TERMS AND CONDITIONS FOR COMPREHENSIVE

MEDICAL PLAN PARTICIPATION IN THE STATE OF WISCONSIN

GROUP HEALTH BENEFIT PROGRAM AND UNIFORM BENEFITS

FOR THE 2017 BENEFIT YEAR

Department of Employee Trust Funds

GROUP INSURANCE BOARD

P.O. Box 7931
Madison, Wisconsin 53707

October 2016

ET-1136-16 (2017 GUIDELINES, REV 2/17) ETG0001

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State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R01/2000))
S. 51.01(5) Wis. Stats.; s. 111.32(13m) Wis. Stats.

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract By Authorized Board

Commodity or Service:
Medical Plan Participation in the State of Wisconsin Group Health Benefit Program

Request for Bid/Proposal No:
ET-1136-16 (Project #ETG0001)

Contract Period:
01/01/2017 thru 12/31/2017 with annual renewal unless otherwise earlier modified or terminated as provided under the GUIDELINES

Authorized Board:
Group Insurance Board

CONTRACT TO PARTICIPATE UNDER GROUP HEALTH BENEFIT PROGRAM

Wis. Stats. § 40.03 (6) (a) 1, 40.51 (6) and (7), 40.51 (4)

1. This CONTRACT is entered into by and between the State of Wisconsin Group Insurance Board (BOARD) and the contractor (known as “the HEALTH PLAN”) whose name, address, and principal officer appears on page ii. The State of Wisconsin Department of Employee Trust Funds (DEPARTMENT) is the sole point of contact for BOARD contracting.
2. The “TERMS AND CONDITIONS FOR COMPREHENSIVE MEDICAL PLAN PARTICIPATION IN THE STATE OF WISCONSIN GROUP HEALTH BENEFIT PROGRAM AND UNIFORM BENEFITS FOR THE 2017 BENEFIT YEAR” (form ET-1136-16), including all attachments and addenda (known as "the GUIDELINES"), are hereby incorporated by reference as if set forth in full.
3. The HEALTH PLAN agrees that in consideration of participating in the State of Wisconsin group health insurance program, it shall observe and comply with all the GUIDELINES' stated terms and conditions, including without limitation the General Requirements, HEALTH PLAN utilization addenda, terms of the described Uniform Benefits, state employee and local public employee group health insurance plans. The HEALTH PLAN affirmatively represents that it meets and shall continue to meet all requirements described in the General Requirements of the GUIDELINES.
4. The HEALTH PLAN further agrees that the BENEFITS and obligations under this agreement are not assignable or transferable except by written agreement of the BOARD and that this agreement is executed with the HEALTH PLAN as presently constituted. Any change in the ownership or controlling interest of the HEALTH PLAN, any acquisition by the HEALTH PLAN of another comprehensive medical plan with which the BOARD has contracted to participate in the state group health program, and any merger between the HEALTH PLAN and any other entity is a significant event requiring notification of the BOARD.
5. In connection with the performance of work under this CONTRACT, the HEALTH PLAN agrees not to discriminate against any employees or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The HEALTH PLAN agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.
6. For purposes of administering this CONTRACT, or in the event of any conflict, ambiguity, or inconsistency among the terms of this CONTRACT and the documents incorporated within, the Order of Precedence to resolve any inconsistencies is:
   1) This CONTRACT;
   2) The GUIDELINES, including all attachments;
   3) Certification to Health Insurance Issuer for Disclosure of PHI to DEPARTMENT; and
   4) Any applicable federal or State statute and rule or regulation.

Contract Number & Service: *ETG0001, Medical Plan Participation in the State of Wisconsin Group Health Benefit Program*

State of Wisconsin Department of Employee Trust Funds
By Authorized Board (Name) Group Insurance Board
By *(Name)* Michael Farrell
Signature
Title Chair, Group Insurance Board
Phone 608-266-9854 (A. John Voelker, Deputy Secretary)
Date *(MM/DD/CCYY)*

To be Completed by the HEALTH PLAN
Legal Company Name
Trade Name
Taxpayer Identification Number
Company Address *(City, State, Zip)*
By *(Name)*
Signature
Date *(MM/DD/CCYY)*

Certification to Health Insurance Issuer for Disclosure of PHI to DEPARTMENT

WHEREAS the Group Insurance Board ("BOARD") is the Plan Sponsor ("Plan Sponsor") of an employee health insurance plan pursuant to Wis. Stats. §§ 40.51 and 40.52; and

WHEREAS, the Department of Employee Trust Funds ("DEPARTMENT") acts on behalf of the Plan Sponsor to administer the employee health insurance plan pursuant to authority delegated by the State of Wisconsin to the Secretary of DEPARTMENT under Wis. Stats. § 40.03(2)(b) and by the Secretary to employees of DEPARTMENT under Wis. Stats. § 40.03(2)(f);

WHEREAS, the employee health insurance plan is administered by the DEPARTMENT on behalf of the Plan Sponsor and is a "group health plan" and Covered Entity within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and

WHEREAS, Insurance Company ("Insurer") and BOARD have entered into an insured service agreement; and

WHEREAS, DEPARTMENT and Insurer desire to exchange health information protected by HIPAA ("Protected Health Information" or "PHI"), pursuant to the authority of 45 CFR §§ 164.504 and164.506 (c)(3); and

WHEREAS, DEPARTMENT occasionally needs certain PHI from Insurer to conduct certain plan administration functions and payment or health care operations as allowed under 45 CFR § 164.504 and § 164.506,

THEREFORE, DEPARTMENT, on behalf of itself and the BOARD, hereby certifies that the documents and materials for the Group Health Plan (hereinafter "Plan Documents") will comply with the requirements of 45 CFR § 164.504 (f)(2) and that DEPARTMENT will safeguard and limit the use and disclosure of PHI that the BOARD may receive from DEPARTMENT to perform the plan administration functions.

Further, DEPARTMENT certifies that:

- DEPARTMENT will not use or disclose PHI other than as permitted or required by the Plan Documents or as required by law;
- DEPARTMENT ensures that any agents, including a subcontractor, to whom it provides PHI, agree to the same restrictions and conditions that apply to DEPARTMENT and BOARD;
- DEPARTMENT will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;

Certification to Health Insurance Issuer for Disclosure of PHI to DEPARTMENT (continued)

- DEPARTMENT will report to the Insurer when DEPARTMENT becomes aware of any use or disclosure of the PHI that is inconsistent with the purpose for which the uses or disclosures were provided to DEPARTMENT;
- DEPARTMENT will make available the Designated Record Set of PHI to members for the purposes of inspection pursuant to 45 CFR § 164.524;
- DEPARTMENT will make available PHI for amendment and incorporate any amendments to PHI pursuant to 45 CFR § 164.526;
- DEPARTMENT will make available the information required to provide an accounting of disclosures pursuant to 45 CFR § 164.528;
- DEPARTMENT shall make its internal practices, books, and records relating to the use and disclosure of PHI received from Insurer available to the Secretary of Health and Human Services for purposes of determining compliance by DEPARTMENT with 45 CFR § 164.504;
- DEPARTMENT shall return or destroy all PHI received from Insurer that DEPARTMENT still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. Except that, if such return or destruction is not feasible, DEPARTMENT will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Employees or classes of employees or other persons under the control of DEPARTMENT who will be given access to the PHI received from Insurer will be restricted to the plan administration functions that the DEPARTMENT performs in the Office of Strategic Health Policy and by Ombudsperson Services staff; and DEPARTMENT will provide an effective mechanism for resolving any issues of noncompliance.

Department of Employee Trust Funds	**Insurance Issuer**
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

State of Wisconsin
Department of Administration
DOA-6448 (R09/2004)

Substitute **W-9**

Division of Executive Budget and Finance
State Controller's Office

DO NOT send to IRS

Taxpayer Identification Number (TIN) Verification

Print or Type
Please see attachment or reverse for complete instructions.
This form can be made available in alternative formats to qualified individuals upon request.

Legal Name (as entered with IRS)
If Sole Proprietorship or LLC Single Owner, enter your Last, First, MI

Trade Name
Enter **Business Name** if different from above.

Remit Address (where check should be mailed)
PO Box or Number and Street, City, State, ZIP + 4

Order Address (where order should be mailed; complete only if different from remit)
PO Box or number and street, City, State, ZIP + 4

1099 Address (for return of 1099 form; complete only if different from remit)
PO Box or number and street, City, State, ZIP + 4

Entity Designation (check only one)
Required

- ☐ Individual/Sole Proprietor/LLC Single Owner
- ☐ Corporation (includes service corporations)
- ☐ Limited Liability Company - Partnership
- ☐ Limited Liability Company - Corporation
- ☐ Government Entity
- ☐ Hospital Exempt from Tax or Government Owned
- ☐ Long Term Care Facility Exempt from Tax or Government Owned
- ☐ All Other Entities

Taxpayer Identification Number (TIN)
If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you show the SSN.

___ ___ ___ ___ ___ ___ ___ ___ ___

Check Only One *Required* (see "Instructions")

- ☐ Social Security Number (SSN)
- ☐ Employer Identification Number (EIN)
- ☐ Individual Taxpayer Identification Number for U.S. Resident Aliens (ITIN)

Certification
Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, AND
2. I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to back up withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I am a U.S. person (including a US resident alien).

Printed Name	Printed Title	Telephone Number ( )
Signature		Date (mm/dd/ccyy)

For Agency Use Only

Agency Number	Contact	Phone Number
Change ☐ Name ☐ Address ☐ Other (explain)		

Return completed form via facsimile machine or to the address listed below.
For your convenience this form has been designed for return in a standard Window envelope.

Forms may be returned to:
Fax Number: ( )
Attn:

STATE OF WISCONSIN
DOA-3477 (R05/98)

Bid / Proposal # _____

Commodity / Service _____

VENDOR INFORMATION

1. BIDDING / PROPOSING COMPANY NAME _____
   FEIN _____

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

2. Name the person to contact for questions concerning this bid / proposal.
   Name _____ Title _____

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

3. Any vendor awarded over $25,000 on this contract must submit affirmative action information to the department. Please name the Personnel / Human Resource and Development or other person responsible for affirmative action in the company to contact about this plan.
   Name _____ Title _____

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

4. Mailing address to which state purchase orders are mailed and person the department may contact concerning orders and billings.
   Name _____ Title _____

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

5. CEO / President Name _____

This document can be made available in accessible formats to qualified individuals with disabilities.