100 GENERAL

105 Introduction

This State of Wisconsin Health Benefit Program Agreement ("AGREEMENT") is for the purposes of administering the HEALTH BENEFIT PROGRAM. The HEALTH BENEFIT PROGRAM is the umbrella term used to describe the program in whole, including the State of Wisconsin Group Benefits Program and the Wisconsin Public Employers Group Benefits Program, herein referred to as "state" and "LOCAL", respectively. The HEALTH BENEFIT PROGRAM is administered for the Group Insurance Board (BOARD) by the State of Wisconsin Department of Employee Trust Funds (DEPARTMENT).

By statute, the BOARD has the authority to negotiate the scope and content of the HEALTH BENEFIT PROGRAM for EMPLOYEES and ANNUITANTS of the State of Wisconsin, as well as for local units of government who choose to participate. The DEPARTMENT regularly provides the most current rosters for state agencies and authorities as well as the local employer roster (forms ET-1404 and ET-1407, respectively).

Eligible PARTICIPANTS have the opportunity to choose a benefit plan design. A minimum of two (2) competing benefit plans is required per Wis. Stat. § 40.51 (6).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) Assist the BOARD in achieving strategy goals of:

    a) Managing total costs.

    b) Supporting PARTICIPANTS by providing them with tools and resources needed to manage their health and health purchasing decisions.

    c) Promoting behavior change and accountability.

d) Retain managed care elements that provide value.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) To continuously evaluate and incorporate innovative approaches to health care delivery.

115 General Requirements

The CONTRACTOR must meet the minimum requirements of Wis. Stat. § 40.03 (6) (a) and this AGREEMENT. The CONTRACTOR must:

1) Share data, claims information and other operational information as necessary for the smooth functioning of the program, for example to the BOARD'S Pharmacy Benefit Manager (PBM), consulting actuary, DEPARTMENT'S data warehouse and the wellness and disease management vendor, using the most recent file and data specifications provided by the DEPARTMENT.

2) Administer deductibles and out-of-pocket maximums that depend upon information sharing from one CONTRACTOR, or vendor specified by the DEPARTMENT, to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) Apply effective methods for containing costs for medical services, HOSPITAL CONFINEMENTS or other BENEFITS to be provided with effective peer and utilization review mechanisms for monitoring health care costs and the administration of Coordination of Benefit (COB) provisions.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with applicable federal or state law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the enrollee expresses, in writing, dissatisfaction with the administration or claims practices or provision of services by the CONTRACTOR. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefit contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.

   b) When necessary, the BOARD intends to take a proactive approach in resolving complaints. The CONTRACTOR must cooperate fully with the efforts of the DEPARTMENT in resolving complaints. Adverse decisions are subject to review by the BOARD for contractual compliance if the PARTICIPANT is not satisfied with the CONTRACTOR'S action on the matter.

   c) The CONTRACTOR must retain records of grievances and submit an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. The annual summary report will contain data and be in a format established by the DEPARTMENT.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) Each CONTRACTOR shall notify the BOARD in writing of any "Significant Event" within ten (10) calendar DAYS after the CONTRACTOR becomes aware of it. (In the event of insolvency, the BOARD must be notified immediately.) As used in this provision, a "significant event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the CONTRACTOR'S ability to meet its obligations under this AGREEMENT, including, but not limited to, any of the following: disposal of major assets; loss of fifteen percent (15%) or more of the CONTRACTOR'S membership; termination or modification of any contract or subcontract if such termination or modification will have a material effect on the CONTRACTOR'S obligations under this AGREEMENT; the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring; the withdrawal of, or notice of intent to withdraw, dissolution of existing relationship, state licensing or certification, United States Department of Health and Human Services (HHS) qualification or any other status under state or federal law; default on a loan or other financial obligations; strikes, slow-downs or substantial impairment of the CONTRACTOR'S facilities or of other facilities used by the CONTRACTOR in the performance of this AGREEMENT.

b) In addition, any change in the ownership of or controlling interest in the CONTRACTOR, any merger with another entity or the CONTRACTOR'S acquisition of another organization that participates in the HEALTH BENEFIT PROGRAM is a "significant event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (fifty-one percent (51%)) interest in the CONTRACTOR or any transfer of ten percent (10%) or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the HEALTH BENEFIT PROGRAM and its PARTICIPANTS. The BOARD agrees to keep the information disclosed as required under paragraph (b) above, confidential under Wis. Stat. § 19.36 (5) of the Wisconsin Public Records Law until the earliest of one of the dates noted below unless the CONTRACTOR waives confidentiality or a court orders the DEPARTMENT or BOARD to disclose the information or the DEPARTMENT or BOARD determines that under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records.

   The BOARD also agrees to notify the CONTRACTOR of a request to disclose the information as a public record prior to making such disclosure, so as to permit the CONTRACTOR to defend the confidentiality of the information. Information disclosed by a CONTRACTOR concerning any change in ownership or controlling interest, any merger or any acquisition of another entity will be disclosed by the BOARD as a public record beginning on the earliest of the following dates:

i) The date the pending change in ownership or controlling interest, any merger or any acquisition of another entity becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.

ii) The date such action becomes effective.

iii) Sixty (60) DAYS after the BOARD receives the information.

d) The BOARD shall reserve the right to institute action as it deems necessary to protect the interests of the PARTICIPANTS of the HEALTH BENEFIT PROGRAM as the result of a "significant event."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for both state and LOCAL PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) Have legal and technical staff available to the DEPARTMENT for consultation as needed for program administration, and for assistance with any appeals processes. The CONTRACTOR shall monitor the development of and provide notification and information to the DEPARTMENT in a timely manner concerning state or federal regulations or legislation that may affect the HEALTH BENEFITS PROGRAM.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) Comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

120 Board Authority

1) Wis. Stat. § 40.03 (6) (a), provides authority for the BOARD to enter into contracts with insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans, or, provide any group insurance plan on a self-insured basis in which case the BOARD shall approve a written description setting forth the terms and conditions of the plan, and may contract directly with providers of HOSPITAL, medical or ancillary services to provide eligible and enrolled EMPLOYEES with the BENEFITS.

2) The BOARD shall establish enrollment periods, known as the IT'S YOUR CHOICE OPEN ENROLLMENT period, which shall permit eligible EMPLOYEES, ANNUITANTS, and CONTINUANTS to enroll or transfer coverage to any benefit plan offered by the BOARD as required by Wis. Stat. § 40.51. Unless otherwise provided by the BOARD, the IT'S YOUR CHOICE OPEN ENROLLMENT period shall be held once annually in the fall of each year with coverage effective the following January 1.

3) The BOARD reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

4) In cases where data submitted by the CONTRACTOR is deemed to be inadequate by the BOARD, DEPARTMENT, or the BOARD'S consulting actuary, the BOARD may take any action up to and including limiting new enrollment into the benefit plan administered by the CONTRACTOR.

5) In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a significant event or significant loss of primary providers and/or HOSPITALS, or no longer meets the MINIMUM PROVIDER ACCESS STANDARDS in this AGREEMENT, or if the BOARD so directs due to a significant event as described in Section 115, the BOARD may do any of the following, including any combination of the following:

   a) Terminate the CONTRACT upon any notice it deems appropriate, including no notice.

   b) Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR change to another benefit plan.

   c) Authorize a special enrollment period so that a SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR may voluntarily change to another benefit plan.

   d) Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.

   e) Require that prior to making a selection between benefit plans, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.

   f) Take no action.

6) The BOARD may forfeit a SUBSCRIBER'S rights to the HEALTH BENEFIT PROGRAM if a PARTICIPANT fraudulently or inappropriately assigns or transfers rights to an ineligible individual(s), or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. 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.

7) The BOARD may initiate disenrollment efforts 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. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. The BOARD may limit re-enrollment options in the HEALTH BENEFITS PROGRAM.

8) The BOARD shall determine all policy for the HEALTH BENEFIT PROGRAM. In the event that the CONTRACTOR requests, in writing, that the BOARD issue program policy determinations or operating guidelines required for proper performance of the AGREEMENT, the DEPARTMENT shall acknowledge receipt of the request in writing and respond to the request within a mutually agreed upon time frame.

9) The BOARD must be notified of any major system changes to the CONTRACTOR'S administrative and/or operative systems.

125 Eligibility

125A General

For HEALTH BENEFIT PROGRAM purposes, eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS), as described in Wis. Stat. § 40.02 (25) (a).

2) Elected state officials (Wis. Stat. § 40.02 (25) (a) 2).

3) Members or EMPLOYEES of the legislature (Wis. Stat. § 40.02 (25) (a) 2).

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance, as described in Wis. Stat. § 40.02 (40).

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave as described in Wis. Stat. § 40.02 (40).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority (Wis. Stat. § 40.02 (25) (b)):

   a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

   b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight percent (28%) or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one percent (21%) or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) LOCAL EMPLOYEES as described in Wis. Stat. § 40.02 (46) or 40.19 (4) (a).

9) ANNUITANTS and CONTINUANTS (Wis. Stat. § 40.02 (25) (b)), which includes the following:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse of a SUBSCRIBER.

c) The surviving insured domestic partner of a SUBSCRIBER.

d) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty

(20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

e) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll in the HEALTH BENEFIT PROGRAM at a later date. Enrollment is restricted to the IT'S YOUR CHOICE OPEN ENROLLMENT period in the fall for coverage effective the following January 1, unless there is a HIPAA qualifying event.

f) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

g) Any retired LOCAL EMPLOYEE under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not those only receiving a duty disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

h) Any LOCAL ANNUITANT receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a).

i) PARTICIPANTS who meet federal or state continuation provisions. See Section 260.

10) Disabled persons entitled to benefits under Wis. Adm. Code § ETF 50.40 or Wis. Stat. § 40.65 include:

a) Insured EMPLOYEES or former EMPLOYEES who choose to continue coverage when the EMPLOYEE'S Long-Term Disability Insurance (LTDI) benefit under Wis. Adm. Code § ETF 50.40 or a duty disability benefit under Wis. Stat. § 40.65 is approved.

b) Previously insured EMPLOYEES or former EMPLOYEES whose coverage lapsed and who are eligible and apply for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65.

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the

date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the HEALTH BENEFIT PROGRAM (including state and LOCAL). In the event it is determined that a DEPENDENT is covered by two (2) separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have thirty (30) DAYS to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The EFFECTIVE DATE will be the first of the month following receipt of the application.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

125G Notice of Qualifying Event

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS, such as divorce. The CONTRACTOR must

provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT.

130 Premiums

For EMPLOYEES and most ANNUITANTS, SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary. Each CONTRACTOR'S claims experience will be reviewed to determine in which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the CONTRACTOR'S efficiency as determined by the BOARD's consulting 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.

For changes in coverage effective after the 1st of the month, the difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

LOCAL EMPLOYERS that base their contribution on a percentage of the lowest / average cost qualified plan must pay at least 50% but not more than 105% of the lowest costs / 88% of the average cost qualified plan in the LOCAL EMPLOYER'S service area (except for eligible employees who work less than half-time. The county of the LOCAL EMPLOYER is considered the service area. At the request of a LOCAL EMPLOYER, the DEPARTMENT will review the service area used to determine the lowest /average cost qualified plan used for determining the LOCAL EMPLOYER'S maximum PREMIUM contribution.

130A Medicare Participant Premiums

A reduction in PREMIUM shall be effective on the first DAY of the calendar month, which begins on or after the date the PARTICIPANT is eligible for the Medicare HOSPITAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

If a Medicare coordinated family PREMIUM category has been established for a family, and one or more family members enrolled in both parts of Medicare dies, the family PREMIUM category in effect shall not change solely as a result of the death.

Except in cases of fraud which shall be subject to Section 155F, coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with UNIFORM BENEFITS. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six (6) months. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with UNIFORM BENEFITS. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

130B Rate-Setting Process

The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. (See attachment.) The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. 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 rate or take other action up to and including limiting new enrollment with the CONTRACTOR when the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.

The CONTRACTOR must submit statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically the STATE and LOCAL EMPLOYEES and DEPENDENTS covered thereunder if experience rated. See Appendix 6. If the premium is community-rated then the CONTRACTOR should give some indication of the percentage the STATE and LOCAL EMPLOYEE groups represent of the total covered community. The BOARD will require each CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant along with supporting documentation deemed necessary by the BOARD's consulting actuary.

The CONTRACTOR will be subject to the provisions of Wis. Stat. Chapter 40, and the administrative rules of the DEPARTMENT. **The BOARD reserves the right to reject any CONTRACTOR'S bid when the BOARD believes it is not in the best interests of the HEALTH BENEFIT PROGRAM.** The BOARD reserves the right to reopen the bid process after final bids are submitted when the BOARD determines that it is in the best interests of the HEALTH BENEFIT PROGRAM.

Rates shall be uniform statewide, except that CONTRACTORS may submit different rates which result from separate plans with mutually exclusive provider networks. CONTRACTORS may separate higher cost providers within geographic areas under the tiered structure into separate

plans if lower rates are achieved while provider access is maintained. 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. CONTRACTORS shall provide rates for each of the program options for the LOCAL group.

The DEPARTMENT reserves the right to audit, at the expense of the CONTRACTOR, the financial and utilization data and other data the organization 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.

Rate adjustments, if any, required for a benefit mandated by applicable state or federal law will occur on January 1 after the next benefit period begins unless otherwise mutually agreed to in writing.

The BOARD limits CONTRACTORS to the following PREMIUM categories, and each CONTRACTOR must provide coverage for each PREMIUM category:

1) Individual (EMPLOYEE Only)

2) Family (EMPLOYEE Plus Eligible DEPENDENTS)

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

3) HDHP Option for eligible non-Medicare individual and family health insurance rates.

4) Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in the utilization data submission without written justification. It may not exceed 50% of the single rate for regular coverage, unless the BOARD's consulting actuary determines that percentage to be lower. Medicare family 2 eligible rate shall be 2 times the individual Medicare coordinated rate; Medicare family 1 rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

   a) Individual

   b) Family 2 (all insureds under Medicare)

   c) Family 1 (at least 1 under Medicare, at least 1 other not under Medicare)

5) Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate. It may not exceed the calculated rate in the utilization data submission without written justification.

   a) Individual

   b) Family

6) Deductible, Coinsurance and HDHP Options for LOCAL Program: The ratio is to be determined annually by the BOARD's consulting actuary based on the relative value of these plans to the Traditional plan, (program option 2/12).

   a) Individual

   b) Family

LOCAL Program: Rates must be no greater than 1.5 times the rate for the state program unless the LOCAL group is sufficiently large that the rate is justified by experience, as determined by the BOARD's consulting actuary.

The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within range percentage to conform to these requirements. The CONTRACTOR will then have the option of accepting the adjusted rates or withdrawing from the HEALTH BENEFIT PROGRAM.

The BOARD will assess administration fees to cover expenses of the DEPARTMENT. This charge is added by the BOARD to the rates quoted by each CONTRACTOR and is collected prior to transmittal of the premiums to the CONTRACTOR.

135 Financial Administration

By the end of each month, the DEPARTMENT will transmit payment to the CONTRACTOR for that month's premium based on the number of enrolled SUBSCRIBERS per the DEPARTMENT'S records. The DEPARTMENT will deduct the pharmacy premium, dental premium if applicable, and other fees required by the BOARD.

135A Prohibited Fees

The CONTRACTOR is prohibited from including in their premium bid:

1) The cost to handle any claims paid outside of UNIFORM BENEFITS.

2) The cost to administer any optional health and wellness benefit(s) beyond UNIFORM BENEFITS.

3) Any fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135B Included Services

The CONTRACTOR may not charge an additional fee for the following services:

1) Expert services. At the request of the DEPARTMENT, the CONTRACTOR shall make available qualified medical consultants to assist the DEPARTMENT in its reviews of questionable claims, claims recommended for denial for medical reasons, reconsiderations and appealed claim determinations.

2) Mailing & Postage. The CONTRACTOR will pay for all mailing, postage and handling costs for the distribution of materials as required by Section 140, or by other express provisions of this CONTRACT.

3) Pilot Programs. At the request of the DEPARTMENT, the CONTRACTOR shall enter into a pilot or limited-term trial. See Section 215C.

135C Recovery of Overpayments

The CONTRACTOR shall have procedures to recover or collect overpayments made under this AGREEMENT, including those payments made for an ineligible person.

135D Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

135E Amounts Owed by Contractor

Funds owed to the BOARD must be paid within thirty (30) calendar DAYS from notification of penalties or monies owed. The CONTRACTOR has thirty (30) calendar DAYS to document any dispute of amounts owed. After thirty (30) DAYS, the DEPARTMENT may collect owed funds by deducting the amounts from the payments made to the CONTRACTOR, and the CONTRACTOR may be subject to further penalties.

135F Automated Clearinghouse (ACH)

The CONTRACTOR shall support an ACH mechanism that allows for the DEPARTMENT to submit premium payments.

140 Participant Materials and Marketing

140A Informational / Marketing Materials

1) All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes written and electronic communication, such as marketing, informational, letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage.

   All HEALTH PLANS must comply with Section 1557 of the Affordable Care Act (ACA) and Federal civil rights laws. Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990, as well as those whose primary language is not English.

   The notice in Appendix A of the federal Section 1557 ACA regulations must be published in conspicuously-visible font size in all significant communications and significant publications, both print and web, related to the State of Wisconsin Group Health Benefits Program. The

CONTRACTOR must use the notice as provided below, or a significantly similar version that meets the regulation requirements.

"Significant communications" and "significant publications," while not defined in the law, are interpreted broadly to include the following:

a) Documents intended for the public, such as outreach, education, and marketing materials;

b) Written notices requiring a response from an individual; and,

c) Written notices to an individual, such as those pertaining to rights and benefits.

The notice is as follows:

"[Name of CONTRACTOR] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of CONTRACTOR]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact [Name of CONTRACTOR'S Civil Rights Coordinator].

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html."

Wherever the above notice in Appendix A. appears, it is also required to contain the tagline in Appendix B., translated into at least the top fifteen (15) languages spoken by individuals with limited English proficiency in the State of Wisconsin. That tagline reads:

> "ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)."

For purposes of consistency with the DEPARTMENT'S It's Your Choice (IYC) materials, it is required to use the top fifteen (15) list provided on the Centers for Medicare and Medicaid Services' website. The CONTRACTOR shall use the translations of the above-referenced tagline as provided by the federal Department of Health and Human Services.

2) The CONTRACTOR must ensure that its marketing and communication materials are culturally sensitive and professional in content, appearance, and design. At the request of the DEPARTMENT, the CONTRACTOR must replace images or artwork on the dedicated website, web-portal, or promotional materials within seven (7) BUSINESS DAYS of the CONTRACTOR'S receipt of the DEPARTMENT'S request. The DEPARTMENT reserves the right to require removal of any objectionable content sooner.

3) The CONTRACTOR'S costs for developing and distributing communications to PARTICIPANTS in order to correct an error in previous CONTRACTOR communication(s) that was the result of a CONTRACTOR error will be at the cost of the CONTRACTOR.

4) The DEPARTMENT reserves the right to require the CONTRACTOR to provide notification to PARTICIPANTS as directed.

140B It's Your Choice Open Enrollment Materials

Each CONTRACTOR will be required to prepare informational materials in a form and content acceptable to the BOARD, as determined by the DEPARTMENT, and clearly indicate any changes from the previous year's materials when submitting draft materials to the DEPARTMENT for review and approval.

1) The CONTRACTOR shall issue written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers (individual and groups or clinics, HOSPITALS, and other facilities) that will not be IN-NETWORK for the upcoming benefit period and include any specific language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. This notification cannot be combined with informational materials sent to non-PARTICIPANTS. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) this written notice was issued.

2) The CONTRACTOR shall submit the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period:

a) CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and website address.

b) Content for the CONTRACTOR'S plan description page, including available features.

c) Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory.

3) The CONTRACTOR shall submit all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval.

4) The CONTRACTOR shall submit three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final format must be provided to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.

145 Information Systems

1) The CONTRACTOR'S systems must have the capability of adapting to any future changes that become necessary as a result of modifications to the state and LOCAL programs and its requirements. The CONTRACTOR'S systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, as requirements may change.

2) If the CONTRACTOR has plans to migrate to a different data or web platform, the DEPARTMENT must be notified no less than six (6) months in advance of the migration.

3) The CONTRACTOR must transmit data SECURELY using current industry standard SECURE transmission protocols, e.g., sFTP/SSH or SSL/TLS. This may require software on desktops or an automated system that collects files from the CONTRACTOR'S repository and SECURELY transmits data.

4) The CONTRACTOR'S data centers, network, web-portal and personal computers (PCs) must be protected by an up-to-date firewall. PCs and applications must be updated with the latest security fixes and continually maintained and up-to-date. Servers must be SECURED with only authorized staff allowed access to servers. Data that is at rest must be encrypted using strong industry standard encryption. The CONTRACTOR must have a password policy with a complex password scheme, which, at a minimum, meet these criteria:

a) A minimum of eight (8) characters,

b) Does not use the user's name or user ID in the password,

c) Requires users to change passwords at least every sixty (60) DAYS,

d) Does not repeat any of the last twenty-four (24) passwords used, and

e) The password must contain at least three (3) of these four (4) data types:

i) Upper case alphabetic letters (A - Z),

ii) Lower case alphabetic letters (a - z),

iii) Numeric (0 - 9),

iv) Special characters (all special characters available on the keyboard).

Other password complexity rules may be acceptable, if approved by the DEPARTMENT.

An audit program must be in place to ensure above practices are being followed. The CONTRACTOR'S staff must be trained and follow SECURE computing best practices. Wireless networks must be protected using strong encryption and password policies. Connectivity to all networks, wired or wireless, must be protected from unwanted/unknown connections. Any sub-contractors must agree to and abide by all the network and data security requirements.

5) All data backups must be handled or transmitted SECURELY. Offsite storage must be audited for compliance (i.e. physical security, all used tapes are accounted for). A business recovery plan must be documented and tested annually, at a minimum, by the CONTRACTOR, and submitted to the DEPARTMENT.

6) The CONTRACTOR must be able to confirm that emails sent to program PARTICIPANTS and/or EMPLOYERS have been successfully transmitted and will track failed emails and initiate requests to be whitelisted for EMPLOYER groups that may be blocking the CONTRACTOR'S email communication. The CONTRACTOR must deliver failed messages to PARTICIPANTS in another format), within ten (10) BUSINESS DAYS, (e.g. hard copy mail, phone call) if the email transmission is not successful.

7) Upon request by the DEPARTMENT, the CONTRACTOR must be able to generate and provide a listing of all individuals that were electronically sent a particular document or communication by the CONTRACTOR or the CONTRACTOR'S subcontractor, the date and time that the document or communication was generated, and the date and time that it was sent to particular individuals. The CONTRACTOR must also provide a listing of those who were sent the communication piece in another format as required by 6), above.

8) The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) DAYS to the DEPARTMENT. Examples of a major system change include a new platform for enrollment, claims payment or data submission system. This does not apply to any program fixes, modifications and enhancements.

150 Data Requirements

150A Data Integration and Technical Requirements

1) The DEPARTMENT is currently in the process of consolidating multiple legacy information technology systems to a single BENEFITS administration system. This new system will become the system of record for enrollment and demographic information. The upgrade to this new system may impact the formatting or data fields required for transmitting enrollment files and may also impact the way in which enrollment data is communicated to the CONTRACTOR. The CONTRACTOR must make any necessary updates to its system to accommodate changes to the enrollment file, per the most recent 834 Companion Guide as issued by the DEPARTMENT. The next roll-out for the new system is currently scheduled for 2018.

2) The DEPARTMENT'S systems identify PARTICIPANT records using an eight (8)-digit member ID. This member ID is transmitted to and must be stored by the CONTRACTOR to communicate information about PARTICIPANTS. The CONTRACTOR must support use of the DEPARTMENT'S member ID in all interfaces that contain PARTICIPANT data. Further, the CONTRACTOR must supply member ID values on any communication or data transmission that refers to individual PARTICIPANTS, including but not limited to HIPAA 834 file transfers, reports, data extracts, and invoices. Given the ubiquitous and central nature of the member ID in the DEPARTMENT'S systems, it is strongly preferred that the member ID is stored in the CONTRACTOR'S system directly, thereby facilitating ad hoc queries, data integrity, and referential integrity within the CONTRACTOR'S system.

3) The CONTRACTOR must follow the DEPARTMENT'S SECURE file transfer protocols (sFTP) using the DEPARTMENT'S sFTP site to submit and retrieve files from DEPARTMENT or provide another acceptable means for SECURE electronic exchanging of files with the DEPARTMENT, as approved by the DEPARTMENT.

4) The CONTRACTOR'S system(s) must be able to accept and accommodate a HIPAA 834 file transfer from the DEPARTMENT, per the most recent 834 Companion Guide (see Appendix 1) as issued by the DEPARTMENT.

    a) The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt.

        The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.

    b) The CONTRACTOR shall assist with a full file comparison (FFC) of enrollment data at the frequency as directed by the DEPARTMENT by submitting a file to the DEPARTMENT containing current enrollment data. The DEPARTMENT will verify that data, compare that data with the DEPARTMENT'S data, and generate an exception report. The CONTRACTOR will be responsible for resolving differences between the

DEPARTMENT'S data and the CONTRACTOR'S data, updating the CONTRACTOR'S data, and informing the DEPARTMENT, as appropriate.

The CONTRACTOR shall maintain an exception report spreadsheet that includes the error details and final resolution, and submit it to the DEPARTMENT, at the frequency directed by the DEPARTMENT. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT.

c) Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY.

5) The CONTRACTOR must establish and maintain a SECURE data transfer with the DEPARTMENT'S data warehouse and as otherwise noted in this section. The CONTRACTOR data transfers include, but will not be limited to:

a) Claims Data - The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document (see Appendix 4), all claims processed for PARTICIPANTS. At least ninety-five percent (95%) of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred percent (100%) of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) Provider Data – The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document (see Appendix 5), the specified data for all IN-NETWORK providers including subcontracted providers. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

c) Pharmacy Claims Data – The CONTRACTOR must establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data as required under Section 240. The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a daily file from the DEPARTMENT'S PBM that will be in a file format compliant with the most recent Pharmacy Data Specifications (see Appendix 2) provided by the DEPARTMENT with consultation with the PBM.

d) Wellness and Disease Management Data – The CONTRACTOR must establish a data transfer process to retrieve this data from the DEPARTMENT'S data warehouse for its

PARTICIPANTS and integrate the data into its medical management program. This data includes results from biometric screenings, health risk assessments, and unique PARTICIPANT enrollment in wellness health coaching and/or disease management programs as provided by the wellness and disease management vendor to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a weekly file from the wellness and disease management vendor that will include this data. The file format must comply with the most recent Wellness Data Specifications (see Appendix 3) as provided by the DEPARTMENT.

e) Dental Claims Data – The CONTRACTOR shall establish a data transfer process to retrieve dental claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data into its medical management program. This data is based on claims data as provided by the DEPARTMENT'S dental benefits administrator to the DEPARTMENT'S data warehouse.

f) Benefit Accumulator Data - On each BUSINESS DAY, the CONTRACTOR must submit and retrieve data files with the vendor designated by the DEPARTMENT for the purpose of calculating the benefit accumulator for medical and pharmacy benefits. The CONTRACTOR must retrieve the pharmacy accumulator data and apply it to any combined deductibles and/or maximum out-of-pocket amounts for PARTICIPANTS. The CONTRACTOR must work with the DEPARTMENT to audit the benefit accumulator against the DEPARTMENT'S PBM to ensure the accumulator amounts are in sync.

6) Delays in submitting program data to DEPARTMENT'S data warehouse must be communicated via email to the DEPARTMENT Program Manager or designee within one (1) DAY of the scheduled transfer.

7) For data transfers between vendors of the state and LOCAL program not specified in this AGREEMENT, the CONTRACTOR must establish vendor to vendor data transfers within ninety (90) calendar DAYS of written notification from the DEPARTMENT to do so.

8) All file formats are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM.

9) The CONTRACTOR data provided to vendors of the state and LOCAL program must be accurate, complete and timely. The CONTRACTOR must not place restrictions on the use of the data provided to the state and LOCAL program vendors.

10) Health information provided to the DEPARTMENT will be de-identified, unless authorized by the PARTICIPANT for the purpose of appeal, issue resolution, or fraud investigation.

150B Data Submission Requirements

The CONTRACTOR shall cooperate with the DEPARTMENT's designated data warehouse vendor by submitting to the vendor all of the following data on a schedule to be determined by the DEPARTMENT:

1) Data on payments for BENEFITS provided to PARTICPANTS under this CONTRACT. Payment data shall include claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties; and

2) Data on other financial transactions associated with claim payments, including charged amount, allowed amount, and charges to members as co-payments, coinsurance, and deductibles; and

3) Data on the providers of those BENEFITS provided under this CONTRACT; and

4) Other data, as specified by the DEPARTMENT.

The CONTRACTOR shall comply with the DEPARTMENT'S specifications for submission of the required data elements in the standard formats attached to this CONTRACT.

To comply with the data submission requirements, the CONTRACTOR must follow the specified data file layout and formatting of all data elements within it and the DEPARTMENT'S specifications for data filtering and extraction. The CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the data dictionary. The claim adjustment data the CONTRACTOR submits must follow the logic the CONTRACTOR defines in the documentation. The CONTRACTOR must provide the DEPARTMENT'S eight (8)-digit member ID on all claim files. On all provider and claim files, the CONTRACTOR must supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES).

The CONTRACTOR must designate someone as a data steward who is knowledgeable of its data and the systems that generate it. The data steward shall attend data submission planning meetings scheduled by the DEPARTMENT'S data warehouse vendor on the DEPARTMENT's behalf and shall be the key point of contact for the DEPARTMENT'S data warehouse vendor on the submission of data and the correction of data errors should they occur.

The CONTRACTOR shall follow the data transmission instructions provided by the DEPARTMENT'S data warehouse vendor, which shall include industry-standard electronic transmission methods via secure Internet technology.

The quality of CONTRACTOR's data submissions will be assessed by the DEPARTMENT'S data warehouse vendor for timeliness, validity and completeness. If the DEPARTMENT'S data warehouse vendor determines that the data submitted by CONTRACTOR fails to meet the DEPARTMENT'S data warehouse vendor's thresholds for data quality, the CONTRACTOR must cooperate with the DEPARTMENT'S data warehouse vendor in submitting corrected data.

The CONTRACTOR must submit data and corrected data when necessary by the dates indicated by the DEPARTMENT'S data warehouse vendor.

The CONTRACTOR agrees to financial penalties for failure to submit data in accordance with this AGREEMENT, and which are assessed by the DEPARTMENT'S data warehouse vendor on behalf of the DEPARTMENT. Charges or penalties that are the direct result of the CONTRACTOR's failure to meet the DEPARTMENT'S data submission requirements, timelines

or other requirements in this AGREEMENT that impact the DEPARTMENT'S data warehouse will be deducted from a future payment(s) owed the CONTRACTOR.

During the initial implementation of the DEPARTMENT'S data warehouse, the CONTRACTOR will have two chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted more than one (1) BUSINESS DAY after the deadline for data file submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARMENT will charge the CONTRACTOR a penalty for each data file submitted after the first submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted after the deadline for submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARMENT will charge the CONTRACTOR a per occurrence penalty for any failure to communicate to the DEPARTMENT'S data warehouse vendor a change to the valid values or data fields in the CONTRACTOR's next data file submission by ten (10) BUSINESS DAYS before the next data file submission deadline.

The penalties assessed in Section 150B apply to the penalty maximum described in Section 315.

155 Miscellaneous General Requirements

155A Reporting Requirements and Deliverables:

1) The CONTRACTOR must submit all reports and deliverables, and comply with all material requirements set forth in this AGREEMENT.

2) Each report submitted by the CONTRACTOR to the DEPARTMENT must:

   a) Be verified by the CONTRACTOR for accuracy and completeness prior to submission,

   b) Be delivered on or before scheduled due dates,

   c) Be submitted as directed by the DEPARTMENT,

   d) Fully disclose all required information in a manner that is responsive and with no material omission, and

   e) Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report.

3) THE DEPARTMENT requirements regarding the frequency of report submissions may change during the term of the CONTRACT. The CONTRACTOR must comply with such changes within forty-five (45) DAYS.

4) The CONTRACTOR must notify the DEPARTMENT regarding any significant changes in its ability to collect information relative to required data or reports

5) The CONTRACTOR must fully support the BOARD and the DEPARTMENT in responding timely to informational requests made by the Legislature.

155B Performance Standards and Penalties

The CONTRACTOR must guarantee performance sufficient to fulfill the needs of the CONTRACT. The CONTRACTOR must meet all performance standards listed in Section 315. After the CONTRACT start date, if additional resources are needed, the CONTRACTOR will bear all costs necessary to satisfy the requirements of the CONTRACT.

Written notification of each failure to meet a performance standard that is listed in Section 315 will be given to the CONTRACTOR prior to assessing penalties. Upon notification by the DEPARTMENT, the CONTRACTOR will have five (5) BUSINESS DAYS to cure the failure, or if agreed to by the DEPARTMENT, to provide an action plan of how the failure will be cured. Additional DAYS can be approved by the DEPARTMENT Program Manager if deemed necessary. If the failure is not resolved within this warning/cure period, penalties may be imposed retroactively to the date of failure to perform. The imposition of penalties is not in lieu of any other remedy available to the DEPARTMENT/BOARD.

If the DEPARTMENT elects to not exercise a penalty clause in a particular instance, this decision shall not be construed as an acceptance of the CONTRACTOR'S performance. The DEPARTMENT retains the right to pursue future assessment of that performance requirement and associated penalties.

The DEPARTMENT shall be the sole determinant as to whether or not the CONTRACTOR meets a performance standard.

155C Nondiscrimination Testing

The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete Internal Revenue Code (IRC) Sec. 105 (h) compliant nondiscrimination testing for the DEPARTMENT at least annually. The DEPARTMENT or its designee will provide a schedule, process for testing, and data requirements. The CONTRACTOR shall complete any necessary requirements by the due date(s) specified by the DEPARTMENT or its designee.

155D Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits.

155E Audit and Other Services

The CONTRACTOR shall be required to maintain sufficient documentation to provide for the financial/management audit of its performance under this AGREEMENT. These shall include, but are not limited to, program expenditures, claim processing efficiency and accuracy, and customer service.

At its discretion, the BOARD may require independent third party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit. The BOARD may also designate a common vendor which shall provide the annual description of BENEFITS and such other information or services it deems appropriate.

The CONTRACTOR shall address any areas for improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. The BOARD shall be notified of all identified areas for improvement and the status of all improvements as necessary.

The BOARD shall make a diligent attempt to select a third party audit firm that is not a competitor of the CONTRACTOR or affiliated with or under the control of a competitor of the CONTRACTOR.

The frequency and extent of such audits shall be determined by the BOARD or DEPARTMENT. Records of paid claims must be maintained in a format and in a media acceptable to the DEPARTMENT.

The CONTRACTOR shall agree to a Service Organization Control (SOC) 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the Statement of Standard for Attestation Engagements (SSAE) 18 and provide a copy of the CPA's report to the DEPARTMENT. The DEPARTMENT will allow time on a case-by-case basis to provide this information if the CONTRACTOR doesn't currently have a completed SSAE 18 audit. The audit report must be submitted annually.

The CONTRACTOR shall submit a Model Audit Rule (MAR) Certification on an annual basis.

The CONTRACTOR shall submit financial stability documentation on an annual basis, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles).

The CONTRACTOR must also cooperate fully with audits and/or reviews conducted by the State of Wisconsin Legislative Audit Bureau (LAB). The LAB conducts periodic and other audits at the requests of legislators.

The CONTRACTOR shall make financial records, claims documentation, and all other relevant records available for review or audit as requested by the DEPARTMENT and shall assist as needed in review of these records.

155F Fraud and Abuse

1) Participant Fraud

   a) Policy on Participant Fraud

      No person other than a PARTICIPANT is entitled to BENEFITS under this AGREEMENT. The SUBSCRIBER or any of his or her DEPENDENTS are not authorized by this AGREEMENT to assign or transfer their rights under the AGREEMENT, aid any other

person in obtaining BENEFITS to which they are entitled or knowingly present or cause a false or fraudulent claim. The SUBSCRIBER'S rights to coverage under the HEALTH BENEFITS PROGRAM are 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 falsely or fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment rights may be limited as determined by the BOARD.

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.

b) Contractor Responsibility Related to Participant Fraud

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any suspected or identified PARTICIPANT fraud. The CONTRACTOR must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT. Fraud may result in the reprocessing of claims and recovery of overpayments. See Section 135C.

2) Contractor Provider Review Requirements

The CONTRACTOR, within thirty (30) DAYS of the execution of this CONTRACT, must submit a fraud and abuse review plan to the DEPARTMENT. Upon the DEPARTMENT'S approval of the plan, the CONTRACTOR must perform QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provide results of material findings to the DEPARTMENT.

Examples of potential provider fraud that could be included in QUARTERLY reviews:

a) Billing for items or services not rendered;

b) Billing for work already reimbursed by another insurer;

c) Overcharging for services or supplies;

d) Completing an unjustified Certificate of Medical Necessity (CMN) form;

e) Double billing resulting in duplicate payment;

f) Misrepresenting medical diagnoses or procedures to maximize payments;

g) Inappropriate use of place of service codes;

h) Knowing misuse of provider identification numbers resulting in improper billing;

i) Providing medically unnecessary services;

j) Routinely waiving deductibles/coinsurances;

k) Submitting bills exceeding the limiting charge;

l) Unbundling (billing for each component of the service instead of billing or using an inclusive code);

m) Up-coding the level of service provided; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H Department May Designate Vendor

At its discretion, the DEPARTMENT may designate a common vendor who shall provide the annual description of BENEFITS and such other information or services it deems appropriate, including audit services.

155I Contract Termination

In addition to the provisions in the Department Standard Terms and Conditions, the following applies if the CONTRACT is terminated:

1) Any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

    a) The CONTRACT maximum is reached.

    b) The attending physician determines that CONFINEMENT is no longer medically necessary.

    c) The end of twelve (12) months after the date of termination.

    d) CONFINEMENT ceases.

2) If the BOARD terminates this CONTRACT, then all rights to BENEFITS shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include, but are not limited to: transferring the patient to another facility; billing the BOARD a fee for service rendered; or permitting OUT-OF-NETWORK providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.

3) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

4) The CONTRACTOR must submit claims data as specified in Section 150 during a six (6) month run-out period following the CONTRACT termination date. The DEPARTMENT will withhold twenty-five percent (25%) of premium payment for the last month of the contract period, to be paid not later than ninety (90) days following the contract termination date, unless there are issues receiving timely run-out claims data.

5) If the CONTRACTOR terminates this CONTRACT, the CONTRACTOR shall not again be considered for participation in the HEALTH BENEFIT PROGRAM under Wis. Stat. § 40.03 (6) (a) for a period of three (3) calendar years.

155J Transition Plan

Upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARMENT. The transition plan must be approved by the DEPARTMENT prior to the transition begin date. Also see the Department Standard Terms and Conditions.

155K Insolvency

The CONTRACTOR shall maintain appropriate bonding and/or reinsurance and shall submit documentation upon request by the DEPARTMENT. The appropriate bonding and/or reinsurance ensures that, in the event the CONTRACTOR becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the CONFINEMENT ceases, the attending physician determines CONFINEMENT is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer coverage to another CONTRACTOR.

160 Submission of New Proposals

The organization must submit a proposal to the BOARD to participate in the HEALTH BENEFIT PROGRAM. The proposal must address each requirement in this section.

The organization must also meet the requirements in this AGREEMENT in order to secure approval from the BOARD to participate in the HEALTH BENEFIT PROGRAM. These requirements have been developed to explain and clarify the general requirements set forth under Wis. Stat. § 40 Subchapter IV, Wis. Adm. Code § ETF 10 and Wis. Adm. Code § ETF 40. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stat. 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.

The BOARD may allow an organization that has substantially but not completely met the requirements of this AGREEMENT to participate but not be considered qualified in the first year of operation in the HEALTH BENEFIT PROGRAM for purposes of establishing the EMPLOYER contribution toward PREMIUM when the contribution is based on a percentage of the lowest / average cost qualified plan.

160A Operating Experience

The organization must have at least one (1) year of operating experience and must be able to demonstrate that the organization has broad-based community support. In determining the operating experience requirements, the BOARD shall consider the period of time elapsing from the date the organization first opens its door to the general public to render health care services to the date that such coverage would be effective for public employees.

To document the community support requirement, the organization must submit information on current enrollments, projected growth and historical data that would support the fact that it has

experienced steady growth since its inception. The organization must provide a current listing of employer/employee groups participating under the program or actively sponsoring participation in the plan. If the organization is so large that providing a listing of each and every participating employer/employee group would be an inconvenience, the BOARD will accept a representative listing of 20 such groups.

The BOARD may waive the one year operating experience and community support requirement(s) in those health service areas where the BOARD has determined there is a need for the promotion of innovative approaches to the delivery of health care such as the concept of direct provider contracting.

160B Financial Requirements

The organization must be able to demonstrate that it has the financial resources necessary to carry out its obligations to PARTICIPANTS covered under the HEALTH BENEFIT PROGRAM.

The BOARD prefers to approve only those organizations that have reached the "breakeven point" and are operating at a level where program income equals expenses. However, the BOARD will consider organizations that are not yet self-sufficient, if it provides evidence that it can meet its short and long-term financial obligations.

In determining financial stability, the BOARD will consider financial soundness of arrangements for health care services, adequate working capital (both current and projected), and insolvency protection for subscribers. See Section 155L for additional detail on insolvency.

The organization must submit documentation of financial stability that may include one or more of the following:

1) Federal qualification under Public Law 93-222 (Health Maintenance Assistance Act of 1973), or subsequent amendments.

2) Incorporation and regulation under the provisions of Chapter 185 and/or 600 through 646 of the Wisconsin Statutes pertaining to insurance plans.

3) Posting financial bond guaranteeing benefit payments in the event the organization fails to meet the continuing requirements for inclusion under the HEALTH BENEFIT PROGRAM and is terminated, or the organization ceases operation. The size of the performance bond required will be based on the number of enrollees and premium income involved.

4) The organization has sponsors who are incorporated under Chapter 613 of the Wisconsin Statutes or otherwise possess an appropriate certificate of authorization to transact insurance business under Wis. Stat. § 601.04, and will guarantee future benefit payments.

5) Other documentation such as reinsurance as provided by Chapter 627 of the Wisconsin Statutes and as authorized by the Commissioner of Insurance. Terminations will be handled in a manner consistent with the intent of Wis. Adm. Code § INS 6.51 (6) and (7), Rules of the Commissioner of Insurance (register date December 1984).

6) The BOARD reserves the right on a case by case basis to request additional documentation of financial stability of a kind and in a form as appropriate.

160C Comprehensive Plans

The BOARD will only consider those organizations that 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 organization whose premium is not satisfactory to the BOARD.

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

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

2) Prepaid group practice HMO.

3) Staff model HMO.

4) Point of service HMO (POS-HMO).

5) Preferred Provider Plan (PPP).

Organizations that embrace the characteristics of one or more of the type of organization models described above may be considered by the 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.

160D Provider Agreements

The organization must submit the following as part of its proposal:

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 organization and hospitals which would be IN-NETWORK for the HEALTH BENEFIT PROGRAM. Specify whether there is a contractual relationship between the organization 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 providers and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how compensation is established, reviewed and changed. The intent is to secure information on how a CONTRACTOR 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 organization. For those organizations where medical specialists are used as referral physicians rather than primary care, the organizations 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 PARTICIPANT to satisfy a deductible or be subject to copayment or coinsurance, 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 organization as full payment for covered services. Each organization must certify that it will "hold harmless" the PARTICIPANT from any effort(s) by third parties to collect payments for medical/hospital services, including those efforts due to the CONTRACTOR'S untimely payment of claim.

   This provision shall be considered as satisfied if arrangements have been made which prevent the PARTICIPANT 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 copayment or coinsurance basis; or in those instances where the PARTICIPANT 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 the UNIFORM BENEFITS plan requirements shall not be subject to the "hold harmless" provision.

160E Capital Equipment and Expenditures

The organization must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically providing services but rather, functioning as a sponsor, include within your proposal the following statement:

> "Section 160E. of the AGREEMENT is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

If the approval of capital equipment and expenditures is subject to review by state and/or federal agencies, the applicant should provide information on all reporting requirements.

160F Enrollment and Reporting

If an organization submits a proposal to participate in the HEALTH BENEFIT PROGRAM and the proposal is approved by the BOARD, the organization will be offered to active and retired EMPLOYEES at a time established by the BOARD (IT'S YOUR CHOICE OPEN ENROLLMENT) subject to the following:

1) The organization must secure a minimum of 100 SUBSCRIBER contracts or demonstrate that 10% of the eligible EMPLOYEES in the service area have opted to participate in the program. The service area means the entire geographic area in which the organization is qualified. See Section 230A.

2) The BOARD may waive the minimum participation requirement set forth under 1) above provided the organization submits a marketing plan which demonstrates that this minimum

number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a similar extent by employees of other groups and the location is convenient to potential SUBSCRIBERS. This marketing plan will be considered confidential by the BOARD insofar as permitted by Wisconsin Law.

160G Rate-Making Process

The organization must submit initial premium rates as described in Section 130B. The organization must include 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 that 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 as confidential by the BOARD insofar as permitted by Wisconsin Law.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates.

160H Submission of Proposals

The proposal must be received by April 15 and include:

1) Fifteen (15) copies.

2) Specific listing of the organization's pre-authorization and referral requirements.

3) Description of case management and disease management activities.

4) List and count of providers under contract arranged by county of practice for state employees, and by zip code for LOCAL employees. An electronic version of the listing must also be made available. The BOARD will expect an updated listing in July in order to determine what region will constitute the CONTRACTOR'S service area.

5) Copy of your detailed contingency plan in the event of strike, disaster, etc. The plan must address the method used for providing services and processing claims under such circumstances.

6) Organizational chart.

7) Statement of agreement to abide by all the terms and conditions set forth in the AGREEMENT.

8) If a PPP, include a schedule of benefits.

The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

160I Implementation

The CONTRACTOR is required to have an Implementation Manager and Implementation Team available to manage the project from the CONTRACT start date until all implementation tasks are complete, as determined by the DEPARTMENT, and all remaining responsibilities are transferred over to the Account Manager and key staff. The Implementation Manager must be available

Monday through Friday from 8:00 a.m. to 4:30 p.m. CST/CDT to assist DEPARTMENT staff. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned, normal business hours. The CONTRACTOR will continuously assess the implementation process to ensure a smooth and successful implementation. The Account Manager who will be responsible for the CONTRACT must be an active member of the Implementation Team.

The CONTRACTOR must conduct status meetings with the DEPARTMENT concerning project development, project implementation and CONTRACTOR performance at least twice a week during implementation and for the first two to three (2-3) months following the launch of the benefit period, unless otherwise approved by the DEPARTMENT in writing. Meetings may be in person or by teleconference/webinar, as determined by the DEPARTMENT.

The DEPARTMENT reserves the right to make on-site visits.

The CONTRACTOR is required to perform and/or manage the following activities by the due date to be indicated by the DEPARTMENT:

1) Implementation Plan: The CONTRACTOR shall submit an implementation plan in a mutually agreed upon format to the DEPARTMENT Program Manager or designee.

2) Fraud and Abuse Review Plan: The CONTRACTOR shall submit a fraud and abuse review plan to the DEPARTMENT.

3) Nondiscrimination Testing Plan: The CONTRACTOR will work with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.

4) Program Information: All program informational materials for the upcoming benefit period shall be submitted to the DEPARTMENT Program Manager or designee for review and approval, including:

    a) Informational mailing to be sent to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.

    b) Web content that consists of customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period.

5) Employer Meeting and Health Fairs: The CONTRACTOR shall attend the It's Your Choice EMPLOYER Kick-Off meeting and shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area

6) Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number shall be operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.

7) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files shall be fully tested and are ready for program operation.

8) Grievance Procedure: The CONTRACTOR shall submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.

9) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational.

10) Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information shall be launched.

11) Data Transfers: The data transfer process to the DEPARTMENT'S data warehouse, or other DEPARTMENT vendor as designated by the DEPARTMENT, shall be established, tested, and working correctly for the following transfers:

    a) Pharmacy Data

    b) Wellness and Disease Management Data

    c) Provider Data

    d) Claims Data