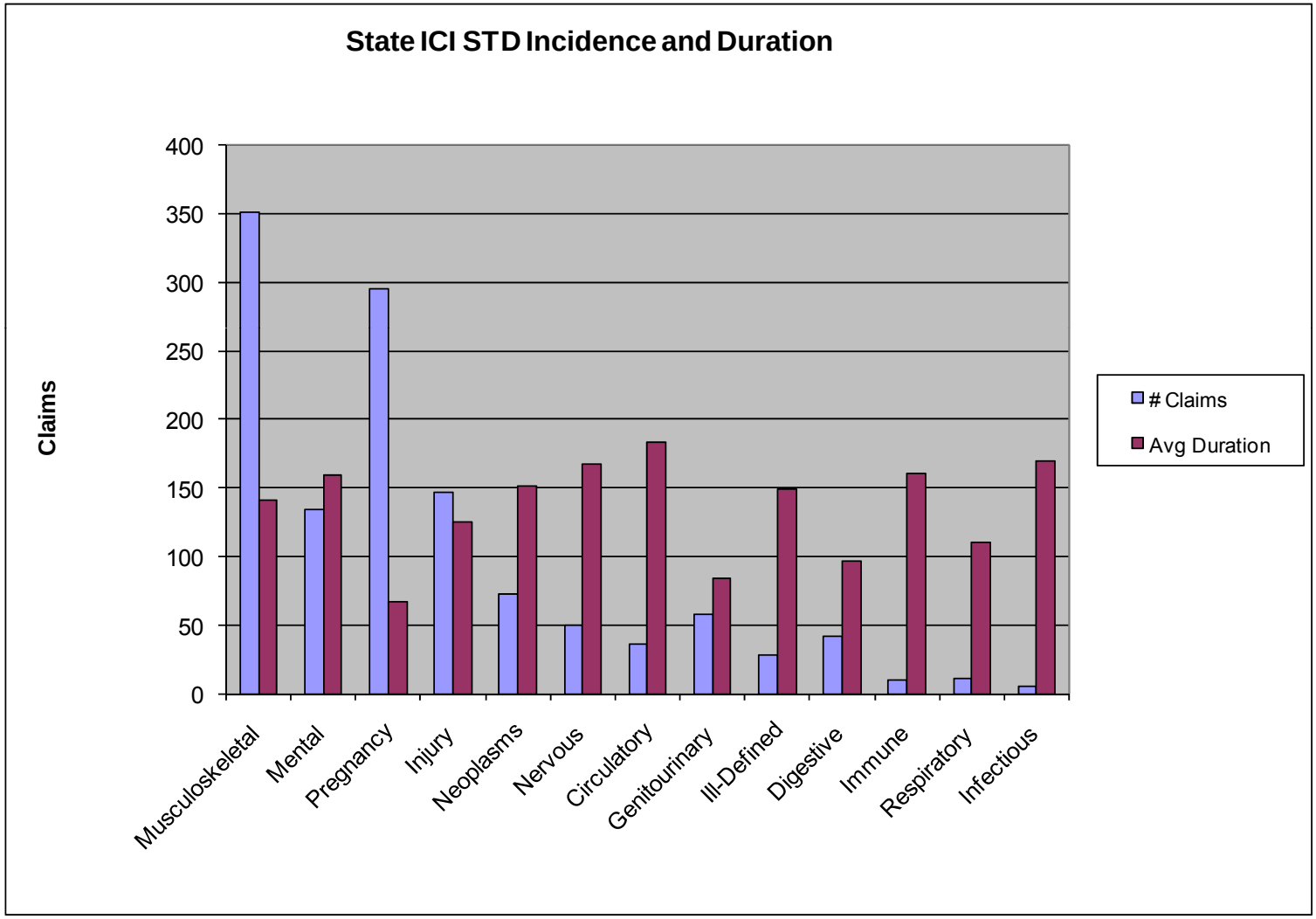
2008 State ICI STD Claims by Disability

Top 13 Categories

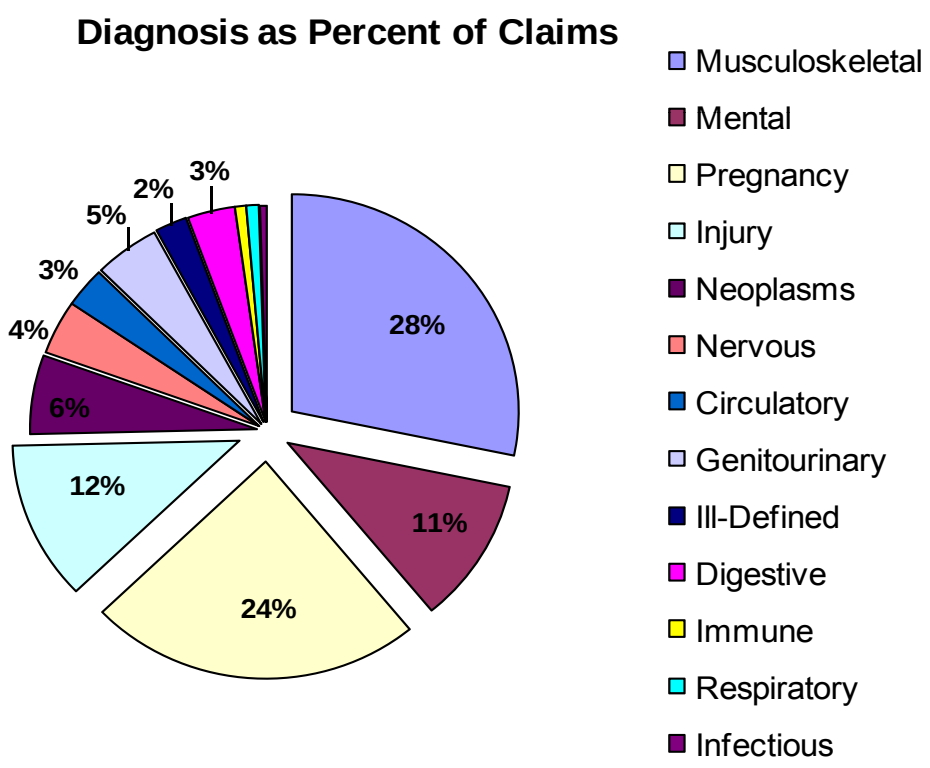
Diagnosis	# Claims	Days Lost	Avg Duration
Musculoskeletal	351	49512	141
Mental Disorders	134	21406	159
Pregnancy	295	19879	67
Injury and Poisoning	147	18485	125
Neoplasm	73	11132	152
Nervous /Sense Organs	50	8387	167
Circulatory System	37	6793	183
Genitourinary System	58	4927	84
Ill-Defined	28	4191	149
Digestive System	42	4110	97
Immune Disorders	10	1614	161
Respiratory System	11	1231	111
Infectious Diseases	6	1024	170

- ICI State STD comprises a majority of the volume and claim processing in administration of ETF's programs
- The chart details what medical conditions drive work absence
- Although there are more Pregnancy claims than Mental Health claims, the Mental Health claims lead to longer durations and more aggregate days lost to disability

Diagnostic Categories and Durations
2008 ICI STD

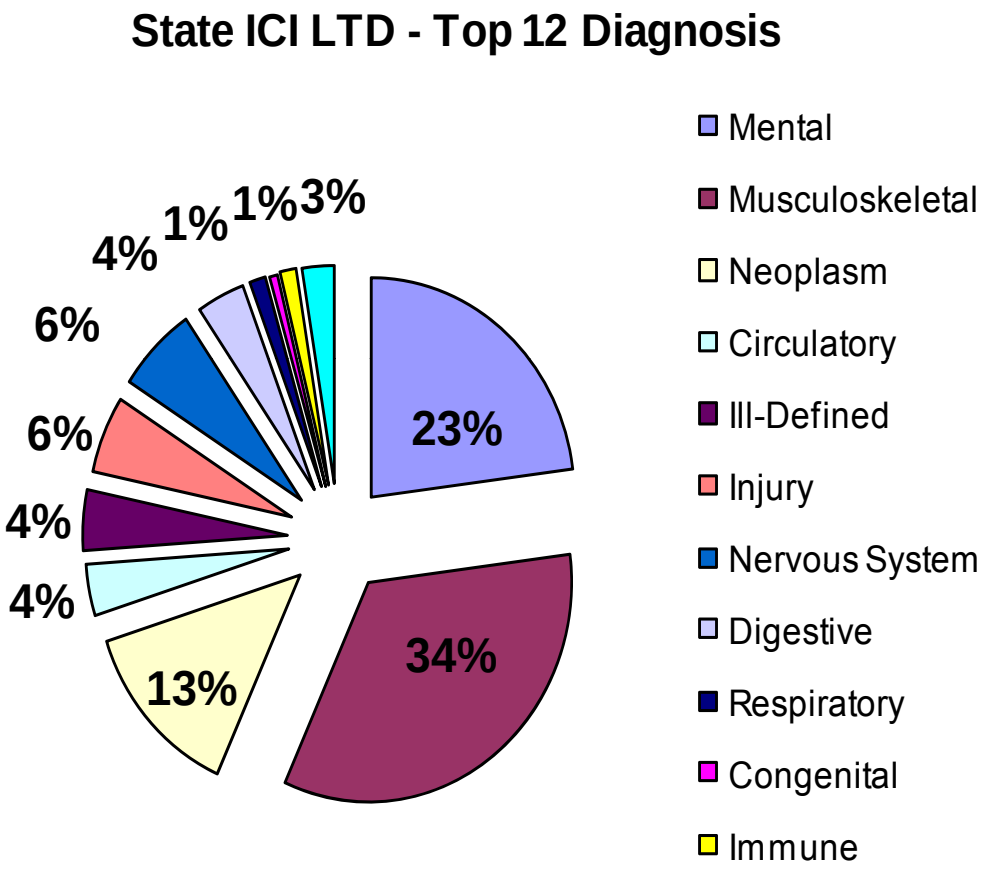


State ICI STD Diagnosis as a Percent of Claims Top 13



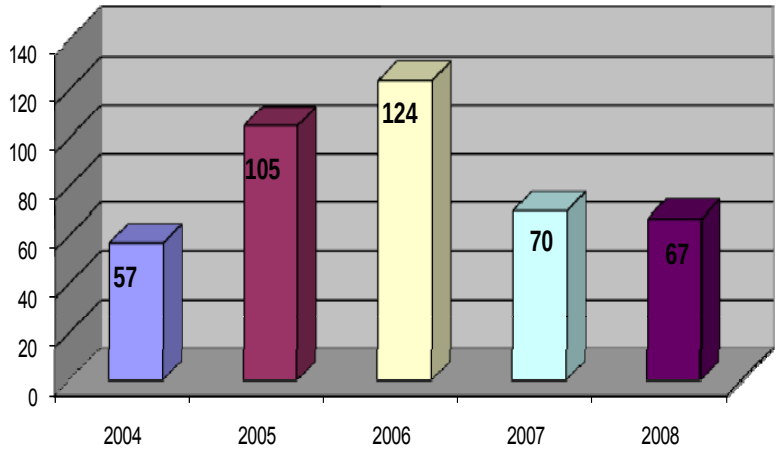
- 75% of claims are generated by the top 4 diagnostic categories
- Mental Health claims are only 11% of all diagnosis categories - but make up the second largest category for total days lost to disability
- Pregnancy incidence is up from last year by 4% from 2007 (20%)

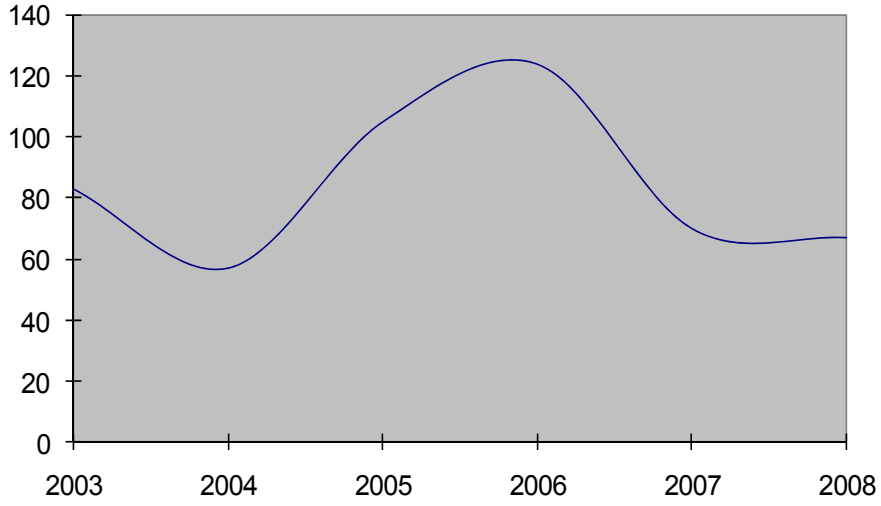
2008 State ICI LTD Claims by Diagnosis



Diagnosis	Claims
Mental	36
Musculoskeletal	53
Neoplasm	21
Circulatory	6
Ill-Defined	7
Injury	9
Nervous System	10
Digestive	6
Respiratory	2
Congenital	1
Immune	2
Other	4

2008 Local ICI Claims Statistics

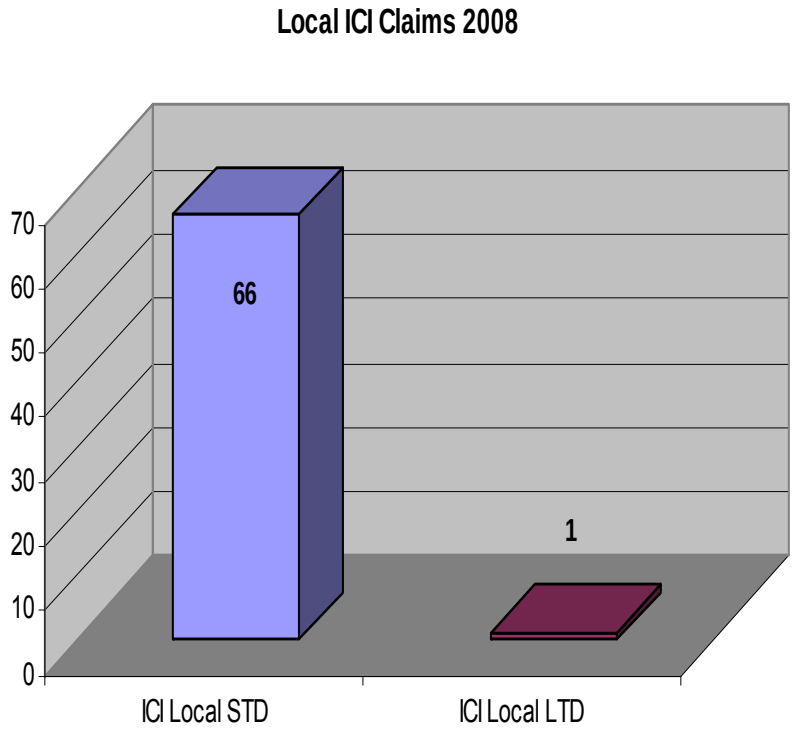




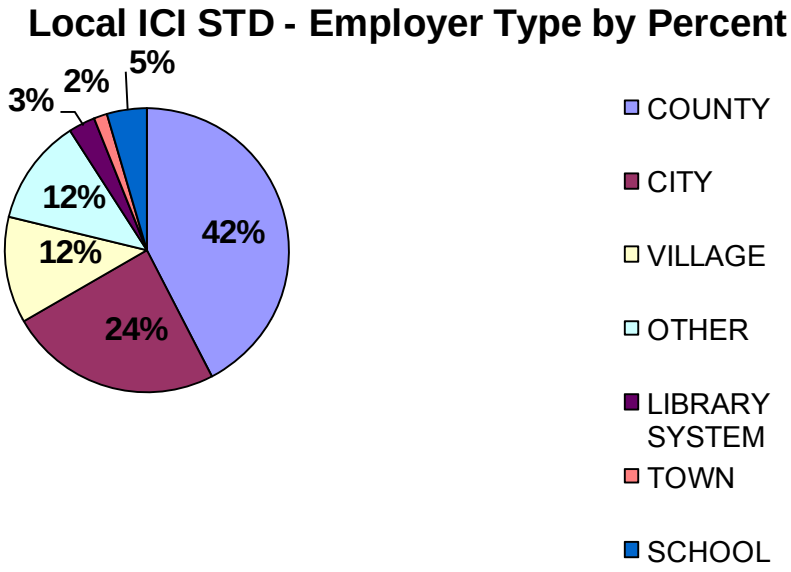
- **ICI Local claim counts rose for three years to a peak in 2006**
- **Counts have leveled off in the last two years**
- **Of the 67 new ICI local claims in 2008, only one became an LTD claim**

2008 Local ICI Claims Statistics

- **66 Short-Term Disability claims are a majority of the Local ICI claims**
- **There was 1 Local ICI LTD claim**
  - **In 2007, there were 64 STD and 6 LTD**



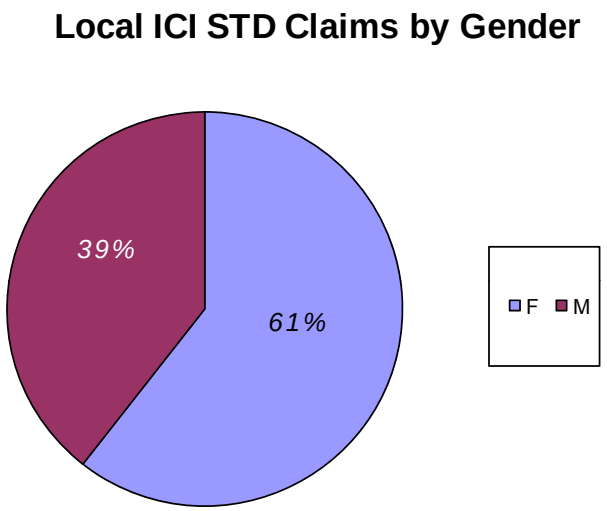
2008 Local ICI Claims by Employer Type



Local ICI	STD
COUNTY	28
CITY	16
VILLAGE	8
OTHER	8
SCHOOL	3
LIBRARY SYSTEM	2
TOWN	1

- **The one new Local ICI LTD claim occurred in the County employer type**
- **There were 64 Local ICI STD claims in 2007 compared to 66 in 2008 and 4 new Local ICI LTD claims in 2007 compared to 1 in 2008**

2008 Local ICI Claims by Gender



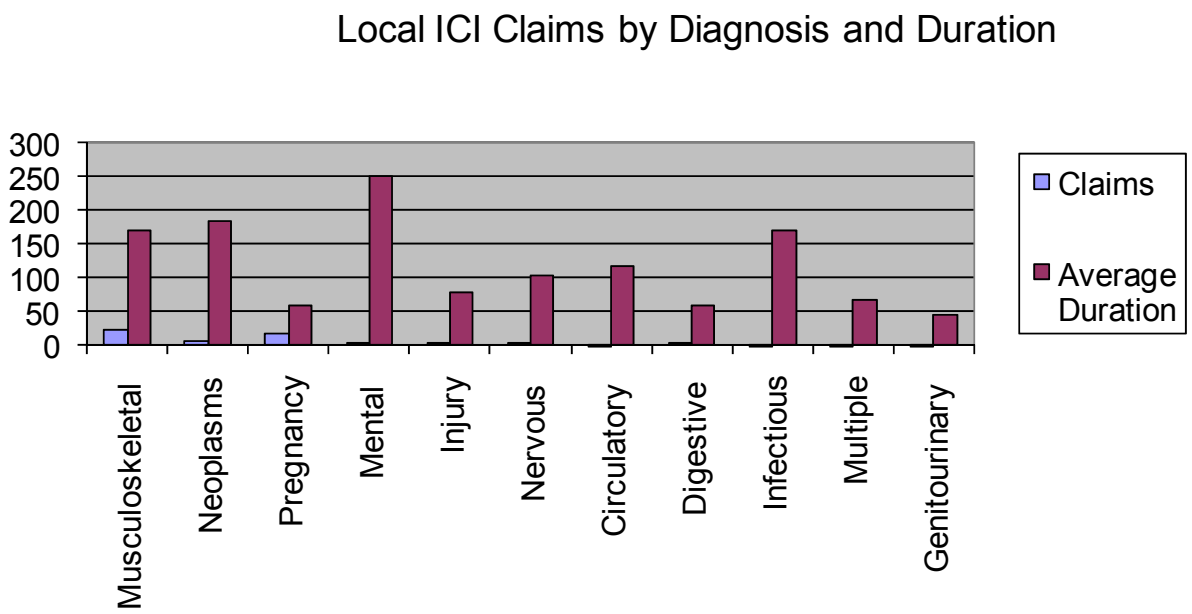
Local ICI STD

- **40 Female**
- **26 Male**
  - **In 2007, there were:**
    - **37 Female and 27 Male**

Local ICI LTD

- **1 Male**
  - **In 2007, there were:**
    - **3 Female and 3 Male**

2008 Local ICI STD Claims by Disability Type



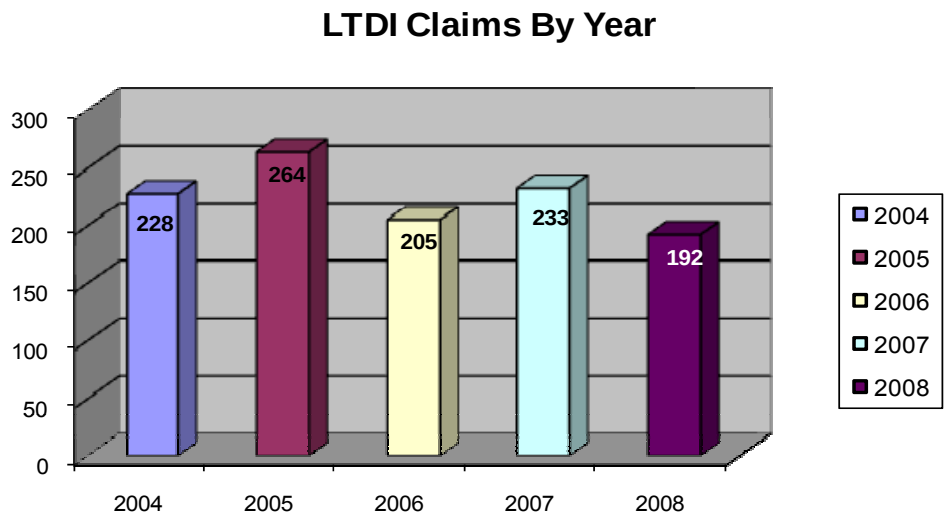
Musculoskeletal	**22**	**169**
Neoplasm	**6**	**182**
Pregnancy	**18**	**57**
Mental Disorders	**4**	**249**
Injury	**5**	**77**
Nervous/Sense	**3**	**102**
Circulatory System	**2**	**116**
Digestive System	**3**	**59**
Infectious Diseases	**1**	**170**
Multiple	**1**	**67**
Genitourinary System	**1**	**45**

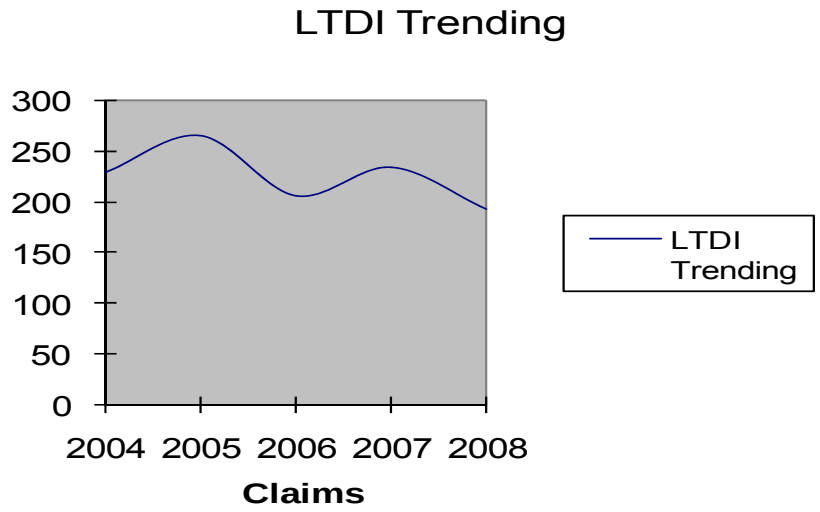
2008 Local ICI LTD Claim by Disability Type

- In 2008, there was only one new Local ICI LTD claim (Ill Defined Condition) that lasted 8 days

- In 2007, there were 6 ICI Local LTD claims:
  - 2 Injury (338 days)
  - 2 Musculoskeletal (86 days)
  - 1 Circulatory (374 days)
  - 1 Genitourinary (284 days)

2008 New LTDI Claims

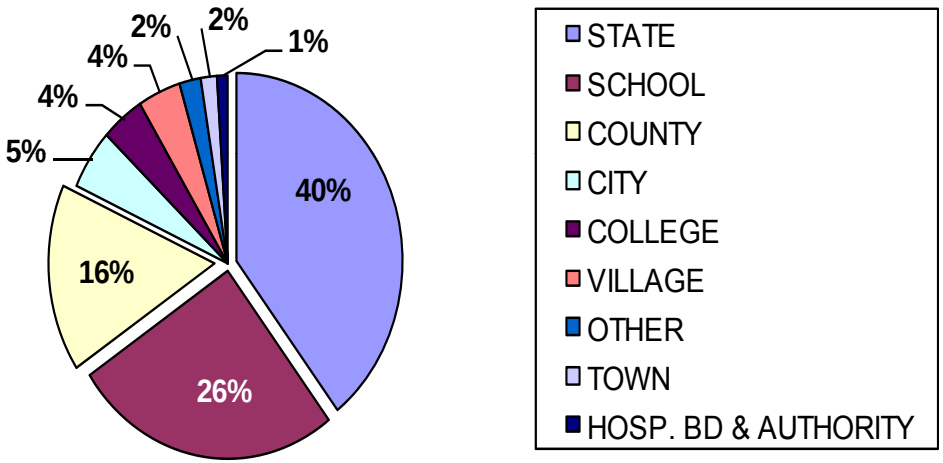




- **5-year data:**
  - **2004- 228 LTDI claims**
  - **2005- 264 LTDI claims**
  - **2006- 205 LTDI claims**
  - **2007- 233 LTDI claims**
  - **2008- 192 New LTDI Claims**
- **2006 comment:**
  - **"We'll monitor to see if the drop in LTDI is a trend or is simply a leveling off pattern."**
- **LTDI has fallen into a predictable pattern**

2008 Total LTDI Claims by Employer Type

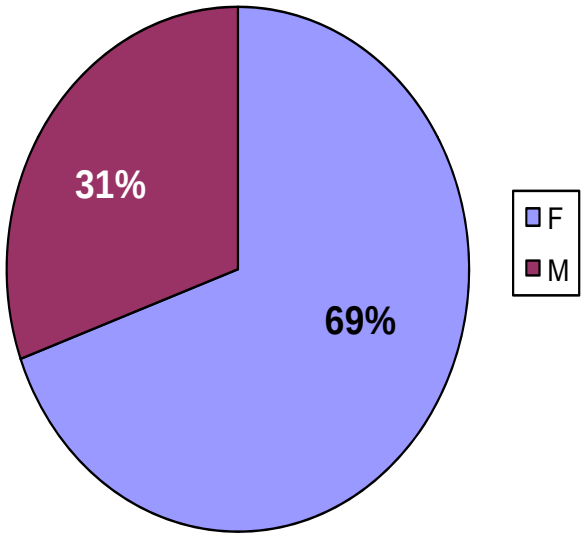
Percent LTDI Claims by Employer



STATE	76
SCHOOL	50
COUNTY	31
CITY	10
COLLEGE	8
VILLAGE	8
OTHER	4
TOWN	3
HOSP. BD & AUTHORITY	2

- **82%** of the LTDI claims were generated out of State, School, and County
- State employer is again the majority at **40%** (37% in 2007)
- School employers make up **26%** (21% in 2007), County employers make up **16%** (15% in 2007)

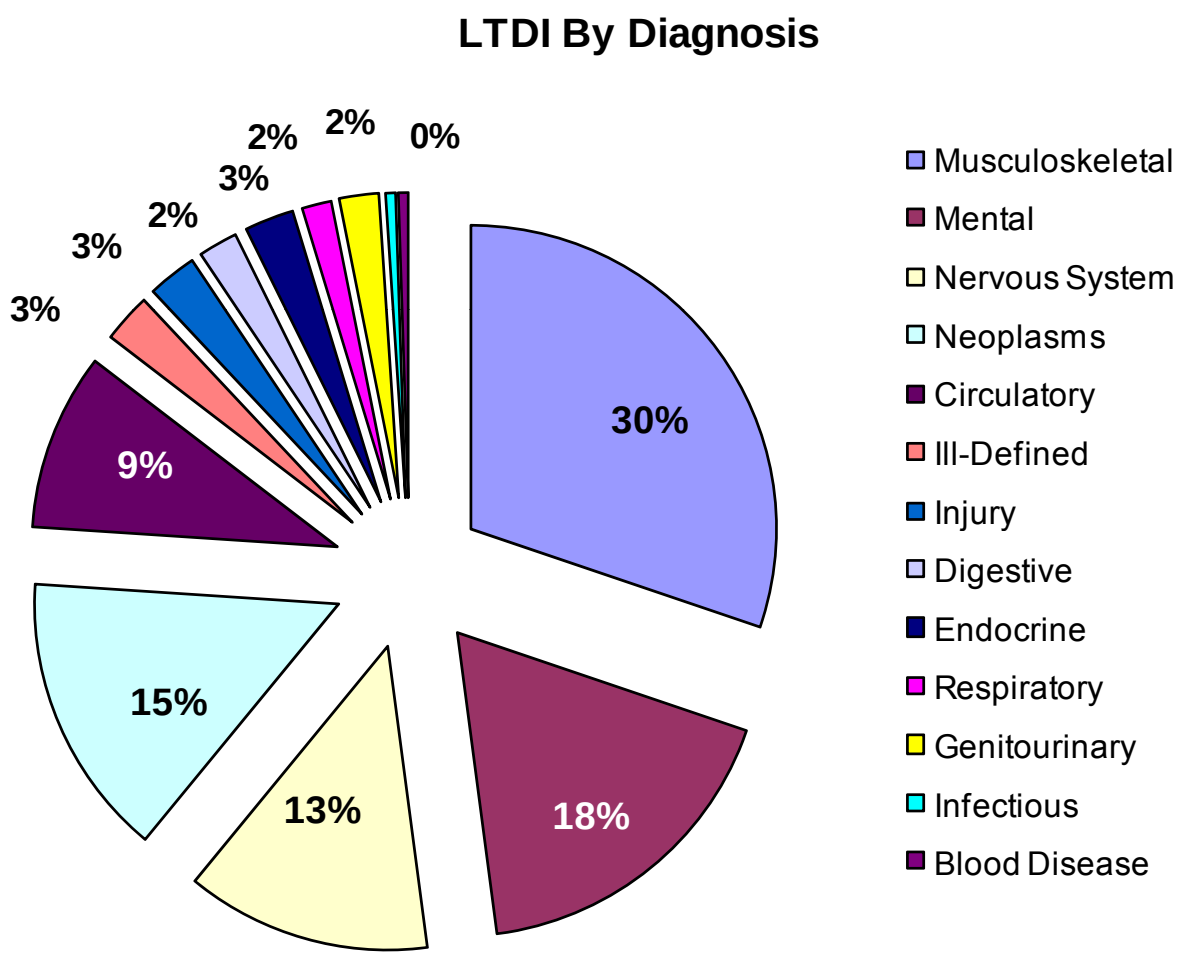
2008 Claims by Gender - LTDI



Of the LTDI Claims

- **Female claims are disproportionately higher than male claims (for approved LTDI claims)**
- **This lines up with WRS population:**
  - **38% Male**
  - **62% Female**

2008 LTDI Claims by Disability Type



Musculoskeletal	58
Mental	34
Nervous System	25
Neoplasms	29
Circulatory	18
Ill-Defined	5
Injury	5
Digestive	4
Endocrine	5
Respiratory	3
Genitourinary	4
Infectious	1
Blood Disease	1

Approach for 2009

- Maintain customer service levels
- Maintain staffing strength, experience and numbers
- Continue to mold Aetna approaches according to ETF's program
- Look for program efficiency and enhancement opportunities – be consultative where possible
- Look to ETF/GIB for priority guidance
- Protect program strengths while evolving the program
- Aetna will continue to value the relationship with the State of Wisconsin GIB and ETF

Questions & Answers

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: April 7, 2009

TO: Group Insurance Board

FROM: Michelle Baxter, Director
Insurance Administration Bureau, Division of Insurance Services

SUBJECT: Health Insurance Enrollment, Validation, and Payment (EVP) Project Update

This memo is for the Board's information only. No action is required.

As outlined in the January 21, 2009, memo to the Board, the Department has started updating the current Health Insurance and Complaint System (HICS) and related processes. The focus of the EVP project is to improve the timeliness and accuracy of premium payments, reduce administrative efforts, and replace the current manual processing of paper documents and reports. The project consists of multiple phases scheduled to be completed during 2009 and 2010. In addition, a new inquiry application allows employers to view or download active employee eligibility data, providing an opportunity to compare ETF enrollment data to their own payroll systems. Phase 1 of the EVP project was successfully completed one week early, and work has started on Phase 2.

Phase 1 introduces new online capabilities for employers and begins streamlining manual processes by giving employers online access to HICS, allowing each employer the ability to view individual participant records, and terminate and reinstate contracts.

Phase 2 will also focus on converting from paper-based, monthly coverage reporting to a web-based system. Premiums due will be determined directly from the enrollment information within the HICS, improving the timeliness and accuracy of payments.

The project continues to focus on improving customer service by providing online services for members and employers, ensuring that participants eligible for medical and pharmacy benefits are receiving those benefits, eliminating duplication of work, and ensuring continued compliance with the Health Insurance Portability and Accountability Act (HIPAA).

I will be at the April 14, 2009, meeting to answer any questions you may have.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	4/14/2009	8

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CORRESPONDENCE MEMORANDUM

DATE: April 3, 2009

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson
Sharon Walk, Executive Staff Assistant

SUBJECT: Correspondence and Complaint Summary

This memo is for the Board's information only. No action is required.

This summary contains a listing of issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following for the period of January 1, 2009, through March 31, 2009:

(1) correspondence received by the Department addressed to the Secretary or the GIB;
(2) the number of requests for information and assistance made to the ombudspersons in the Quality Assurance Services Bureau (QASB).

QASB staff will be available at the Board meeting to address any questions you have regarding this report. Thank you.

Correspondence:

	Number
Health Insurance	
• Participant expressed concern about an article published in the Milwaukee Journal Sentinel that contained misinformation about the state group health insurance program.	**1**
• Annuitant questioned health insurance costs and inquired about the possibility of serving on or assisting the Group Insurance Board.	**1**
• Annuitant is having difficulty getting his Long-Term Disability Insurance (LTDI) carrier to comply with the Federal Pension Protection Act of 2006 with respect to the payment of premiums for LTDI coverage.	**1**
• Annuitant received conflicting information from physician and Wisconsin Physicians Service (WPS) regarding whether or not the physician was a preferred provider.	**1**
• Participant concern about the $60 co-pay for an emergency room visit.	**1**
• Annuitant wants the Standard Plan to include fitness club membership.	**1**
TOTAL	**6**

Reviewed and approved by Matt Stohr, Director, Office of Legislative Affairs, Communications and Quality Assurance.

_____ _____
Signature Date

Board	Mtg Date	Item #
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Contacts to Ombudspersons:
From January 1, 2009, through March 31, 2009, 371 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, which includes Medicare Part D.

Recurring issues that staff identified during this period include:

- Participants having problems with benefit programs other than the health insurance program have increased in 2009, including OSER's DentalBlue program, WRS retirement benefits and Epic. *From January through March 2009, we received nearly twice the number of contacts related to "other" programs than during the same period in 2008. These complaints typically involve incorrect enrollment information or disputes involving eligibility.*

- Participants in need of assistance with new or continuing Medicare coordination of benefits or enrollment problems (which result in neither insurer paying claims until the primary versus secondary payer problem is resolved) - *Ombudspersons regularly work with Medicare, health plans, and advocacy organizations on behalf of our participants to help expedite resolution of these problems.*

- Participants who have questions about enrollment in Humana's Medicare Advantage Private Fee for Service (PFFS) plan, questions about obtaining coverage under Medicare B and Medicare D, problems with premium payment, or difficulty disenrolling from Humana's PFFS plan.

- Participants looking for miscellaneous information related to retirement benefits, beneficiary designations, Variable and Core Funds, and other items*. Additionally, we have had many contacts from participants who want assistance to better understand their options (such as the application process for Lump Sum retirement or separation payments) or information on how to make a hardship request to quickly access funds from their Wisconsin Retirement System account or Wisconsin Deferred Compensation program account. Also, it is not uncommon to be contacted by participants in need of information on how best to resolve provider billing issues and/or Coordination of Benefits with Medicare, Veterans Administration benefits and our Group Health Insurance program.*

- Participants who do not fully understand their coverage or reasons for denials. *Ombudspersons regularly work with participants to help them better understand the characteristics of their ETF-administered benefit programs*.

- Participants experiencing enrollment and eligibility problems. *Most of these were related to coverage of dependents, questions regarding late Dual Choice application process and/or the Dual Choice rescind process. This also included working collaboratively with health plans, Pharmacy Benefit Manager (PBM) and other ETF staff to resolve eligibility issues immediately, to allow members to obtain necessary covered prescriptions.*

- Participants for whom a claim or deductible/copayment discrepancy occurred between health plan or PBM and the participant's provider. *Ombudspersons routinely assist members when their claims have been denied, excess copayment is applied, or when provider billing errors occur. Staff have noted that there has been a disproportionate number of complaints involving Anthem's and Humana's benefit administration as compared*

to other plans. ETF staff (including Ombudspersons and Insurance Services staff) have been working with key Anthem staff to assist in tracking open complaints and plan accountability for customer service and benefit administration issues. Staff are discussing ways to address issues with Humana as well.

- Participants with questions about their new health plan, ID cards or network provider information.

The following tables summarize the method of contact and program areas involved compared to the same period in 2008.

Total Contacts	**2009**	**2008**
January	137	162
February	103	175
March	131	116
Total	371	453

Method of Contact	**Jan-Mar 2009**	**Jan-Mar 2008**
Telephone	294	339
E-mail/Contact Us Internet Page	47	94
US Mail	24	12
Walk-In	6	8

Number of Contacts by Program	**Jan-Mar 2009**	**Jan-Mar 2008**
Health Insurance-HMO's	170	192
Health Insurance-Self Funded	55	112
Pharmacy Benefits	55	95
Non WRS Programs (DentalBlue)	21	21
Disability/Income Continuation Insurance	6	9
All Other Program Types* (Life Insurance, ERA, EPIC, Spectera, WRS/ASLCC and WDC)	44	24

* It is not common to receive a large number of complaints regarding these programs. The availability of ombudsperson assistance in this area is not widely known and most of these programs are not under contract with ETF; rather, they are benefits that the Board simply approves to be offered through payroll deduction.

Key:

- *ASLCC: Accumulated Sick Leave Conversion Credit*
- *ERA: Employee Reimbursement Accounts. Optional pre-tax savings account for medical expenses and dependent care.*
- *EPIC: Optional supplemental benefit plan that provides coverage for dental, excess medical and accidental death and dismemberment.*
- *Spectera: Optional vision benefit*
- *WDC: Wisconsin Deferred Compensation*
- *WRS: Wisconsin Retirement System*

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CORRESPONDENCE MEMORANDUM

DATE: April 1, 2009

TO: Group Insurance Board

FROM: Cindy Gilles
Board Liaison

SUBJECT: 2010 Group Insurance Board Meeting Dates

This memo is for the Board's information only. No action is required.

The following are the 2010 meeting dates for the Group Insurance Board. Please check your schedules to determine if these dates will be convenient for you. You will receive information on specific times prior to each meeting.

Tuesday, February 9, 2010
Tuesday, April 13, 2010
Tuesday, June 8, 2010
Tuesday, August 24, 2010
Tuesday, November 9, 2010

If you have questions regarding this schedule, please feel free to contact me at (608) 261-0736.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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CORRESPONDENCE MEMORANDUM

DATE: March 30, 2009

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

This memo is provided for informational purposes only. No Board action is necessary.

Over the past year, the number of pending appeals has remained steady, with a monthly average of 31. The chart below shows pending appeals during the past 12 months.

	Employee Trust Funds (ETF) Board	Wisconsin Retirement (WR) Board	Teachers Retirement (TR) Board	Group Insurance (GI) Board	Deferred Compensation (DC) Board	TOTAL
April 2008	13	5	1	5	0	24
May 2008	15	5	0	4	0	24
June 2008	17	7	0	6	0	30
July 2008	18	8	0	8	0	34
August 2008	14	9	0	8	0	31
September 2008	16	9	0	8	0	33
October 2008	13	8	0	7	0	28
November 2008	13	9	0	8	0	30
December 2008	13	9	0	7	0	29
January 2009	17	11	0	10	0	38
February 2009	20	9	0	9	0	38
March 2009	19	7	0	9	0	35

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

Board	Mtg Date	Item #
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The appeals currently pending before the Group Insurance Board (Board) can be divided into the following categories:

Long-Term Disability Insurance (LTDI) denial	5
Health insurance coverage	3
Denial of coverage for gastric bypass surgery	1
Total	9

Independent Record Review Process

As some Board members may recall, in 2000 the appeal backlog stood at 300+ cases and the typical appellant was required to wait an average of three years for a final decision. The Department consulted with Nancy Williams of William Mercer, Inc., who proposed several changes to the appeals process. One of these changes was the implementation of an Independent Record Review (IRR) process.

With an IRR, when an appeal is received by the Department, the appellant is contacted to discuss the matter. The IRR process functions independently within the Department. The member is given an opportunity to discuss the matter with someone who was not involved in making the ETF determination. In some situations, explaining the statutory language that was used in the decision helps resolve the matter. Other times, creative solutions are found that allow the Department to grant a benefit while staying within the confines of Chapter 40.

Several examples of recent appeals that have been resolved through the IRR process are summarized below:

2008-028-GIB The participant filed an application for LTDI benefits. The employer statement indicated that the employer wished to contest the disability claim. The application was denied and the participant filed an appeal. A review of the situation found that the employer objected to the LTDI because the appellant also had a claim for Worker's Compensation. The employer was hoping to use the LTDI as leverage to get the appellant to settle his Worker's Compensation claim. After negotiation with the employer and the appellant, a settlement was reached on the Worker's Compensation claim and the employer withdrew its opposition to the LTDI. The appellant then withdrew his appeal.

2008-034-GIB In this case, the participant was receiving Income Continuation Insurance (ICI) benefits. She applied for a retirement benefit and took a lump sum payment. She was informed that the retirement benefit would be offset from her ICI benefit. She objected to this interpretation of the ICI plan and filed an appeal. After several conversations in which the application of the ICI plan was explained, she withdrew her appeal.

2008-039-GIB The participant applied for LTDI. She was required to obtain two qualifying medical reports. She obtained two medical reports but one of them was non-qualifying. She was given an opportunity to file a third report but the one year time period expired and the application was denied. Subsequently, she filed an appeal. She was encouraged to reapply for LTDI benefits. She provided

two qualifying medical reports and the benefit was granted. The appellant decided to withdraw her appeal.

2006-076-GIB The appellant originally applied for LTDI. The appellant submitted three medical reports. Two of the medicals were non-qualifying and the application was denied. The appellant filed an appeal. The appellant was encouraged to reapply for LTDI. As part of the second application, she was able to obtain two qualifying medical reports and the benefit was granted. The appeal was withdrawn.

Staff will be available at the April 14, 2009, meeting to answer any questions you may have.

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CORRESPONDENCE MEMORANDUM

DATE: March 16, 2009

TO: Group Insurance Board

FROM: David H. Nispel, General Counsel

SUBJECT: Clearinghouse Rule 08-079
Insurance Coverage of Insured Dependent

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

On November 11, 2008, the Board approved the final draft report of this administrative rule. The rule has now completed its legislative review process with no objections. It will be published in the Wisconsin Administrative Register in April. The effective date of the rule will be May 1, 2009.

This administrative rule provides that health insurance coverage for surviving insured dependents will automatically continue despite the death of the insured employee or annuitant who had family health insurance coverage in effect. Currently, an application must be completed and submitted to maintain coverage. This rule removes that requirement. Payment of the insurance premiums is provided for in the rule.

The rule designates who will be responsible for making decisions about the health insurance coverage following the insured employee's death. The responsible person will have control over the health insurance coverage and will make the annual Dual-Choice decisions. The duration of coverage for a surviving insured dependent other than a spouse is to be established by the terms of the group health insurance contract. A surviving spouse is entitled to coverage for life, unless the surviving spouse cancels the coverage voluntarily or coverage is cancelled for non-payment of premiums.

The primary goal of the rule is to reduce or eliminate interruptions in coverage for surviving dependents who wish to continue health coverage. Another goal is to reduce staff time spent soliciting applications, reminding surviving dependents of the application deadline, and handling telephone calls and correspondence concerning health coverage that was involuntarily terminated.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	04/14/09	8