STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

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Correspondence Memorandum

Date: August 3, 2017

To: Group Insurance Board

From: Shayna Schomber, Optional & Self-Insured Health Benefits Manager
Office of Strategic Health Policy

Subject: Optional Insurance and Long Term Care Insurance Program Proposals

ETF recommends the Group Insurance Board (Board) approve the following, effective January 1, 2018:

- **EPIC Benefits+**
  - **Core Benefits Premium Changes:**
    - **Active decrease 0.8%**
    - **Annuitant decrease 0.6%**
  - **Vision Add-on Premium Changes:**
    - **Active decrease 10.0%**
    - **Annuitant decrease 25.0%**
- **EPIC Dental Wisconsin**
  - **PPO and Select Plan Benefit Changes**
  - **PPO Premium Changes:**
    - **Active decrease 9.0%**
    - **Annuitant rate change 0.0%**
  - **Select Premium Changes:**
    - **Active increase 2.5%**
    - **Annuitant increase 7.5%**
- **Renew Mutual of Omaha contract with no changes**

Background

Under the authority granted to the Group Insurance Board (Board) by Wis. Stats. §40.03 (6) (b) and §40.55, and pursuant to §20.921 (1) (a) (3) and Wis. Admin. Code ETF 10.20 and ETF 41, the Board is authorized to approve Optional Insurance Program plans to be offered via payroll deduction. Proposals for changes to benefits and/or premiums for existing plans are reviewed under the Board's Guidelines for Optional Plans (ET-7422) and Standards for Proposing and Offering Long Term Care (ET-7423).

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Lisa Ellinger Electronically Signed 8/21/17

Board	Mtg Date	Item #
GIB	8.30.17	5A

EPIC Proposals
ETF received proposals from EPIC for the Benefits+ and Dental Wisconsin plans on March 31, 2017 (Attachment A) with proposed rate changes for 2018. No benefit changes were proposed for the Benefits+ plan; however, EPIC requested benefit changes for the Dental Wisconsin PPO and Select Plans.

ETF negotiated changes to the proposed rates and benefits to reduce member confusion and maximize administrative efficiency. These changes are reflected in EPIC's final proposal amendment, dated July 28, 2017 (Attachment B).

Benefit Changes
The final proposed benefit changes to Dental Wisconsin are as follows:

- Change the annual benefit maximum
  - Existing enrollees: increase from $1,000 to $1,250 per member
  - New enrollees*: introduce a tiered annual maximum, similar to the Benefits+ dental coverage:

Tiered Benefit Maximums	
Year 1	$600
Year 2	$800
Year 3+	$1,250

- Remove the 3-month waiting period on basic and major restorative coverage
- Remove the waiting period waiver and remove the creditable coverage provision for orthodontic coverage
- Increase the waiting period on orthodontic coverage from 12 to 24 months for new enrollees*

*New enrollees include employees who do not elect EPIC Dental Wisconsin at the time of hire, beginning in 2018.

Premium Rate Changes
EPIC's proposals also included premium rate adjustments for Benefits+ and Dental Wisconsin. The rates proposed in the March 31, 2017 proposal are listed in the table below.

EPIC Plans 2018 Proposed Rates

Actives

	Single		Family		2017-2018
	2017	2018	2017	2018	Net Change
Benefits+ Total	$21.56	$22.12	$64.68	$66.38	2.7%
Vision Add-on	$4.04	$3.84	$10.48	$9.96	-5.0%
Dental WI PPO	$24.60	$24.60	$88.02	$88.02	0.0%
Dental WI Select	$20.52	$21.86	$71.58	$76.24	6.5%

Annuitants

	Single		Family		2017-2018
	2017	2018	2017	2018	Net Change
Benefits+ Total	$28.90	$29.72	$79.62	$81.88	2.7%
Vision Add-on	$4.34	$4.12	$11.30	$10.74	-5.0%
Dental WI PPO	$35.62	$39.00	$127.48	$139.60	9.5%
Dental WI Select	$25.64	$28.72	$89.48	$100.22	12.0%

Milliman reviewed the March 31, 2017, proposals from EPIC and recommended changes to the proposed rates. EPIC submitted amended proposals on June 9, 2017 based on recommendations from Milliman and ETF. The amended rates for EPIC Benefits+ and Dental Wisconsin are below.

EPIC Plans 2018 Amended Rates

Actives

	Single		Family		2017-2018
	2017	2018	2017	2018	Net Change
Benefits+ Total	$21.56	$21.38	$64.68	$64.14	-0.8%
Vision Add-on	$4.04	$3.64	$10.48	$9.44	-10.0%
Dental WI PPO	$24.60	$22.38	$88.02	$80.10	-9.0%
Dental WI Select	$20.52	$21.04	$71.58	$73.36	2.5%

Annuitants

	Single		Family		2017-2018
	2017	2018	2017	2018	Net Change
Benefits+ Total	$28.90	$28.74	$79.62	$79.16	-0.6%
Vision Add-on	$4.34	$3.26	$11.30	$8.48	-25.0%
Dental WI PPO	$35.62	$35.62	$127.48	$127.48	0%
Dental WI Select	$25.64	$27.56	$89.48	$96.20	7.5%

Actuarial Review

Milliman reviewed EPIC's amended proposals and the projected loss ratios for 2018 (Attachment C). The rates were adjusted from the March 31, 2017, proposal in order to achieve more equitable rates across the populations. With this adjustment, the rates and benefits in the plans appear to be reasonable and are expected to achieve the 75% minimum loss ratio.

Mutual of Omaha Proposal

ETF received a letter from Mutual of Omaha on June 14, 2017 requesting to renew their existing plan for 2018 with no changes to rates or contract terms (Attachment D). ETF is prepared to release the new contract for signature upon Board approval.

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

Attachment A: EPIC Proposal dated March 31, 2017
Attachment B: EPIC Proposal Amendment dated July 28, 2017
Attachment C: Milliman Actuarial Review of EPIC Proposals dated June 20, 2017
Attachment D: Mutual of Omaha Renewal Letter dated June 14, 2017

EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

March 31, 2017

Shayna Schomber, MBA
Manager of Self-Insured Benefits & Uniform Dental
Manager of Employee Pay-All Optional Insurance Plans
Office of Strategic Health Policy / Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Dear Ms. Schomber,

In the past two years, many positive changes have taken place affecting the business relationship between The EPIC Life Insurance Company (d.b.a. EPIC Specialty Benefits), Employee Trust Funds (ETF) and the State of Wisconsin employer groups. Through the new contract and arrangement, EPIC's coverage has become more standardized to meet the needs of the STAR and the University of Wisconsin's PeopleSoft Human Resource Systems to streamline processes, along with the continued exchange of data with the established payroll systems.

EPIC will continue to conform with the State of Wisconsin Group Health Insurance Program. Any eligibility changes implemented in 2017 for 2018 by the State, EPIC will conform to those changes (such as a decision on domestic partners).

Below is a summary of our current plan offerings and request for 2018 changes.

Dental Wisconsin

EPIC offers the State of Wisconsin employees and their dependents the option to select between a dental Preferred Provider Option (PPO) and an indemnity Select Plan. The Dental Wisconsin PPO benefits incorporate preventative, basic, major and orthodontia services. This was developed to provide coverage to the employees that may not have dental coverage. The Dental Wisconsin Select plan is a supplemental dental plan that does not cover preventative services, but provides coverage for basic, major and orthodontia services. This plan fills the coverage gap and assists with out of pocket costs that would otherwise be the member's responsibility.

EPIC is requesting rate and benefits changes on both the PPO and Select plans for 2018. Along with these rate and benefit changes, EPIC will offer a Special Enrollment to late enrollees. Details on the proposed benefit changes follow below.

PPO Benefit Changes for Existing Enrollees and Timely Entrants

EPIC is proposing to remove the Basic and Major waiting periods that are currently included in the plan and eliminating the creditable coverage provision. EPIC is also proposing to increase the annual maximum from $1,000 to $1,500 per member.

PPO Benefit Changes for Special Enrollees Beginning in 2018

EPIC is proposing to remove the Basic and Major waiting periods that are currently included in the plan. We are also proposing changing the orthodontic waiting period from 12 to 24 months and eliminating the creditable coverage provision. EPIC is also proposing a phased (or tiered) annual maximum that will have a schedule of $750 during first year of coverage, $1,000 during second year of coverage, and $1,500 during third and subsequent years of coverage.

Select Benefit Changes for Existing Enrollees and Timely Entrants

EPIC is proposing to remove the Basic and Major waiting periods that are currently included in the plan and eliminating the creditable coverage provision.

Select Benefit Changes for Special Enrollees Beginning in 2018

EPIC is proposing to remove the Basic and Major waiting periods that are currently included in the plan. We are also proposing changing the Orthodontic waiting period from 12 to 24 months and eliminating the creditable coverage provision. EPIC is also proposing a phased (or tiered) annual maximum that will have a schedule of $500 during first year of coverage, $750 during second year of coverage, and $1,000 during third and subsequent years of coverage.

There is more information on the Dental Wisconsin rate and benefit changes in the attached Actuarial Memorandum.

EPIC Benefits+

Since 1994, EPIC has offered the State of Wisconsin employees an Optional Insurance Plan. This plan offers the employees the combined coverage for accidental death and dismemberment, a hospital surgical benefit and dental coverage, with an option to include a vision benefit. This provides additional benefits not offered by any other carrier that help the member with vision, dental, and non-medical out of pocket costs.

EPIC is requesting rate changes for 2018 for active employees and annuitants. Along with this rate change, EPIC is continuing a phased (or tiered) annual maximum that will have a schedule of $750 during first year of coverage, $1,000 during second year of coverage, and $1,500 during third and subsequent years of coverage; with a 24-month waiting period on

orthodontics. The attached Actuarial Memorandum has more details on the proposed rate changes.

It is EPIC's intent to exclude re-enrollment of any member who was termed mid-year in 2017 for non-payment of premium. This was communicated to the member through our delinquent process.

I hope you find EPIC's request demonstrative of our commitment to State of Wisconsin employees and annuitants. The enclosed provides information supporting our request.

Sincerely,

Wendy Hougan
Strategic Account Executive

Attachments

- Supporting Information
- Actuarial Memorandum

OCI Identification Number: 39-1502108
EPIC was incorporated August 30, 1984 as a wholly owned subsidiary of Wisconsin Physicians Service Insurance Corporation ("WPS"), a Wisconsin health service insurance corporation licensed under WI ST § 613. EPIC is a licensed under Wisconsin. ST § 611 as a Domestic Insurance Corporation specializing in term life, disability, accident, dental, vision and health insurance to group subscribers in 27 states. 100% of all outstanding voting securities of EPIC, comprised of a single class of common stock, are directly owned by WPS.

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

Plan Benefits Description

Outline of Plan Benefits

Please see attached Actuarial Memorandum.

Detailed List of Exclusions and Limitations

Benefits+ Exclusions

Dental Exclusions - This plan does not cover: • dental services incurred for the replacement of a full upper or a full lower denture regardless of cause after we have included the charge for such denture(s) at least once in considering benefits under this or a similar dental expense benefit provision • dental services incurred for relining of dentures • orthodontic treatment that begins after a covered dependent reaches age 19 • dental services that are not medically necessary or not required
in accordance with accepted dental practices • diagnostic and preventive dental services including, but not limited to, dental examinations, regular and periodontal cleaning, fluoride, x-rays, sealants, and emergency evaluations • orthodontic services and supplies incurred: (1) during the first 12 calendar months following a new entrant's effective date of coverage under the policy; or (2) during the first 24 calendar months following a late enrollee's effective date of coverage under the policy
• dental services not specifically identified as being covered under the policy • dental services and supplies for cosmetic treatment, unless necessitated as a result of injuries sustained while the member is covered under the policy • dental services and supplies provided in connection with the treatment of the temporomandibular joint • dental services furnished by the U.S. Veterans Administration, except for such services for which under applicable federal law the policy is the primary
payor and the U.S. Veterans Administration is the secondary payor • dental services, including oral surgical services, except as specifically stated above.

Hospital and Surgery Benefit Exclusions - This plan does not cover: hospital confinement that does not medically require the patient to be hospitalized or surgery not medically necessary, as determined by us • routine newborn care. Initial hospital and nursery care, per day, for evaluation and management of normal newborn infant • hospital confinement or surgery services connected with: obesity, weight reduction, or dietetic control care, except for morbid obesity and disease etiology • reconstructive surgery, except for such surgery required: (1) to repair a significant defect caused by an injury; (2) to repair a defect caused by congenital anomaly causing a functional impairment of a dependent child; (3) incidental to a mastectomy; or (4) due to an illness • eye refractive surgery • hospital confinement or surgery services in connection with care for, or leading to, sexual transformation • reversal of sterilization • hospital confinement or surgery services in connection with artificial insemination or fertilization methods including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures that are incidental to such insemination or fertilization methods • dental services, including oral surgical services.

Hospital - A hospital does not include, as determined by us: • a convalescent or extended care facility unit within or affiliated with the hospital • a clinic • a nursing, rest or convalescent home • an extended care facility • a facility operated mainly for care of the aged • sub-acute care center • a health resort, spa or sanitarium. Ambulatory Surgical Center: An Ambulatory Surgical Center means a licensed facility where the patient is admitted to and discharged within the same day, with the primary purpose to provide surgical procedures. It has one or more physicians on duty whenever a patient is in the center.
An Ambulatory Surgical Center does not include, as determined by us: • an office maintained by a physician for the practice of medicine • a facility which provides services or overnight accommodations for patients.

AD&D Exclusions - In addition to the general exclusions, this plan does not cover any loss due to • injury you receive while operating, riding in or descending from any aircraft, except as a fare-paying passenger in a commercial aircraft on a regularly scheduled flight • illness or disease • bacterial infections (unless due to accidental food poisoning) • injury sustained while intoxicated • injury sustained while under the influence of any controlled substance unless prescribed by and taken under the direction of a physician • an intentionally self-inflicted injury or illness, suicide or attempted suicide, whether a member is sane or insane • your participation in a riot or in the commission of a crime.

Vision Exclusions - The vision plan does not cover: • vision care services not recommended by a vision care provider • periodic vision examinations except as stated in the policy • eye examinations required by an employer as a condition of employment • vision care services provided in connection with special procedures such as orthoptics and visual training • lenses which do not provide vision correction • charges for the replacement of lost or stolen lenses or frames within 24 months of service • vision care services for any injury or illness arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under workers' compensation or similar laws have been claimed, paid, waived or compromised or whether you're covered under worker's compensation insurance (n/a in SD). • vision care services furnished by the U.S. Veterans Administration, except for such vision care services which under the policy we are the primary payor and the U.S. Veterans Administration is the secondary payor

under applicable federal law (n/a in MO) . • vision care services furnished by any federal or state agency or a local political subdivision when the member is not liable for the costs in the absence of insurance, unless coverage under the policy is required by any state or federal law • vision care services covered by Medicare, if a member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare (n/a in MO) • vision care services for any injury or illness caused by: (a) atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile (n/a in MO and WV) • vision care services in connection with any illness or injury caused by your: (a) engaging in an illegal occupation; or (b) commission of, or attempt to commit a felony; or (c) self-inflicted injury • medical treatment provided outside of the United States or Canada • vision care services provided by practitioners who do not meet the definition of vision care provider • vision care services provided when your coverage was not effective under the policy. This includes vision care services provided either prior
to your effective date of coverage or after coverage terminated under the policy. • vision care services for which you have no legal obligation to pay • that portion of the amount billed for a vision care service covered under the policy that exceeds our determination of the charge for such vision care service • comprehensive low vision evaluations,
subsequent follow-up visits following such evaluation or low vision aids for which prior notification was not sent to the Claim Administrator • medically necessary contact lenses prescribed for you for which prior notification was not approved by the Claim Administrator • eye refractive surgery, except as specifically stated in the policy • preparation, fitting, or purchase of eye glasses or contact lenses, or eye refractive surgery, except as specifically stated in the policy; vision therapy, including
orthoptic therapy and pleoptic therapy.

General Exclusions – This policy provides no benefits for: • hospital confinement, surgery services, or dental services for any illness or injury arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under workers' compensation or similar laws have been claimed, paid, waived or compromised or whether you're covered under workers' compensation insurance • hospital confinement, surgery services, or dental services
furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless coverage is required by any state or federal law • hospital confinement, surgery services, or dental services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile • cosmetic treatment or surgery • war, declared or undeclared • taking part in a riot, felony or insurrection • services provided by members of a member's immediate family or anyone else living with him/her • hospital confinement, surgery services, or dental services for which a proof of claim is not provided to us • health care services which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section
632.895 (9), Wisconsin Statutes, as amended.

General Information - coverage is will not be allowed for any member who has been delinquent since the 2017 enrollment opportunity.

Dental Wisconsin Exclusions.

The following aren't covered under the policy. The policy provides no benefits for: Dental services for any illness or injury covered by Worker's Compensation or similar laws, even if a member doesn't choose to claim such benefits. • Dental services furnished by the U.S. Veterans Administration, except for such dental services for which under the policy we are the primary payor and the U. S. Veterans Administration is the secondary payor under applicable federal law. • Dental services furnished by any federal or state agency or a local political subdivision when the member is not liable for the costs in the absence of insurance, unless coverage under the policy is required by any state or federal law. • Dental services covered by Medicare, if a member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare. • Dental services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile. • Dental services for cosmetic purposes, unless necessitated as a result of injuries sustained while the member is covered under the policy. • Dental services which aren't dentally necessary or which aren't appropriate to the treatment of an illness or injury as determined by us. • Dental services provided by members of a member's immediate family or anyone else living with him/her • Dental services which are experimental or investigative. • Dental services not specifically identified as being covered under the policy. • Dental services when not provided by a dentist, physician or a licensed dental professional performing a related service requested by a dentist or physician. • Dental services provided when a member's coverage was not effective under the policy. This includes care provided either prior to the member's effective date of coverage or after his/her coverage terminated under the policy. • Dental services in connection with any illness or injury caused by a member's commission of, or attempt to commit, an assault, battery, felony, or act of aggression, nsurrection, rebellion, participation in a riot or engaging in an illegal occupation. • Dental services for replacement of a lost or stolen prosthesis or for a replacement or second prosthesis. • Dental services for oral hygiene, dietary, or plaque control instructions and programs. • Athletic mouth guards. • Any amount billed by a dentist, physician or licensed dental professional because of the patient's failure to appear for a scheduled appointment. • Dental services received from the dental or medical department of any employer, union, employee benefit association, trustee, or for services of a dentist or clinic contracted for or by any such organization. • Dental services for dentures, crowns, inlays, onlays, bridgework or appliances for altering vertical dimensions. • Dental services for denture or bridgework adjustments provided to a member within six months of the placement of a denture or bridgework with that member. • That portion of the amount billed for a porcelain-veneer crown or pontic on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds our determination of the charge for a full-cast metal crown or pontic. • Dental services for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the reasonable charge for the permanent denture or bridge. • Dental services provided, for, or in connection with, precision or semi precision attachments, denture duplication or other customized attachments. • Drugs and medicines, other than injectable antibiotics administered by a dentist or physician as a result of dental treatment. • Orthodontia services except as specifically

provided by the policy. • Dental services or that portion thereof, for which the member has no legal obligation to pay. • Dental services, including, but not limited to, oral surgical services, or that portion thereof, which are covered expenses under the member's EPIC group health coverage or any other medical coverage that he/she has, or for which benefits are paid under such EPIC coverage or other coverage. • Dental services provided during any waiting periods. • Dental services provided in connection with the treatment of the temporomandibular joint, except for oral surgical services. • That portion of the amount billed for the dental service covered under the policy that exceeds our determination of the charge for such dental service. • Orthodontia services for other than malocclusion of natural teeth. • Crowns for the purpose of periodontal splinting. General Information - This brochure is only a general outline of benefits, limitations, and exclusions. You can find a more detailed description of coverage in the applicable certificate of insurance. A certificate will be issued to each employee who becomes insured under the plan. The words "charge" and "charges" as used in this brochure mean an amount we determine as reasonable, considering factors such as the amount providers charge for similar services and supplies provided in the same geographic area. Coverage is subject to all terms and conditions of the policy, which is your contract of insurance. The policy consists of the group master policy, including the application and all policy riders and endorsement.

Conforming to State of Wisconsin Group Health Insurance Programs

The eligibility of EPIC's plans meets these requirements.

Member Complaints and Grievances

Grievance Procedures for Dental, Vision and Hospital and Outpatient Surgery Indemnity Benefits.

Situations might occasionally arise when you, as a member, question or are unhappy with a claims decision made by us or some aspect of our policy administration, claims processing, or service that you received from us. For example, you may question why we made a claims decision or denied benefits for a claim submitted. Since most questions about our payment of benefits, claims processing decision, policy administration, or provision of service can usually be resolved by us without you having to file a grievance under this provision, we urge you first to try to resolve any problem, question, or concern that you have by directly contacting our Member Services Department.

Under this provision you have the right to file a written grievance with us in accordance with your grievance rights under Sections 632.853, and 632.855, Wisconsin Statutes, and Section Ins. 18, Wisconsin Administrative Code, as amended, respectively.

Sections 632.853 and 632.855, Wisconsin Statutes, apply to filing a grievance involving our denial of benefits or coverage for a claim, pre-authorization request, or other request for benefits or coverage submitted to us for a prescription legend drug, durable medical equipment or similar medical device, or an experimental treatment. Only you, as the member, or your authorized representative can use this provision to exercise your right to file a grievance, except as follows. Subject to Section 632.853, Wisconsin Statues, as amended, your physician may only use this provision to file a grievance on your behalf with respect to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or similar medical device.

The grievance procedure provided under this provision is intended solely to provide you with only the rights available to you, as the member, in accordance with these Wisconsin statutes and this administrative rule, to that extent these laws apply to you. This provision shall be applied and strictly construed by us in accordance with these laws.

But before filing a grievance under this provision, we urge you first to contact our Member Services Department to see if we can resolve this matter to your satisfaction. The first step toward resolving a problem, question, or concern is to bring this matter to our attention by telephoning our Member Services Department. Please see our telephone number shown on your EPIC Identification Card. Our Member Services representative will take your information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. Our representative will then discuss the matter with the Supervisor of our Member Services Department.

If we agree with your proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action that resolves the matter. If, after receiving our response you are still unhappy with our subsequent claims processing action or administrative action that we believe resolves the matter as you proposed, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure explained below.

If our Grievance/Appeal Committee upholds our original decision which you questioned or with which you disagreed and if you had contacted us by writing a letter, then we'll automatically forward this matter to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below.

The grievance procedure differs depending upon the type of grievance that is filed with us. Paragraph 1 below describes the procedure that we use for handling grievances that are not "expedited grievances" as that term is defined in Section II. of the policy. Paragraph 2. below describes the procedure that we use for handling expedited grievances.

For the purpose of paragraph 1. and 2. below, the terms "you" or "your" and "authorized representative" are defined as follows:

"authorized representative" is a person the member designates to file a grievance on his/her behalf and/or to act for him/her. By designating an authorized representative, this means that for purposes of the grievance the member is also authorizing us to treat that person as if he/she is the member. The member's

designation also authorizes us to send that person, not the member, our written decision responding to the grievance. Our committee's written decision will contain personal information about the member, including his/her confidential medical information, if any, that applies to the matter which is being grieved.

"You" or "your" shall mean you, as a member, your authorized representative or your physician (if your physician submitted the grievance that pertains to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or a similar medical device).

1. Grievance Procedure for Grievances That Are Not Expedited Grievances (For Expedited Grievances, please see paragraph 2. below).

a. To file a grievance, you should write down the concerns, issues, and comments and mail, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Committee at the address shown below. For example, if we denied benefits for your claim because we determined the hospital confinement, surgery services or dental services provided to you was not "medically necessary" as that term is defined in Section II. of the policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the hospital confinement, surgery services, or dental services was medically necessary under the policy. Please mail, fax, or deliver your written grievance to us at the following address:

Grievance/Appeal Committee
The EPIC Life Insurance Company
P. O. Box 8430
Madison, Wisconsin 53708-8430
Fax Number**:** (608) 223-2159

We cannot accept telephone requests for a grievance. Your grievance must be in writing. Please deliver, fax, or mail your grievance to us at the address shown above. You have three years after you received our initial notice of denial or partial denial of your claim to file a grievance.

b. We will acknowledge our receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of our receipt of the grievance.

c. As soon as reasonably possible following our receipt of the grievance, our Grievance/Appeal Committee will review the grievance. Our

Grievance/Appeal Committee will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Committee upholds our original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below. Under no circumstances will the time frame exceed the time stated in paragraphs e. and f. below.

d. You have a right to appear in person before the Grievance/Appeal Committee which meets at our offices in Madison, Wisconsin, to present written or oral information to the committee and to submit written questions to the person(s) responsible for making the determination which resulted in the grievance. In the committee's written decision to the grievance the committee will respond to all of the written questions submitted to the committee prior to or at that meeting. The committee will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence that are followed. Also, cross-examination of the committee's members, its advisors, or EPIC employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the committee. The person's presentation to the committee may be tape-recorded by the committee. If you attend the meeting to present the reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by the internal practices, rules and requirements established by the committee to handle grievances effectively and efficiently in accordance with the applicable laws.

e. Within 30 days after our receipt of the grievance, the Grievance/Appeal Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms. conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the grievance by regular mail using the United States

Postal Service unless that person's grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.

f. While reviewing your grievance the committee may need additional time to make its decision. In that case, before the 30-day period mentioned in paragraph 5. above has expired, the committee will send you a written notice by letter that the committee needs an extension of time to complete its review of the grievance and make its decision, how much additional time we need, and when the committee's decision is expected to be made, and the reason additional time is needed. The committee then has an additional 30 days after the first 30-day period has expired (or within 60 days from the date we first received the grievance) to provide you with its written decision. We are precluded by law from delaying our committee's decision beyond that 60-day period even if you request a delay beyond the end of this 60-day period.

g. We will retain our records of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

2. Grievance Procedure for Grievances That Are Expedited Grievances (For Grievances that are not Expedited Grievances, please see paragraph 1. above).

a. Please see the definition of the term "expedited grievance" in Section II. Only an expedited grievance that meets that definition's requirements will be handled by us under this provision. If the request is not an expedited grievance as that term is defined, please use the grievance procedure set forth in paragraph 1. above.

To file an expedited grievance, you must call the telephone number shown below to give us the concerns, issues, and comments underlying your grievance, or write down the concerns, issues, and comments and mail, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Committee at the address shown below. For example, if we denied benefits for your claim because we determined that a prescription legend drug, a durable medical equipment or medical device, or a treatment provided to you was not "medically necessary" and/or "experimental" as those terms are defined in Section II. of the policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the health

care service was medically necessary and/or not experimental under the policy. Any grievance filed by your physician regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under the policy.

Grievance/Appeal Committee
Expedited Grievance
The EPIC Life Insurance Company
P.O. Box 8430
Madison, Wisconsin 53708-8430
Phone: 1-800-520-5750
Fax Number: (608) 223-2159

b. As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Committee will review the expedited grievance. Our Grievance/Appeal Committee will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Committee upholds our original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained below. Under no circumstances will the time frame exceed the time stated in paragraph c. below.

c. As expeditiously as the participant's health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance/Appeal Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, that has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the expedited grievance by regular mail using the United States Postal Service unless that person's expedited

grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.

d. We will retain our records of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

Premium

Please see attached Actuarial Memorandum.

Actuarial Analysis

Please see attached Actuarial Memorandum.

Financial Information

The WPS (Wisconsin Physicians Service) Accounting Department will be sending financial information directly. WPS is EPIC's parent company.

Performance Standards

2016 Performance Standards

Customer Service		
Standard	**Performance Measure**	**Threshold**
Inquiry from Payroll office	Acknowledge w/in 1 business days	96%
Complete response w/in 6 business days		97%
Inquiry from ETF staff on behalf of another agency	Acknowledge w/in 1 business days	96%
Complete response w/in 6 business days		97%
Direct Member Inquiry	Acknowledge w/in 1 business day	88%
Complete Response w/in 5 business days		85%
Billing to non-active members	Bill is accurate	Not available at this time
Refunds	Correct refund issued within 15 days of receipt of complete documentation	Not available at this time
Member Grievance	Process from Ins Ch. 18, Wis. Adm. Code is followed, including timelines	89%
Telephone response time	Calls dropped while in queue	97%
Telephone access for members	Available 7AM – 6 PM Central Time Mon-Fri	98%

Claim Processing time	Claim correctly paid within 10 days of receipt of all necessary information	89%
Web Portal Availability	Portal available for member use	97%

Enrollment Accuracy and Timeliness		
Standard	**Performance Measure**	**Threshold**
STAR agency	Upload enrollment files successfully, as scheduled	100%
Non STAR agency	Open enrollment - Complete enrollment within 15 business days after close of open enrollment period	95%
New hire or change in eligibility – within 10 business days of receipt of completed paperwork		95%
Census file accuracy	Reconcile to agency payroll records within 5 business days of receipt	Not available at this time- Audit processes still taking place
ID cards to member	Open Enrollment – by Jan 15 of each year	100%
New hire or change in eligibility - Within 10 business days of receipt of completed paperwork		100%
Disenrollment	Processed within 5 business days of receipt	96%

Reports Due		
Timing	**Performance Measure**	**Due Date**
Monthly	Appropriate billing file to agency, continuation members	Completed within 5 days
Quarterly	Accurately and completely report customer service and enrollment statistics	Completed 30 days after quarter end
Annually	Report of member grievances and resolution, along with aggregate data of Quarterly reports	Completed by March 1 of each year for preceding calendar year

Timing	**Performance Measure**	**Due Date**
Monthly	Appropriate billing file to agency, continuation members	Due 10 days after quarter end

Quarterly	Accurately and completely report customer service and enrollment statistics	Due 30 days after quarter end
Annually	Report of member grievances and resolution, along with aggregate data of Quarterly reports	Due by March 1 of each year for preceding calendar year

Contact Information

Representatives responsible for responding to the follow-up questions related to this proposal:

Wendy Hougan[1]
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Madison, WI 53708
(608) 977- 6608
Wendy.Hougan@epiclife.com

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PO Box 8430
Madison, WI 53708
(608) 977- 6660
Daniel.Rodriguez@epiclife.com

Gary Butzlaff
Director, Actuarial Services and Systems
PO Box 8430
Madison, WI 53708
(608) 977- 6560
Gary.Butzlaff@epiclife.com

[1] Wendy is also the representative who will manage contract negotiation and administration.

EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

State of Wisconsin Employees Voluntary Benefits Programs Benefit and Rate Change Actuarial Memorandum

1. Scope and Purpose

   The EPIC Life Insurance Company (EPIC) provides State of Wisconsin employees, COBRA continuants, and annuitants the opportunity to purchase two benefit programs – Benefits+ and Dental Wisconsin – on an employee-pay-all basis. This memo provides the State of Wisconsin Department of Employee Trust Funds and Group Insurance Board supporting rationale for premium rate and benefit changes effective January 1, 2018. The memo may not be appropriate for other purposes.

   EPIC is proposing the following changes to reflect claims experience, account for inflation and/or utilization trends, and address adverse selection resulting from the Group Insurance Board's open enrollment requirements:

   a. Benefits+

      i. Increase total "core" benefits rates, i.e., accidental death and dismemberment (AD&D), dental, and hospital indemnity, 2.7%. Rate changes for each core benefit will vary by subscriber status, i.e., active employee and COBRA continuant versus annuitants, to reflect claims experience.

      ii. Decrease vision rates 5%.

   b. Dental Wisconsin

      i. PPO

         1. Increase the annual maximum from $1,000 to $1,500 for existing or timely enrolled members.

         2. Introduce a phased (or tiered) annual maximum for late entrants via special enrollment as follows:

            a. $750 during first year of coverage
            b. $1,000 during second year of coverage
            c. $1,500 during third and subsequent years of coverage

         3. Remove the waiting period on basic and major restorative coverages.

         4. Remove the waiver of the orthodontic waiting period for timely enrolled members or late entrants via special enrollment.

5. Increase the waiting period on orthodontic coverage from 12 to 24 months for late entrants via special enrollment.

6. Maintain active employees and COBRA continuants' current rates.

7. Increase annuitants' rates 9.5%.

ii. Select

1. Introduce a phased (or tiered) annual maximum for late entrants via special enrollment as follows:

   a. $500 during first year of coverage
   b. $750 during second year of coverage
   c. $1,000 during third and subsequent years of coverage

2. Remove the waiting period on basic and major restorative coverages.

3. Remove the waiver of the orthodontic waiting period for timely enrolled members or late entrants via special enrollment.

4. Increase the waiting period on orthodontic coverage from 12 to 24 months for late entrants via special enrollment.

5. Increase active employees and COBRA continuants' rates 6.5%.

6. Increase annuitants' rates 12%.

2. Benefit Description

Benefits+ is comprised of three mandatory (or core) benefits – AD&D, dental, and hospital indemnity. Benefits+ subscribers can optionally enroll in vision coverage. EPIC proposes no changes to existing core or vision benefits.

Existing AD&D benefits are as follows:

Event	*Active/COBRA*			*Annuitant*		
	Employee	*Spouse*	*Child*	*Employee*	*Spouse*	*Child*
Death	$15,000	$7,500	$3,000	$7,500	$3,750	$1,500
Loss of both feet or hands	$15,000	$7,500	$3,000	$7,500	$3,750	$1,500
Loss of one hand, one foot, or sight in both eyes	$15,000	$7,500	$3,000	$7,500	$3,750	$1,500
Loss of one hand or foot and sight in one eye	$15,000	$7,500	$3,000	$7,500	$3,750	$1,500
Loss of one foot or hand	$7,500	$3,750	$1,500	$3,750	$1,875	$750
Loss of sight in one eye	$7,500	$3,750	$1,500	$3,750	$1,875	$750

Existing dental benefits are as follows:

Category	*Provision*
Diagnostic/Preventive Coinsurance	No Coverage
Basic Restorative Coinsurance	50%
Major Restorative Coinsurance	50%
Annual Deductible per Member	$75
Annual Maximum per Member - Existing member or timely entrant - Late entrant via special enrollment o First year of coverage o Second year of coverage o Third and subsequent years	 $1,500 $750 $1,000 $1,500
Category	*Provision*
Orthodontics Coinsurance	50%
Orthodontics Lifetime Maximum per Member	$1,200
Orthodontics Coverage Applies To	Dependent children until age 19
Orthodontics Waiting Period - Timely entrant - Late entrant via special enrollment	 12 Months 24 Months

Existing hospital indemnity benefits are as follows:

	Members Under Age 65	*Members Age 65+*
Inpatient hospital - Elimination period - Maximum benefit - Daily benefit	 2 days 363 days $200	 5 days 360 days $150
Outpatient surgery benefit per case	$200	$150

Exhibit A provides a complete summary of existing vision benefits.

Dental Wisconsin provides two options – PPO and Select. PPO is a comprehensive plan intended for members who want or need coverage for a broad spectrum of dental care. Select is a supplemental plan intended for members who have diagnostic and preventive coverage through a different plan, such as the state's uniform dental benefit.

EPIC proposes the following changes to the PPO plan:

	In-Network		*Out-of-Network*	
Benefit	*Current*	*Proposed*	*Current*	*Proposed*
Diagnostic/Preventive Coinsurance[1]	100%		75%	
Basic Coinsurance[2]	75%		55%	
Major Restorative Coinsurance[3]	50%		25%	
Annual Maximum per Member - Existing member or timely entrant - Late entrant via special enrollment o First year of coverage o Second year of coverage o Third and subsequent years	 $1,000 $1,000 $1,000 $1,000	 $1,500 $750 $1,000 $1,500	 $1,000 $1,000 $1,000 $1,000	 $1,500 $750 $1,000 $1,500
Annual Deductible per Member	$25		$50	

	In-Network		*Out-of-Network*	
Benefit	*Current*	*Proposed*	*Current*	*Proposed*
Orthodontics Coinsurance	50%		50%	
Orthodontics Lifetime Maximum	$1,000		$1,000	
Orthodontics Coverage Applies To	Dependent children until age 19		Dependent children until age 19	
Provider Network	Delta Dental PPO		Delta Dental Premier and Nonparticipating	
Waiting Periods				
- Basic Restorative	3 Months	None	3 Months	None
- Major Restorative	3 Months	None	3 Months	None
- Orthodontics				
o Timely entrant	12 Months	12 Months[4]	12 Months	12 Months[4]
o Late entrant via special enrollment	12 Months	24 Months[4]	12 Months	24 Months[4]

[1] *Includes coverage for space maintainers as a diagnostic/preventive benefit.*
[2] *Does not provide coverage for surgical extractions.*
[3] *Provides major restorative benefits for all periodontic and endodontic services.*
[4] *Waiver of waiting period due to prior comparable coverage has been removed.*

EPIC proposes the following changes to the Select plan:

Benefit	*Current*	*Proposed*
Diagnostic/Preventive Coinsurance	No coverage	
Basic Coinsurance[1]	75%	
Major Restorative Coinsurance[2]	50%	
Annual Maximum per Member		
- Existing member or timely entrant	$1,000	$1,000
- Late entrant via special enrollment		
o First year of coverage	$1,000	$500
o Second year of coverage	$1,000	$750
o Third and subsequent years	$1,000	$1,000
Annual Deductible per Member	$50	
Orthodontics Coinsurance	50%	
Orthodontics Lifetime Maximum	$1,000	
Orthodontics Coverage Applies To	Dependent children until age 19	
Provider Network	Any dentist	
Waiting Periods		
- Basic Restorative	3 Months	None
- Major Restorative	3 Months	None
- Orthodontics		
o Timely entrant	12 Months	12 Months[3]
o Late entrant via special enrollment	12 Months	24 Months[3]

[1] *Does not provide coverage for surgical extractions.*
[2] *Provides major restorative benefits for all periodontic and endodontic services.*
[3] *Waiver of waiting period due to prior comparable coverage has been removed.*

3. Morbidity

With the exception of Benefits+ AD&D, we used actual 2016 experience. For Benefits+ AD&D, we used actual 2014 to 2016 experience.

4. Persistency

   We assumed a 100% annual persistency rate for Benefits+ subscribers.

   For Dental Wisconsin, our annual persistency rate assumptions vary by subscriber type as shown in the table below:

Subscriber Type	*Active/COBRA*	*Annuitants*
Regular Enrollees or Enrolled Before 2015	92%	110%[1]
2015 Special Enrollees	80%	N/A
2016 Special Enrollees	80%	N/A
2017 Special Enrollees	80%	70%
2018 Special Enrollees	80%	70%

[1] *Reflects subscribers who move into annuitant status upon retirement.*

   Exhibit B provides supporting information for the Dental Wisconsin persistency assumptions.

5. Expenses

   We used a 25% retention assumption across all plans and options.

6. Premium Classes

   We maintain different premium rate structures for active employees and COBRA continuants versus annuitants. Rates also vary as follows by family size:

   - Employee-only
   - Employee plus spouse
   - Employee plus child or children
   - Family

7. Trend Assumptions

   a. Benefits+

      i. AD&D – This benefit is not subject to a typical medical-type trend assumption.

      ii. Dental – We used a 4% trend assumption.

      iii. Hospital indemnity – We used a 1% trend assumption.

      iv. Optional vision – We used a 1% trend assumption.

b. Dental Wisconsin – Exhibit C provides our trend assumptions, which reflect the following three factors:

   i. "Regular trend" – We used a 4% trend assumption.

   ii. Selection wear-off – We assumed that the adverse experience from special enrollees will moderate as time passes.

   iii. Change in annual maximum

      1. PPO – With the exception of 2018 Special Enrollees, we assumed that 2018 claim costs will increase 14% due to the increase to the annual maximum. For 2018 Special Enrollees, we assumed that 2018 claim costs will decrease 11% due to the introduction of the phased (or tiered) annual maximum.

      2. Select – For 2018 Special Enrollees, we assumed that 2018 claim costs will decrease 35% due to the introduction of the phased (or tiered) annual maximum.

Exhibit B provides support for the experience moderation of Dental Wisconsin special enrollees.

8. Minimum Loss Ratio

   DETF's "Guidelines for Offering Optional Insurance Plans" specify a minimum 75% loss ratio.

9. Anticipated Loss Ratio

   We project the following 2018 loss ratios:

   a. Benefits+ – 75.1%
   b. Dental Wisconsin PPO – 75.1%
   c. Dental Wisconsin Select – 75.3%
   d. All Plans Total – 75.2%

   Exhibit D provides supporting information. With the exception of Benefits+ Vision, actual 2016 experience includes claims paid through February 2017. Benefits+ Vision experience includes claims paid through January 2017.

   Exhibit E summarizes the Benefits+ AD&D experience used to calculate the Adjusted Claims Per Employee Per Month (PEPM) for estimating 2018's incurred claims.

10. Experience

Following is EPIC's 2016 Benefits+ underwriting experience including core claims paid through February 2017 and vision claims paid through January 2017:

Benefit	Average Subscriber Enrollment	Premium	Incurred Claims	Loss Ratio
AD&D	17,301	$69,875	$16,500	23.6%
Dental	17,301	$6,158,861	$5,189,967	84.3%
Hospital Indemnity	17,301	$1,432,936	$785,947	54.8%
Total Core		$7,661,671	$5,992,414	78.2%
Optional Vision	4,051	$341,703	$197,298	57.7%

Following is EPIC's 2016 Dental Wisconsin underwriting experience including claims paid through February 2017:

Plan	Subscriber Type	Average Subscriber Enrollment	Premium	Incurred Claims	Loss Ratio
PPO	Active/COBRA	3,025	$1,638,082	$985,201	60.1%
	Annuitant	312	$195,846	$152,844	78.0%
	Total	3,338	$1,833,928	$1,138,045	62.1%
Select	Active/COBRA	4,942	$2,267,572	$1,773,714	78.2%
	Annuitant	518	$219,580	$189,852	86.5%
	Total	5,460	$2,487,152	$1,963,566	78.9%
Total	Active/COBRA	7,967	$3,905,654	$2,758,915	70.6%
	Annuitant	831	$415,426	$342,696	82.5%
	Total	8,798	$4,321,080	$3,101,611	71.8%

Exhibit F provides additional experience data for Benefits+ and the two Dental Wisconsin plans.

11. History of Rate Adjustments

Exhibit G provides our Benefits+ and Dental Wisconsin rate history since January 1, 2004. Our rate changes effective January 1, 2017 attempted to balance the Benefits+ core loss ratios.

12. Proposed Effective Date

We propose implementing the revised premium rates and benefits effective January 1, 2018.

13. Actuarial Certification

I certify the following to the best of my knowledge and judgment:

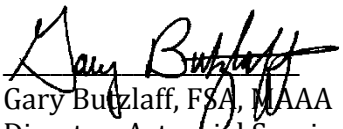
a. I am a member of the American Academy of Actuaries and meet its qualification standards for rendering this actuarial opinion.

b. The entire rate filing is in compliance with the applicable laws of the State and with the rules of the Department of Employee Trust Funds and Group Insurance Board.

c. The rate filing complies with applicable Actuarial Standards of Practice including No. 8, "Regulatory Filings for Rates and Financial Projects for Health Plans," as adopted March 2014 by the Actuarial Standards Board.

d. The plan's benefits are reasonable in relation to the proposed premiums.

e. The plan's premiums are not excessive, inadequate, or unfairly discriminatory.



March 31, 2017
Date

Gary Butzlaff, FSA, MAAA
Director, Actuarial Services and Systems
EPIC Life Insurance Company

Attachments

EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

July 28, 2017

Shayna Schomber
Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Dear Ms. Schomber,

On March 31, we proposed changes to the Benefits+ and Dental Wisconsin plans for the 2018 plan year. We have updated our proposed rates, copy attached, to account for several revised financial parameters and your desire to streamline state agencies' administration of the plans by using the same annual maximums for both Dental Wisconsin plans.

Benefits+

We propose a 0.8% overall reduction to rates for the core benefits package consisting of accidental death and dismemberment, hospital indemnity, and supplemental dental. The actual amount varies slightly for active employees and continuants (0.8%) versus annuitants (0.6%). We also propose optional vision rate reductions of 10% for active employees and continuants and 25% for annuitants. These rate changes reflect the following updates to our March 31 proposal:

1) Updated claims experience
2) A lower dental trend assumption
3) A higher target loss ratio
4) Using some Benefits+ core revenue to fund a higher Dental Wisconsin Select annual plan maximum

Dental Wisconsin

As with Benefits+ we have reduced our dental trend assumption and increased our target loss ratio. We reviewed but did not use updated claims experience because it has not changed materially. We also propose updated risk management provisions to improve consistency with Benefits+ and to more effectively manage adverse selection that results from offering enrollment opportunities after employees' initial eligibility. Our updated benefit and rate proposals are as follows:

<u>PPO</u>
We propose 1) increasing the annual maximum from $1,000 to $1,250, 2) reducing active employee and continuants' rates 9%, and 3) holding annuitants' rates at their 2017 levels.

Select

We propose 1) increasing the annual maximum from $1,000 to $1,250, 2) increasing active employee and continuants' rates 2.5%, and 3) increasing annuitants' rates 7.5%. These rate increases fund about half of the cost increase for the higher annual maximum. Benefits+ core funds the other half.

PPO and Select Risk Management Provisions

We propose 1) adopting a tiered or graded annual maximum for late enrollees, 2) removing basic and major restorative waiting periods, and 3) adopting a 12-month orthodontic waiting period for regular enrollees and a 24-month orthodontic waiting period for late enrollees. These changes mean that we are also retiring proof of comparable coverage as justification for reducing members' waiting periods. Late enrollees whose coverage begins on or after January 2018 will have the following tiered annual maximums:

Coverage Period	*PPO*	*Select*
First Year	$600	$600
Second Year	$800	$800
Third & Subsequent Years	$1,250	$1,250

To further manage selection concerns for both Benefits+ and Dental Wisconsin, we are not planning to allow special enrollee annuitants to re-enroll through the annual "It's Your Choice" process if they voluntarily terminate coverage mid-year. We advise people of this consequence during our normal termination process. We will however allow retiring members who are confused during this transition and initially enroll as a continuant to re-enroll as an annuitant.

As I mentioned above, we have increased the target loss ratio for both plans relative to our March 31 filing. This change should allow us to more consistently achieve the Group Insurance Board's minimum loss ratio.

Lastly, since our proposal involves both benefit and premium rate changes, we will offer an enrollment opportunity for all EPIC plans during this fall's "It's Your Choice" period. We hope you find this proposal acceptable and responsive to your needs and look forward to working with you as your employee pay-all optional benefits strategy comes into focus for 2019 and beyond.

Sincerely,

Colleen Walsh
Senior Director, Sales and Account Management

Attachment
By e-mail

2018 Proposed Rates for State of Wisconsin Employees Voluntary Insurance Program

Benefits+

Core Benefits

		Active Employees & COBRA Continuants				*- - - - - - - - Annuitants - - - - - - - -*			
		Employee	*Employee plus*			*Employee*	*Employee plus*		
From	*Through*	*Only*	*Spouse*	*Child(ren)*	*Family*	*Only*	*Spouse*	*Child(ren)*	*Family*
1/2018	12/2018	$21.38	$42.76	$42.76	$64.14	$28.74	$57.36	$66.58	$79.16

Optional Vision

		Active Employees & COBRA Continuants				*- - - - - - - - Annuitants - - - - - - - -*			
		Employee	*Employee plus*			*Employee*	*Employee plus*		
From	*Through*	*Only*	*Spouse*	*Child(ren)*	*Family*	*Only*	*Spouse*	*Child(ren)*	*Family*
1/2018	12/2018	$3.64	$6.40	$6.40	$9.44	$3.26	$5.86	$5.56	$8.48

Dental Wisconsin

PPO

		Active Employees & COBRA Continuants				*- - - - - - - - Annuitants - - - - - - - -*			
		Employee	*Employee plus*			*Employee*	*Employee plus*		
From	*Through*	*Only*	*Spouse*	*Child(ren)*	*Family*	*Only*	*Spouse*	*Child(ren)*	*Family*
1/2018	12/2018	$22.38	$47.40	$52.98	$80.10	$35.62	$75.42	$84.34	$127.48

Select

		Active Employees & COBRA Continuants				*- - - - - - - - Annuitants - - - - - - - -*			
		Employee	*Employee plus*			*Employee*	*Employee plus*		
From	*Through*	*Only*	*Spouse*	*Child(ren)*	*Family*	*Only*	*Spouse*	*Child(ren)*	*Family*
1/2018	12/2018	$21.04	$43.24	$49.90	$73.36	$27.56	$56.68	$65.40	$96.20

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June 20, 2017

Ms. Eileen K. Mallow
Deputy Director
Office of Strategic Health Policy
Wisconsin Department of Employee Trust Funds
Madison, WI 53707

RE: EPIC Life Insurance Company 2018 Renewal Proposal Review

Dear Eileen:

Thank you for contacting Milliman to assist the Wisconsin Department of Employee Trust Funds (the Department) with a review of EPIC Life Insurance Company's (EPIC's) 2018 renewal proposal. The purpose of this letter is to provide you with a review of EPIC's renewal proposal.

Background

EPIC currently provides Preferred Provider Option (PPO) Dental, Indemnity Select Dental, and Benefits+ plans. The Benefits+ plan includes accidental death and dismemberment (AD&D), hospital surgical, dental, and optional vision coverage. As part of the 2018 renewal proposal, EPIC has provided premium rates for these plans supported by an actuarial experience exhibit. The Department has engaged Milliman to review EPIC's proposed rate action.

On June 15, 2017, you provided us with EPIC's 2018 renewal proposal and supporting documentation, including an experience exhibit. We are now providing you with our review of EPIC's 2018 renewal proposal.

Results

Summary Findings

We have performed a review of EPIC's renewal proposal for the Preferred Provider Option (PPO) Dental, Indemnity Select Dental, and Benefits+ plans. We have reviewed EPIC's methodology and assumptions for the Dental Wisconsin Dental plans and the Benefits+ plans and view them as reasonable.

Detailed Findings

Dental Wisconsin Dental Plan

We have reviewed EPIC's 2018 renewal proposal for the Dental Wisconsin dental plan. For 2018 EPIC is proposing the following rate changes.

Dental Wisconsin Dental Plan
EPIC's Proposed Rate Changes for 2018

Benefit	Active/ COBRA	Annuitant
PPO	-9.0%	0.0%
Select	2.5%	7.5%

In addition, EPIC is proposing several benefit changes for both the PPO and Select plans.

1. PPO Plan
    a. Increase the annual maximum from $1,000 to $1,250 for existing or timely enrolled members.
    b. Introduce a phased (or tiered) annual maximum for late entrants via special enrollment as follows (Note that the current annual maximum is $1,000):
        i. $625 during first year of coverage
        ii. $825 during second year of coverage
        iii. $1,250 during third and subsequent years of coverage
    c. Remove the 3 month waiting period on basic and major restorative coverages.
    d. Remove the waiver of the orthodontic waiting period for timely enrolled members or late entrants via special enrollment.
    e. Increase the waiting period on orthodontic coverage from 12 to 24 months for late entrants via special enrollment.

2. Select Plan
    a. Introduce a phased (or tiered) annual maximum for late entrants via special enrollment as follows (Note that the current annual maximum is $1,000):
        i. $500 during first year of coverage
        ii. $675 during second year of coverage
        iii. $1,000 during third and subsequent years of coverage
    b. Remove the 3 month waiting period on basic and major restorative coverages.
    c. Remove the waiver of the orthodontic waiting period for timely enrolled members or late entrants via special enrollment.
    d. Increase the waiting period on orthodontic coverage from 12 to 24 months for late entrants via special enrollment.

EPIC projects these rate changes to result in the following projected loss ratios for 2018.

Dental Wisconsin Dental Plan
Projected 2018 Loss Ratios

Option	Active/ COBRA	Annuitant	Total
PPO	76.4%	76.5%	76.4%
Select	76.7%	76.8%	76.7%
Total	76.6%	76.6%	76.6%

We have reviewed EPIC's projections and assumptions for reasonableness. We have performed the following analysis.

1. Review of claims trend assumptions – EPIC assumed a 3% annual dental trend rate. Based on Milliman's Health Cost Guidelines™ - Dental, we expect current dental trends to be between 1.0% and 5.0%. The 3% trend is in middle of the range we expect to see. As a reasonability check, we have reviewed EPIC's 2015 and 2016 experience for active enrollees that was provided in Exhibit B of the proposal. The claim costs per employee per month (PEPM) and the 2016 over 2015 changes are shown below. Overall, the claim costs PEPM have decreased from 2015 to 2016.

Dental Wisconsin Dental Plan
2015 Claim Cost PEPM

	Regular Enrollees or Enrolled Before 2015	2015 Special Enrollees	2016 Special Enrollees	Total
PPO	$30.25	$36.73	N/A	$31.19
Select	$25.89	$44.30	N/A	$27.60
Total	$27.51	$40.56	N/A	$28.97

Dental Wisconsin Dental Plan
2016 Claim Cost PEPM

	Regular Enrollees or Enrolled Before 2016	2015 Special Enrollees	2016 Special Enrollees	Total
PPO	$25.87	$28.99	$31.13	$27.14
Select	$26.61	$36.71	$39.37	$29.84
Total	$26.33	$32.86	$36.47	$28.82

Dental Wisconsin Dental Plan
2016/2015 Trend

Product	Regular Enrollees or Enrolled Before 2015	2015 Special Enrollees	2016 Special Enrollees	Total
PPO	-14.5%	-21.1%	N/A	-13.0%
Select	2.8%	-17.1%	N/A	8.1%
Total	-4.3%	-19.0%	N/A	-0.5%

2. Benefit Changes – We have reviewed the proposed benefit changes and the impact on the projections based on information from Milliman's Health Cost Guidelines™. The proposed claim adjustments appear reasonable.

3. Subsidizations – Based on conversations with the Department, we believe that the Department would prefer loss ratios be similar across the covered populations. The proposed rate changes for 2018 are expected to produce relatively consistent loss ratios across the covered populations and result in a composite loss ratio above 75%.

For both the 2015 and 2016 experience periods, EPIC's loss ratio was less than the 75% loss ratio requirement for the state. While the proposed assumptions for plan designs

and benefit changes project a loss ratio that will meet the 75%, the actual loss ratio will depend on the extent to which future experience conforms to the assumptions made for this analysis. Based on our overall review of the renewal proposal for the Dental Wisconsin Dental plan we believe the methodology and assumptions are reasonable.

EPIC Benefits+ Plan

We have reviewed EPIC's 2018 renewal proposal for the Benefits+ plan. For 2018 EPIC is proposing the following rate changes.

EPIC Benefits+ Plan
EPIC's Proposed Rate Changes for 2018

Option	Active/ COBRA	Annuitant	Total
AD&D	-20.0%	0.0%	
Dental	-1.5%	-1.5%	
Hosp Ind	-3.0%	-1.5%	
Total Core	**-1.8%**	**-1.5%**	**-1.7%**
Vision	**-10.0%**	**-25.0%**	
Total	**-2.3%**	**-1.7%**	**-2.1%**

EPIC projects these rate changes to result in the following projected loss ratios for 2018.

EPIC Benefits+ Plan
Projected 2018 Loss Ratios

Option	Active/ COBRA	Annuitant	Total
AD&D	40.5%	67.8%	51.9%
Dental	77.1%	76.8%	77.0%
Hosp Ind	77.0%	78.3%	77.5%
Total Core	**76.8%**	**76.9%**	**76.8%**
Vision	**69.6%**	**60.4%**	**69.2%**
Total	**76.4%**	**76.8%**	**76.5%**

We have reviewed EPIC's projections and assumptions for reasonableness. We have performed the following analysis.

1. Review of claims trend assumptions.
    a. AD&D – EPIC assumed a 0% trend for the AD&D benefits. This is consistent with our expectations as this benefit is not subject to medical trends.
    b. Dental – EPIC assumed a 3.0% annual dental trend rate. Based on Milliman's Health Cost Guidelines™ this assumption is reasonable. We expect current dental trends to be between 1.0% and 5.0%. We have also reviewed the claims experience for 2015 and 2016 for the Benefits+ dental product using information from the prior 2017 proposals. Based on this information, the current dental trend was between 3.0% and 5.0%.
    c. Hospital Indemnity – EPIC assumed a 1.0% annual trend rate. As this benefit pays a fixed indemnity amount, we would not typically assume any trend for this benefit. It is possible that there may be increased utilization over time for these benefits as well as aging of the covered population. As such, we do not view the 1.0% as an unreasonable assumption that would need to change.
    d. Optional Vision – EPIC assumed a 1.0% annual trend rate. Based on our experience, vision trends are usually low and we view this as a reasonable assumption.

2. Review of AD&D Benefit – The loss ratios for the AD&D benefit vary significantly between Active/COBRA members and Annuitants. Given that the frequency of AD&D claims is very small, we do not view the experience as credible and would expect significant volatility in those loss ratios from year to year. Using the membership count, earned premium, and benefit schedule, we have estimated an annual claim cost per $1,000 for the AD&D benefit and compared it to industry data published by the Society of Actuaries. We believe the proposed premiums for the AD&D benefit are reasonable.

3. Subsidizations – Based on conversations with the Department, we believe that the Department would prefer loss ratios be similar across the covered populations. The proposed rate changes for 2018 are expected to produce relatively consistent loss ratios across the covered populations and result in a composite loss ratio above 75%, however, the Vision product by itself is expected to produce a loss ratio below the 75% requirement.

Based on our overall review of the renewal proposal for the Benefits+ plan, we believe the methodology and assumptions are reasonable.

In addition, per your request, we have also compared the cost sharing of the different dental plans by looking at the percent of costs expected to be covered by the dental plans. The table below summarizes the percentage of total costs covered. The 100% plan reflects a dental plan with no cost sharing for comparison. This is not a plan that is offered by EPIC.

EPIC Dental Plans

Dental Plan	Percent of Costs Covered
100%	100%
PPO	56%
Select	31%
Benefits +	27%

Data Sources

We relied on information provided by both the Department and EPIC when preparing this report. In addition to our phone conversations and email correspondence over the past few weeks we relied on the following file in preparing this communication:

- EPIC Cover Letter and Actuarial Memo 2016-03-11.pdf
- EPIC Cover Letter and Actuarial Memo 2016-06-10.pdf
- EPIC Proposal 2017-03-31.pdf
- EPIC Cover Letter and Actuarial Memo 2017-06-09.pdf

In order to compare the costs of the various dental plans, we utilized Milliman's 2017 Health Cost Guidelines™ Dental Rating Model.

Use of Work Product

Milliman has prepared this letter for the specific purpose of providing you with a review of EPIC Life Insurance Company's 2018 renewal proposal. This letter should not be used for any other purpose. Milliman's work is prepared solely for the use and benefit of the Wisconsin Department of Employee Trust Funds (the Department) in accordance with its statutory and regulatory requirements. Milliman recognizes that materials it delivers to the Department may be public records subject to disclosure to third parties, however, Milliman does not intend to benefit and assumes no duty or liability to any third parties who receive Milliman's work and may include disclaimer language on its work product so stating. The Department agrees not to remove any such disclaimer language from Milliman's work. To the extent that Milliman's work is not subject to disclosure under applicable public records laws, the Department agrees that it shall not disclose Milliman's work product to third parties without Milliman's prior written consent; provided, however, that the Department may distribute Milliman's work to (i) its professional service providers who are subject to a duty of confidentiality and who agree to not use Milliman's work product for any purpose other than to provide services to the Department, or (ii) any applicable regulatory or governmental agency, as required.

In order to provide the information requested by the Department, we have constructed several projection models. Differences between our amounts and actual amounts depend

on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that the actual benefits and experience deviates from expected benefits and experience.

In performing this analysis, we relied on data and other information provided by the Wisconsin Department of Employee Trust Funds and EPIC Life Insurance Company. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

I, Michael Weilant, am a Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Next Steps

Eileen, please review the attached information and let me know if it is consistent with your expectations. If you have any questions, please do not hesitate to call me at (813) 282-9262.

Sincerely,

Michael Weilant, FSA, MAAA
Principal & Consulting Actuary

Attachment D

UNITED *of* OMAHA LIFE INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
402 342 7600
mutualofomaha.com

June 14, 2017

Ms. Shayna Schomber
Manager of Employee Pay-All Optional Insurance Plans
Office of Strategic Health Policy
Department of Employee Trust Funds
Shayna.schomber@wisconsin.gov
608 261-8956

RE: Mutual of Omaha Wisconsin Group Insurance 2018 Contract

Dear Ms. Schomber,

As noted in your email to Bob Pearson on May 30th, the Mutual of Omaha contract ends with the ETF on 12/31/17. In order to expedite the annual review process with your contract/procurement staff, this letter acknowledges that we intend to continue our agreement under the same terms as outlined in the 2017 agreement.

If you have any further questions, please feel free to contact me.

Sincerely,

Adam Walling, FSA, MAAA
LTC Product Performance Director

CC:
Bob Pearson