**Appendix 1 - Administrative Services for the State of Wisconsin**

**Pharmacy Benefit Program**

**State of Wisconsin Pharmacy Benefit Program Agreement**

Revised March 5, 2024

**Issued by the State of Wisconsin**

**Department of Employee Trust Funds**

**On behalf of the Group Insurance Board**

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# 000 Definitions

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Pharmacy Benefits (of this AGREEMENT), the RFP #ETC0049, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

**AGREEMENT** means the State of Wisconsin Pharmacy Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the PHARMACY BENEFIT PROGRAM.

**ANNUITANT**

When not specified, ANNUITANT means all ANNUITANTS, including state and LOCAL.

**STATE ANNUITANT** means any retired EMPLOYEE of the State of Wisconsin: receiving animmediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under [Wis. Adm. Code § ETF 50.40](http://docs.legis.wisconsin.gov/code/admin_code/etf/50/III/40), a currently insured recipient of a disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/65); or a terminated EMPLOYEE with twenty (20) yearsof creditable service.

**LOCAL ANNUITANT** means:

1. Any currently insured retired EMPLOYEE of a participating EMPLOYER: receiving an immediate annuity under the Wisconsin Retirement System, or a long-term disability benefit under [Wis. Adm. Code § ETF 50.40](http://docs.legis.wisconsin.gov/code/admin_code/etf/50/III/40), or a disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/65), or a person with twenty (20) years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by the DEPARTMENT under [Wis. Stat. § 40.19 (4) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/19/4/a).
2. A retired public employee under [Wis. Stat. § 40.02 (25) (b) 11](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/b/11), who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/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)](http://docs.legis.wisconsin.gov/document/statutes/40.51(10)) to elect the Local Annuitant Health Program (LAHP).

**BENEFITS** means those items and services as listed in Uniform Pharmacy Benefits. A PARTICIPANT’S right to BENEFITS is subject to the terms, conditions, limitations and exclusions of the PHARMACY BENEFIT PLAN.

**BOARD** means the State of Wisconsin Group Insurance Board.

**BUSINESS DAY** means each calendar DAY except Saturday, Sunday, and official State of Wisconsin holidays (see also: DAY).

**CMS** means Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.

**COINSURANCE** means that portion of the charge for COVERED PRODUCTS, calculated as a percentage of the charge for such services, which is to be paid by PARTICIPANTS pursuant to the PHARMACY BENEFIT PLAN.

**CONTINUANT** means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in the PHARMACY BENEFIT PLAN.

**CONTRACT** means this document which includes all exhibits, attachments, supplements, endorsements or riders and the CONTRACTOR’S PROPOSAL.

**CONTRACTOR** means the legal signatory to this AGREEMENT.

**COPAYMENT** means a fixed dollar portion of the charge for COVERED PRODUCTS, which is to be paid by PARTICIPANTS pursuant to the PHARMACY BENEFIT PLAN.

**COVERED PRODUCTS** means those PRODUCTS that are covered under the PHARMACY BENEFIT PLAN. COVERED PRODUCTS may include, but are not limited to, brand or generic prescription medications, medications not requiring a prescription, and/or medical supplies and equipment.

**DAY** means Business DAY unless otherwise indicated.

**DEDUCTIBLE** means a predetermined amount of money that a PARTICIPANT must pay before benefits are eligible for payment.

**DEPARTMENT** means the State of Wisconsin Department of Employee Trust Funds.

**DEPENDENT** as defined in Uniform Pharmacy Benefits.

**DISPENSE AS WRITTEN or DAW** indicates the prescriber's instruction regarding substitution of generic equivalents, or an order to dispense the specific prescribed medication, based on the DAW code used:

|  |  |
| --- | --- |
| Code | Code value |
| 0 | No Product Selection Indicated/No Special Instructions |
| 1 | Substitution NOT Allowed by Prescriber |
| 2 | Substitution Allowed - Patient Requested That Brand Product Be Dispensed |
| 3 | Substitution Allowed - Pharmacist Selected Product Dispensed |
| 4 | Substitution Allowed - Generic Drug Not in Stock |
| 5 | Substitution Allowed - Brand Drug Dispensed as Generic |
| 6 | Override DAW Code |
| 7 | Substitution NOT Allowed - Brand Drug Mandated by Law |
| 8 | Substitution Allowed - Generic Drug Not Available in Marketplace |
| 9 | Other |

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

**EGWP or “800 SERIES” EGWP** means Employer Group Waiver Plan as defined by CMS.

**ELECTRONIC PRIOR AUTHORIZATION (ePA)** - allows prescribers to access and

submit prior authorizations at the time of prescribing through their electronic health record (eHR) systems.

**ELIGIBLE PRODUCT** means the brand name or generic PRODUCT that is included in the CONTRACTOR-recommended and BOARD-approved formulary and for which a PRODUCT manufacturer and CONTRACTOR have entered into a contractual REBATE agreement.

**EMPLOYEE**

When not specified, EMPLOYEE means all EMPLOYEES, including state and LOCAL.

**STATE EMPLOYEE** means an ELIGIBLE EMPLOYEE of the State of Wisconsin as defined under [Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., or 8](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25).

**LOCAL EMPLOYEE** means an ELIGIBLE EMPLOYEE as defined under [Wis. Stat. § 40.02 (46)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/46) or [40.19 (4) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/19/4/a), of an EMPLOYER as defined under [Wis. Stat. § 40.02 (28)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/28), other than the state, which has acted under [Wis. Stat. § 40.51 (7)](https://docs.legis.wisconsin.gov/statutes/statutes/40/IV/51/7), to make health care coverage available to its EMPLOYEES.

**EMPLOYER**

When not specified, EMPLOYER means all EMPLOYERS, including state and LOCAL.

**STATE EMPLOYER** means an eligible State of Wisconsin agency as defined in [Wis. Stat. § 40.02 (54)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/54).

**LOCAL EMPLOYER** means an employer who has acted under [Wis. Stat. § 40.51 (7)](https://docs.legis.wisconsin.gov/statutes/statutes/40/IV/51/7), to make health care coverage available to its EMPLOYEES.

**HEALTH BENEFIT PROGRAM** means the program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

**IDENTIFICATION CARDS or ID CARDS** means cards indicating eligibility of PARTICIPANTS, printed in the most current NCPDP (National Council for Prescription Drug Processing) version. These cards will be distributed upon initial enrollment, upon a change in the PHARMACY BENEFIT PLAN, or upon request of the PARTICIPANT.

**IT’S YOUR CHOICE OPEN ENROLLMENT or IYC** means the enrollment period referred to in the DEPARTMENT materials as the IYC enrollment period that is available at least annually to insured SUBSCRIBERS allowing them the opportunity to change health plans and/or coverage and also to eligible individuals to enroll for coverage in any health plan offered by the BOARD.

**LOCAL** means a Wisconsin Public Employer who has acted under [Wis. Stat. § 40.51 (7)](https://docs.legis.wisconsin.gov/statutes/statutes/40/IV/51/7), to participate in the HEALTH BENEFIT PROGRAM for its EMPLOYEES.

**MEDICARE ADVANTAGE** means a program defined under Title 18, Part C of the U.S. Social Security act of 1965, as amended.

**MEDICARE PART A** means the hospital insurance program defined under Title 18, Part A of the U.S. Social Security Act of 1965, as amended, and covers inpatient care.

**MEDICARE PART B** means the medical insurance program defined under Title 18, Part B of the U.S. Social Security Act of 1965, as amended, and covers outpatient care.

**ONLINE TRANSACTION PROCESSING** means the process of settling claims, from submission through final disposition, between two or more parties.

**PARTICIPANT** means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT for enrollment and are entitled to BENEFITS.

**PARTICIPATING PHARMACY** means a pharmacy or a company that is authorized to represent one or more subsidiary, affiliated, or franchised pharmacies, that has entered into a PARTICIPATING PHARMACY agreement with CONTRACTOR to provide COVERED PRODUCTS to PARTICIPANTS.

**PARTICIPATING PRESCRIBERS** means those prescribers who are authorized to prescribe medication to PARTICIPANTS under the PHARMACY BENEFIT PLAN.

**PBM** means Pharmacy Benefit Manager.

**PHARMACY BENEFIT PLAN** means the portion of the BOARD’s HEALTH BENEFIT PROGRAM that provides for the coverage of certain pharmacological and related COVERED PRODUCTS subject to certain COPAYMENTS, DEDUCTIBLES, or COINSURANCE requirements, limitations and exclusions as described in the Uniform Pharmacy Benefits.

**PREMIUM** means the rates shown in the IYC materials that includes the medical, pharmacy, and dental (when applicable) components, and administration fees required by the BOARD. Those rates may be revised by the BOARD annually, effective on each succeeding January 1 following the effective date of this AGREEMENT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

**PRIOR AUTHORIZATION** means a prospective review to verify that certain criteria approved by the DEPARTMENT are satisfied for specific PRODUCTS prior to processing the claim for such PRODUCTS.

**PRODUCTS** means brand or generic prescription medications, medications not requiring a prescription, and/or medical supplies and equipment.

**PROPOSAL** means the complete response of a proposer submitted and setting forth the proposer’s pricing for providing the services described in the Request for Proposal (RFP) #ETC0049.

**QUARTERLY** meansa period consisting ofevery consecutive three (3) months beginning January 2026.

**REBATE** means the total dollar amount paid by a PRODUCT manufacturer to CONTRACTOR for ELIGIBLE PRODUCT utilization. This includes any revenue offered by a PRODUCT manufacturer for administrative services.

**RxBENEFIT CHECK (**real-time pharmacy benefits)- an inquiry or trial adjudication providing up-to-minute info back to a provider through its eHR regarding a specific member’s pharmacy benefits, including applicable member monetary costs at the pharmacy for a particular drug, alternatives, and any applicable utilization management criteria.

**SECURE** means the confidentiality, integrity, and availability of the DEPARTMENT’S data is of the highest priority and must be protected at all times. All related hardware, software, firmware, protocols, methods, policies, procedures, standards, and guidelines that govern, store, or transport the data must be implemented in manners consistent with current industry standards, such as, but not limited to the Health Insurance Portability and Accountability Act (HIPAA), Genetic Information Nondiscrimination Act (GINA), National Institute of Standards and Technology (NIST) 800-53, and Center for Internet Security (CIS) Critical Security Controls to ensure the protection of all DEPARTMENT data.

**SPECIALTY DRUGS** means high-cost, large-molecule prescription medications used to treat complex and/or chronic conditions (e.g. cancer, rheumatoid arthritis, multiple sclerosis). These drugs often require special handling and administration.

**SUBSCRIBER** means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

**UNIFORM PHARMACY BENEFITS** mean the BENEFITS described in Section 400 that are

administered to PARTICIPANTS enrolled in the HEALTH BENEFIT PROGRAM.

**WRAP PLAN** means the benefits coverage made additionally available to PARTICIPANTS in the BOARD’s EGWP plan. This additional coverage supplements the Medicare Part D coverage and seeks to align PARTICIPANT coverage with the coverage experienced during employment.

# 

# 100 General

## 105 Introduction

This State of Wisconsin Pharmacy Benefit Program Agreement (“AGREEMENT”) is for the purposes of administering the PHARMACY BENEFIT PLAN. The PHARMACY BENEFIT PLAN is the umbrella term used to describe the portion of the HEALTH BENEFIT PROGRAM that provides pharmaceutical coverage for the State of Wisconsin Group Benefits Program and the Wisconsin Public Employers Group Benefits Program, herein referred to as “STATE” and “LOCAL”, respectively. The PHARMACY BENEFIT PLAN is administered for the Group Insurance Board (BOARD) by the State of Wisconsin Department of Employee Trust Funds (DEPARTMENT).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETC0049 and in the PROPOSAL.

By statute, the BOARD has the authority to negotiate the scope and content of the PHARMACY 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).

## 110 Objectives

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

1. Management and delivery of pharmacy benefits per the GUIDELINES as provided by the BOARD.
2. To provide excellent customer service to PARTICIPANTS.
3. To provide high-quality services at a competitive price.
4. To provide complete transparency in the contracting, purchasing, and provision of pharmacy benefits through this program as defined in the RFP #ETC0049 for PBM services.
5. Accurate, timely and responsive administration of pharmacy claims.
6. To assist the BOARD in achieving strategic goals that include:
   1. Managing total pharmacy costs.
   2. Supporting PARTICIPANTS by providing them with tools and resources needed to manage their drug utilization decisions and their overall health.
   3. Promoting behavior change and accountability.

## 115 General Requirements

The CONTRACTOR must meet the minimum requirements of [Wis. Stat. § 40.03 (6) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/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 health plans participating in the health insurance program, the BOARD’s consulting actuary, DEPARTMENT’S data warehouse, the wellness and disease management vendor, and the DEPARTMENT’s insurance administration 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 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.
8. Apply effective methods for containing costs for pharmacy BENEFITS with effective utilization review mechanisms for monitoring prescription drug related 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.
   1. This includes a formal grievance procedure, which at a minimum complies with [federal](http://docs.legis.wisconsin.gov/code/admin_code/ins/18/II/03) 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 PARTICIPANT 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.
   2. 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 compliance with the terms of this agreement if the PARTICIPANT is not satisfied with the CONTRACTOR’S action on the matter.
   3. 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.

1. Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in services provided by a non-PARTICIPATING PHARMACY.
2. 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.
3. Provide DEPARTMENT-approved materials to PARTICIPANTS as required under this AGREEMENT.
4. Provide notification of all significant events:
   1. The 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 (15%) percent or more of the CONTRACTOR’S program 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, or 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.
   2. In addition, any change in the ownership of or controlling interest in the CONTRACTOR, or any merger with another entity 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent 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.
   3. 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 PHARMACY Benefit PLAN and its PARTICIPANTS. The BOARD agrees to keep the information disclosed as required under paragraph (b) above, confidential under [Wis. Stat. § 19.36 (5)](http://docs.legis.wisconsin.gov/statutes/statutes/19/II/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 the BOARD to disclose the information or the DEPARTMENT or the 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:

* + 1. 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.
    2. The date such action becomes effective.
    3. Sixty (60) DAYS after the BOARD receives the information.
  1. The BOARD shall reserve the right to institute action as it deems necessary to protect the interests of the PARTICIPANTS of the PHARMACY BENEFIT PLAN as the result of a "significant event."

1. 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. Notwithstanding the foregoing, the DEPARMENT and CONTRACTOR will work together to minimize all processes where social security numbers are used in order to limit potential security risks, with the goal of removing the use of social security numbers entirely by Contractor, if practicable.
2. Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.
3. 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 PHARMACY benefits PLAN. Notwithstanding the foregoing, information provided by CONTRACTOR to the DEPARTMENT shall not be deemed to be legal advice provided to the DEPARTMENT or be deemed as intended to replace or over-rule any legal advice provided to the DEPARTMENT by the State of Wisconsin’s attorneys.
4. Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.
5. Comply with all applicable requirements and provisions of the [Americans with Disabilities Act (ADA) of 1990](https://www.ada.gov/pubs/ada.htm). Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.
6. The DEPARTMENT must be notified of any changes to the CONTRACTOR’S administrative and/or operative systems.

## 120 Board Authority

1. [Wis. Stat. § 40.03 (6) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/03), 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](https://docs.legis.wisconsin.gov/statutes/statutes/40/IV/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, the DEPARTMENT, or the BOARD’S consulting actuary, the BOARD may take any action up to and including limiting new enrollment into the PHARMACY BENEFIT PROGRAM 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 PARTICIPATING PHARMACIES, or if the BOARD so directs due to a significant event as described in [Section 115,](#_115_General_Requirements_1) the BOARD may do any of the following, including any combination of the following:
   1. Terminate the CONTRACT upon any notice it deems appropriate, including no notice.
   2. Close the PHARMACY BENEFIT PROGRAM administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.
   3. Take no action.
6. The BOARD may forfeit a SUBSCRIBER'S rights to the PHARMACY BENEFIT PLAN 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 PHARMACY BENEFITS PROGRAM.
8. The BOARD shall determine all policy for the PHARMACY BENEFIT PLAN. 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 PHARMACY BENEFIT PLAN 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)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/).
2. Elected state officials ([Wis. Stat. § 40.02 (25) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/) 2).
3. Members or EMPLOYEES of the legislature ([Wis. Stat. § 40.02 (25) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/) 2).
4. Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under [Wis. Stat. § 40.02 (25) (a) 3](http://docs.legis.wisconsin.gov/document/statutes/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)](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/a).
6. Any EMPLOYEE on layoff whose premiums are being paid from accumulated unused sick leave as described in [Wis. Stat. § 40.02 (40)](http://docs.legis.wisconsin.gov/document/statutes/40.05(4)(bm)).
7. The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority ([Wis. Stat. §40.02 (25) (b)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/b/)):
   1. 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.
   2. 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.
   3. Certain visiting faculty members in the UW System.
   4. 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.
   5. 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.
   6. 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 (28%) percent 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 (21%) percent 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.
   7. Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.
   8. 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)](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/b)), which includes the following:
   1. 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)](https://docs.legis.wisconsin.gov/statutes/statutes/40/II/25/1).
   2. The surviving spouse of a SUBSCRIBER.
   3. The surviving insured domestic partner of a SUBSCRIBER.
   4. 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 PHARMACY BENEFIT PLAN if a timely application is submitted.
   5. 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 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.
   6. Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.
   7. Any retired LOCAL EMPLOYEE under [Wis. Stat. § 40.02 (25) (b) 11](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/02/25/b/11), who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/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)](http://docs.legis.wisconsin.gov/document/statutes/40.51(10)) to elect the Local Annuitant Health Program (LAHP).
   8. Any LOCAL ANNUITANT receiving an annuity through a program administered by the DEPARTMENT under [Wis. Stat. § 40.19 (4) (a)](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/19/4/a).
   9. PARTICIPANTS who meet federal or state continuation provisions. See [Section 260](#_260_Continuation).
10. Disabled persons entitled to benefits under [Wis. Adm. Code § ETF 50.40](http://docs.legis.wisconsin.gov/code/admin_code/etf/50/III/40) or [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/65) include:
    1. 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](http://docs.legis.wisconsin.gov/code/admin_code/etf/50/III/40)  or a duty disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/65) is approved.
    2. 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](http://docs.legis.wisconsin.gov/code/admin_code/etf/50/III/40), or a duty disability benefit under [Wis. Stat. § 40.65](https://docs.legis.wisconsin.gov/statutes/statutes/40/V/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 PHARMACY BENEFIT PLAN.

### 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 PHARMACY BENEFIT PLAN (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 Medicare 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 Premiums

The BOARD determines the portion of the total PREMIUM for the HEALTH BENEFIT PROGRAM that applies to the PHARMACY BENEFIT PLAN. This PHARMACY BENEFIT PLAN portion of the PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD’S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1. Projection of incurred claims costs for the renewal benefit period.
2. The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.
3. Actual and projected weighted cost and utilization trends for the immediate-past, current and renewal benefit period, for both the PHARMACY BENEFIT PLAN and the CONTRACTOR’s book of business.
4. Actual and projected Medicare Part D subsidies, administrative fees and REBATE histories.
5. Updates regarding the pharmacy network contracting and discount negotiation efforts; drug manufacturer REBATE and pricing negotiation efforts; clinical programs; new drug indications and pipeline projections; and brand-to-generic savings.
6. Complete documentation of the methodology and assumptions utilized to develop the projected costs.
7. Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network pharmacy fee-structure analysis, pharmacy negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

The CONTRACTOR will work with the BOARD’S consulting actuary independently to agree on a format, and the frequency of providing this data.

1. 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 245 and 250.
2. 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.
3. 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.
4. Medicare Participant Premiums
5. 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 HOSPTIAL 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.
6. 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.
7. Except in cases of fraud which shall be subject to Section 150E, 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 Pharmacy Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide HEALTH BENEFIT PROGRAM contractor. 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.
8. 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 Pharmacy Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide HEALTH BENEFIT PROGRAM contractor. 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.

## 130 Administrative Fee and Financial Administration

### **130A** Financial Provisions

1. **Claims Invoicing**:
   1. The BOARD assumes all financial responsibility for claims submitted for PARTICIPANTS to the CONTRACTOR, whether by PARTICIPATING PHARMACIES or PARTICIPANTS. The DEPARTMENT shall initiate Automated Clearinghouse (“ACH”) transfers to the CONTRACTOR within four (4) business days of receipt of the CONTRACTOR’S invoices as authorized below for administrative fees and commercial line of business, and within three (3) business days for EGWP line of business.
   2. Billing and payment cycles for pharmacy claims and administrative fees will occur twice monthly. Billing and payment cycles for claims submitted directly by PARTICIPANTS will occur monthly. Billing and payment cycles may be modified if mutually agreed upon by the CONTRACTOR and the DEPARTMENT. The CONTRACTOR will electronically send invoices, in forms satisfactory to both parties, to the DEPARTMENT as follows:
      1. Pharmacy Claims Reimbursement. Cycle I: Encompasses prescription claims processed day one (1) through day fifteen (15). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle. Cycle II: Encompasses prescription claims processed day sixteen (16) through the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.
      2. Member Claims Reimbursements (manual claims received directly from PARTICIPANTS). Each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.
2. **Administrative and Other Fee Invoicing**:
   1. As payment in full for the services described in this CONTRACT (except as expressly set forth otherwise herein), the BOARD agrees to pay a per-member-per-month (PMPM) administrative fee that is multiplied by the number of active members in the claims processing system on the fifteenth (15th) of each month.
   2. Payments shall be made semi-monthly, based on the number of active members in the claims processing system on the 15th of the month.
      1. Administrative Fees. Cycle I: Encompasses administrative fees for services provided from day one (1) through day fifteen (15). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two business days after the end of the cycle. Cycle II: Encompasses administrative fees for services provided from sixteen (16) through the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.
      2. Other Fees. For any fees other than the administrative fees, each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.
   3. The PMPM administrative fee effective January 1, 2026, may be adjusted annually, during the initial term of the contract, as of January 1 of each year. Cost increases for any CONTRACT shall be negotiated in good faith and mutually agreed upon by both parties.
   4. **Medicare Part D Drug Program.** The CONTRACTOR shall administer a Medicare Part D Program for eligible PARTICIPANTS as described in Section 215C. Payment in full by the BOARD for Medicare Part D related services will be a PMPM administrative fee that is multiplied by the number of Medicare Part D active members in the claims processing system on the fifteenth (15th) of each month.
   5. In the event the BOARD determines that additional services, not originally contemplated in this CONTRACT, are necessary to realize the purposes or in the best interests of the individuals covered by the pharmacy benefit, the DEPARTMENT may first approach the CONTRACTOR about providing those services. If the parties both agree, the DEPARTMENT and the CONTRACTOR shall negotiate in good faith in an attempt to establish fair and reasonable additional compensation for the CONTRACTOR to perform the additional services. If unable to reach an agreement, the DEPARTMENT may seek the services elsewhere.

f) e-Prescribing for commercial line of business

Up to $0.145 fee per eligibility transaction (transaction fees subject to change).

Notwithstanding the foregoing, if Contractor’s provider of e-prescribing services,

increases the amount that it charges Contractor for e-prescribing provided to Eligible Persons under this Agreement, then Contractor may increase the amount that it charges Department for e-Prescribing hereunder by the amount of such increase, provided Contractor gives Department prior written notice of any such price increase.

g)Electronic Prior Authorization (ePA) pass through of vendor transaction costs.

h) RxBenefit Check pass through of vendor transaction costs.

1. **REBATE Calculation and Payment.** The DEPARTMENT will receive 100% of all earned REBATES, including future REBATES on new, REBATE--ELIGIBLE PRODUCTS such as SPECIALTY DRUGS.
   1. The DEPARTMENT shall have the right, at its expense, at reasonable times and upon reasonable notice, to review and audit the books and records of the CONTRACTOR pertaining to such REBATES; provided, however, that the CONTRACTOR shall not be obligated to disclose any documents or information that would cause the CONTRACTOR to violate any laws, any contractual obligations of confidentiality, or other legally binding obligations.
   2. The DEPARTMENT will receive REBATE payments on at least a QUARTERLY basis. The CONTRACTOR will provide additional rebate reports as necessary.

**c)** Group Purchasing Organization (GPO). Contractor implemented a GPO for the

Department’s commercial members on October 1, 2021 and will begin for Medicare Advantage employer group waiver plans (EGWP) members on January 1, 2022. Contractor’s GPO rebate calculation and payments to the Department will extend through the term of this Contract, December 31, 2024. Contractor will hold a limited number of direct contracts with pharmaceutical manufacturers. The majority of contracts with pharmaceutical manufacturers will be held through the GPO that Contractor is a member of. Contractor will perform an annual audit and include Department and its claims as part of that audit. Department will be able to audit Contractor’s rebate information allowing Department to confirm that: i) 100% of all rebates, manufacturer administration fees, and price protection were fully passed through to Department, ii) Rebates were invoiced and paid correctly, and iii) Rebate metric guarantees, if any, were met and calculated per the terms of this Agreement. Contractor will cooperate in good faith to obtain information from the GPO to the extent practicable under Contractor contract terms with the GPO. $0.40 PMPM will be collected as a Rebate administration fee from the Rebates collected before being passed back to Department.

1. **Pass Through of Drug Manufacturer Revenue.** The DEPARTMENT will receive 100% of all drug manufacturer revenue obtained by the CONTRACTOR, including, but not limited to, administrative fees; data fees; clinical programs fees; education and research grants; invoice charge-back fees; and product selection switching incentives.
   1. The DEPARTMENT shall have the right, at its expense, at reasonable times and upon reasonable notice, to review and audit the books and records of the CONTRACTOR pertaining to such revenue.
   2. The DEPARTMENT will receive drug manufacturer revenue payments on at least a QUARTERLY basis. The CONTRACTOR will provide additional revenue payment reports as necessary.
2. **Contractor Maximum Allowable Cost List.** The CONTRACTOR maintains a single Maximum Allowable Cost (“MAC”) list for generic drug PRODUCTS that is the basis for payment of multi-source PRODUCTS from all distribution channels, including but not limited to retail, mail and specialty pharmacies. The unit cost of products on the MAC is solely determined by CONTRACTOR and updated at least quarterly based upon review and analysis of current pricing in the marketplace. In addition, MAC prices may be increased or decreased as needed to account for sudden fluctuations in pharmacy acquisition costs and MAC prices for new generic entities may be established prior to the QUARTERLY updates. The MAC list will be the same for each distribution channel (i.e. Retail, Retail 90 day, Mail Order, Specialty) and the basis for generic DRUG reimbursement at PARTICIPATING PHARMACIES.
3. **Banking:**

* 1. The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT within four (4) business days following the DEPARTMENT’S receipt of the request for payment by the CONTRACTOR or three (3) days for EGWP services as set forth above. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.
  2. The CONTRACTOR shall perform a monthly bank reconciliation and provide a reconciliation report to the DEPARTMENT within twenty (20) BUSINESS DAYS following each month’s end.
  3. The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT’S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred, and by STATE and LOCAL subgroups.
  4. No such amounts that are rightfully transferred to the CONTRACTOR shall be considered PHARMACY BENEFIT PROGRAM assets. Amounts incorrectly transferred to the CONTRACTOR by the DEPARTMENT on behalf of the BOARD remain assets of the Public Employee Trust Fund for which the BOARD is trustee.

### 130B Prohibited Fees

1. The CONTRACTOR is prohibited from including in their administrative fee the cost to handle any claims paid outside of Uniform Pharmacy Benefits or IYC Medicare Plus benefits unless expressly authorized by the DEPARTMENT.
2. The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.
3. The payments to the CONTRACTOR under the terms of the CONTRACT do not include compensation for providing the following services:
   * 1. *On-site personnel*. At the DEPARTMENT’s request, the CONTRACTOR shall provide on-site support and administrative services by providing personnel to work at the DEPARTMENT offices to perform tasks associated with the administration of the contract.
     2. *Expert services*. At the request of the BOARD, the CONTRACTOR shall make available to the DEPARTMENT 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.
     3. *Mailing & Postage*. The CONTRACTOR will pay for all mailing, postage and handling costs for the distribution of materials as required by 135 Participant Materials and Marketing, Section 135 Participant Materials and Marketing, or by other express provisions of this CONTRACT.
     4. *Pilot Clinical Services*. Any clinical services entered into as a pilot or limited-term trial shall be paid for by the CONTRACTOR.

### 130C Recovery of Overpayments

1. Overpayments:
2. If it is determined that any payment has been made under the PHARMACY BENEFIT PLAN and this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.
3. If any overpayments made for benefits for ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments.
4. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR’S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments.
5. Any overpayment caused by the CONTRACTOR’S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.
6. The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR’S determination that such overpayment is uncollectible after using such recovery and collection procedures.
7. The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.
8. The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.
9. The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.
10. Disputes Over Payments to a PARTICIPATING PHARMACY:

Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay a PARTICIPATING PHARMACY as determined by the provisions of the agreement between the CONTRACTOR and PARTICIPATING PHARMACY. Disputes as to payment will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the PARTICIPATING PHARMACY in a reasonable time frame. The CONTRACTOR shall inform the DEPARTMENT as soon as is reasonably possible of any such disputes.

If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

### 130D Automated Clearinghouse (ACH)

The CONTRACTOR shall support an ACH mechanism to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

## 135 Participant Materials and Marketing

### 135A 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 PHARMACY BENEFIT PLAN. 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.

CONTRACTOR must follow the guidance issued in [Section 1557](https://www.federalregister.gov/articles/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov) of the Affordable Care Act (ACA) and Federal civil rights laws. Upon request, the CONTRACTOR 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](https://www.federalregister.gov/articles/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov) 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 and Wisconsin Public Employers Group Health Insurance Programs. 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:

1. Documents intended for the public, such as outreach, education, and marketing materials;
2. Written notices requiring a response from an individual; and,
3. 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 CONTRACTOR*] 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 CONTRACTOR*] 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 Ave SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 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 IYC materials, the CONTRACTOR is required to use the [top fifteen (15) language list](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf) provided on the Centers for Medicare and Medicaid Services’ [website](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf). The CONTRACTOR shall use the [translations](http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html) of the above-referenced tagline as provided by the federal Department of Health and Human Services.

1. 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.
2. 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.
3. The DEPARTMENT reserves the right to require the CONTRACTOR to provide notification to PARTICIPANTS as directed.

a) If the DEPARTMENT requests that the CONTRACTOR provide any notifications, which are of a type and level that are different from those provided previously by CONTRACTOR and which would result in increased costs to the CONTRACTOR of $50,000 or more, then the parties will negotiate in good faith regarding the terms and conditions under which CONTRACTOR will provide such notifications, and CONTRACTOR will not be obligated to provide such notifications until the parties have agreed on such terms.

b) Increased costs mentioned above do not include prohibited fees as set forth in Section130B

### 135B It’s Your Choice Open Enrollment Materials

The 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 PARTICIPATING PHARMACIES 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 PHARMACY BENEFIT PLAN 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:
   1. CONTRACTOR information, including address, toll-free customer service telephone number, and website address.
   2. CONTRACTOR’s content for the pharmacy benefit related information page, including available features.
   3. Information for PARTICIPANTS to access the CONTRACTOR’s pharmacy network directory on its web site, including a link to the pharmacy network 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 to the DEPARTMENT at least two (2) weeks prior to the start of the IT’S YOUR CHOICE OPEN ENROLLMENT period.

### 135C Required Member and Prescriber Outreach

When making any changes to the formulary, the CONTRACTOR will be required to send notification a minimum 90 days prior to the change to all PARTICIPANTS who are currently prescribed drugs affected by the change. The notification should include the drug affected, the tier/cost-share level of the drug prior to change, the tier/cost-share level of the drug after change, contact information for the CONTRACTOR’s customer service, and information on members’ rights to appeal. This does not preclude the CONTRACTOR from implementing the formulary change immediately for PARTICIPANTS who have a new prescription written for the affected drug.

The CONTRACTOR will also be required to update formulary information on PRESCRIBERS and PARTICIPATING PHARMACIES portal as part of the CONTRACTOR’s standard formulary notification process. In addition, CONTRACTOR will be required to send notification of any negative formulary updates directly to frequent PRESCRIBERS. Portal updates and direct notification to frequent PRESCRIBERS should be made no less than 90 days prior to the change in formulary.

## 140 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 their 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. All ETF related data in the claims processing system (including eligibility) that is at rest must be encrypted. The CONTRACTOR must have a password policy with a complex password scheme, which, at a minimum, meet these criteria:
   1. A minimum of eight (8) characters,
   2. Does not use the user’s name or user ID in the password,
   3. Requires users to change passwords at least every sixty (60) DAYS,
   4. Does not repeat any of the last twenty-four (24) passwords used, and
   5. The password must contain at least three (3) of these four (4) data types:
      1. Upper case alphabetic letters (A - Z),
      2. Lower case alphabetic letters (a - z),
      3. Numeric (0 - 9),
      4. 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 subcontractors must agree to and abide by all the network and data security requirements.

1. 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.
2. 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.
3. 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.
4. 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 PHARMACY BENEFIT PLAN 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. This does not apply to any program fixes, modifications and enhancements.

## 145 Data Requirements

### 145A Data Integration and Technical Requirements

The DEPARTMENT is currently in the process of consolidating multiple legacy information technology systems to a single Insurance Administration System (IAS). This new IAS 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 deployment of IAS is currently scheduled for 2025.

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.

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

### 145B Eligibility/834 File Requirements

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 as issued by the DEPARTMENT.

1. 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.
2. 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.
3. 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.
4. 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.
5. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY.

### 145C Data Warehouse File Requirements

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:

* 1. Pharmacy Claims Data - The CONTRACTOR must submit on a monthly basis, or other frequency agreed upon by the CONTRACTOR and the DEPARMENT, to the DEPARTMENT’S data warehouse in the file format specified by the DEPARTMENT in the most recent Pharmacy Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent 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 (100%) percent 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.
  2. PARTICIPATING PHARMACY Data – The CONTRACTOR must submit on a monthly basis, or other frequency agreed upon by the CONTRACTOR and the DEPARTMENT, to the DEPARTMENT’S data warehouse, in the file format specified by the DEPARTMENT in the most recent Network Pharmacy Data Specifications document, the current list, as of the periodic file creation of PARTICIPATING PHARMACIES available to CONTRACTOR in the network(s) employed by CONTRACTOR. The electronic information includes pharmacy demographic information and any industry standard identifiers. 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.
  3. Medical Claims Data – The CONTRACTOR must establish a data transfer process to retrieve medical claims data from the DEPARTMENT’S data warehouse for its PARTICIPANTS and integrate the data as required later in this section. The medical claims data is based on data provided by the DEPARTMENT’s contracted, participating health coverage plans 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 participating health coverage plans that will be in a file format compliant with the most recent Claims Data Specifications provided by the DEPARTMENT with consultation with the participating health coverage plans.
  4. 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 as provided by the DEPARTMENT.
  5. 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.
  6. 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 HEALTH BENEFIT PROGRAM contractors to ensure the accumulator amounts are in sync.

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

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

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

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.

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.

### 145D Data Integration and Use

The CONTRACTOR shall provide and receive all reasonable requests for data and other information as needed in a file format as identified by the DEPARTMENT. The CONTRACTOR will place no restraints on the use of the data; provided that the DEPARTMENT shall not disclose to third parties any data received from CONTRACTOR that constitutes a trade secret as defined under Wisconsin law.

The CONTRACTOR will provide the DEPARTMENT with an electronic file in the DEPARTMENT-specified standard format of all paid, denied, rejected, and duplicate claims for the BOARD’s PRESCRIPTION DRUG PLAN on a daily basis for the purposes of integration into the DEPARTMENT’s data warehouse. Such data also be provided from time to time, at the request of the DEPARTMENT, to a DEPARTMENT designee for purposes of assisting in the implementation and management of disease management programs or other programs desired by the BOARD.

The CONTRACTOR shall submit all prescription drug claims (except Medicaid) data to WHIO for the CONTRACTOR’S commercial and Medicare lives residing in Wisconsin at a minimum. Claims shall be submitted to WHIO in a manner compliant with WHIO requirements.

The CONTRACTOR agrees to assign ID numbers according to the system established by the DEPARTMENT. Social security numbers shall be incorporated into the PARTICIPANT'S data file and may be used for identification purposes only and not disclosed and used for any other purpose, unless the parties have agreed upon a different identification system.

### 145E 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 PARTICIPANTS 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;
    2. Data on other financial transactions associated with claim payments, including charged amount, allowed amount, per-claim rebates, discounts, and charges to members as co-payments, coinsurance, and deductibles;
    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. A unique person/member identified is required on all data files and the identifier must match the person identifier on the DEPARTMENT’S eligibility file. 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 DEPARMTENT’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, which are assessed by the DEPARTMENT’S data warehouse vendor on behalf of the DEPARTMENT and which are the direct result of the CONTRACTOR’S failure to meet the DEPARTMENT’S data submission requirements or timelines, and which the DEPARTMENT will invoice the 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) Calendar Days, the Department may collect owed fund by deducting the amounts from any payments owed to the CONTRACTOR, and the Contractor may be subject to further penalties.

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 DEPARTMENT 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 (1) BUSINESS DAYS before the next data file submission deadline.

The penalties assessed in Section 145E apply to the penalty maximum described in Section 315.

## 150 Miscellaneous General Requirements

### 150A Reporting Requirements and Deliverables:

1. The CONTRACTOR will provide the DEPARTMENT with standard management reports as determined by the DEPARTMENT.

Non-standard reports may be requested by the BOARD as may be agreed to from time to time by the BOARD and the CONTRACTOR. The BOARD will review all reports and statements provided by the CONTRACTOR and will notify the CONTRACTOR in writing of any errors or objections known to the BOARD. These reports shall cover both the commercial and Medicare populations of the PHARMACY BENEFIT PLAN.

1. Each report submitted by the CONTRACTOR to the DEPARTMENT must:
   1. Be verified by the CONTRACTOR for accuracy and completeness prior to submission,
   2. Be delivered on or before scheduled due dates,
   3. Be submitted as directed by the DEPARTMENT,
   4. Fully disclose all required information in a manner that is responsive and with no material omission, and
   5. Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report, if applicable.
2. 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.
3. The CONTRACTOR must notify the DEPARTMENT regarding any significant changes in its ability to collect information relative to required data or reports.
4. The CONTRACTOR will present to the DEPARTMENT semi-annually on the overall status of the PHARMACY BENEFIT PLAN to include reviews of drug utilization (SPECIALTY DRUGS and non-specialty drugs); formulary, network and clinical program management; historical and prospective trends; drug pipeline forecasting; and PHARMACY BENEFIT PLAN opportunities. Information and data will be presented for both the commercial and Medicare populations of the PHARMACY BENEFIT PLAN.
5. The CONTRACTOR must fully support the BOARD and the DEPARTMENT in responding timely to informational requests made by the Legislature.
6. The CONTRACTOR shall promptly respond to all inquiries from the BOARD and the DEPARTMENT concerning any aspect of the PHARMACY BENEFIT PLAN management.
7. The CONTRACTOR shall work cooperatively with BOARD designees on budget and policy implementation.

### 150B Performance Standards and Penalties

1. The CONTRACTOR must guarantee performance sufficient to fulfill the needs of the CONTRACT. The CONTRACTOR must meet all performance standards listed in [Section 315](#_315_Performance_Standards). After the CONTRACT start date, if additional resources are needed, the CONTRACTOR will bear all costs necessary to satisfy the requirements of the CONTRACT.
2. Written notification of each failure to meet a performance standard that is listed in [Section 315](#_315_Performance_Standards) 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.
3. 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.
4. The DEPARTMENT shall be the sole determinant as to whether or not the CONTRACTOR meets a performance standard.

### 150C Nondiscrimination Testing

The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete [Internal Revenue Code (IRC) Sec. 105(h)](https://www.law.cornell.edu/uscode/text/26/105) compliant nondiscrimination testing for the DEPARTMENT. 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.

### 150D Audit and Other Services

1. **Records**. The CONTRACTOR shall maintain books, records, documents and other evidence pertaining to the administrative services under this CONTRACT to the extent and in such detail as shall properly reflect all performance of the CONTRACTOR’s duties herein and in accordance with full transparency as defined in the RFP #ETC0049.
2. **Cooperation with Auditors**. The CONTRACTOR will, in conjunction with BOARD-designated personnel, participate in and cooperate fully with audits of the CONTRACTOR’s services under this CONTRACT as required under Federal or State law, and with other audits or reviews of the CONTRACTOR’s services under this CONTRACT determined by the BOARD to be necessary and appropriate. This may include an audit on behalf of the Wisconsin State Legislature by the Legislative Audit Bureau (LAB). The LAB conducts periodic and other audits at the request of legislators.
3. **Annual Audits.**
   * 1. The CONTRACTOR is required to submit to annual audits of its services, operations, and compliance under this CONTRACT according to audit guidelines established by the BOARD and in accordance with full transparency as defined in the RFP #ETC0049. The audits will be completed by the firm contracted by the BOARD to complete third party contract audits of the PHARMACY BENEFIT PLAN, and will be paid for by the BOARD. The audits by the third party contractor will be based upon BOARD specifications and will evaluate 100% of the claims processed by the CONTRACTOR. The audit firm will deliver to both the CONTRACTOR and to the BOARD a report of findings and recommendations within the guidelines established by the BOARD.
     2. The report will be prepared in accordance with generally accepted auditing standards, and will include the following matters and other matters as agreed by the BOARD and the CONTRACTOR: comprehensive compliance audit of the program; evaluation of internal control; risk assessment of the administration of the program; analyses of data, billing, etc. to ascertain compliance with CONTRACT provisions and accepted accounting principles, good business practice, etc.; and substantive tests to evaluate the accuracy of recording and processing transactions and the effectiveness, efficiency, and economy of transaction processing.
     3. The audits by the third party contractor of the BOARD will also audit the flow and proper use of the BOARD’s funds through the CONTRACTOR’s claims processing system; review the content of, and audit cash flows pertaining to all contracts between the CONTRACTOR and pharmaceutical manufacturers, including payments of REBATES from those manufacturers to the CONTRACTOR; and review the content of, and audit cash flows pertaining to all contracts between the CONTRACTOR and PARTICIPATING PHARMACIES.
     4. 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) 16 and provide a copy of the CPA’s report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.
4. **Internal Controls Review.** The CONTRACTOR will cooperate with an independent third-party auditor’s study and evaluation of and testing of the effectiveness of the internal controls over its contract tasks at least once per year. The study evaluation shall be at the BOARD’s expense.

### 150E Fraud and Abuse

1. **Participant Fraud**
   1. 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 PHARMACY BENEFITS PLAN 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.

* 1. 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. For information see Section[130C Recovery of Overpayments](#G130C).

1. **Pharmacy and Prescriber 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 findings that could be included in QUARTERLY reviews include, but are not limited to:

* 1. Controlled Substance Prescribing: Identification of PARICIPANTS who have received multiple prescriptions in drug categories with high potential for abuse (e.g. opioids, benzodiazepines, barbiturates, amphetamines, etc.) from more than one provider and filled at more than one pharmacy.
  2. Duplicate Therapy: Identification of PARTICI[ANTS who are prescribed multiple drug regimens of related medications for more than one condition, by more than one provider;
  3. Evidence of claims testing, excessive claim rejections and/or overcharge for cost of drug or PARTICIPANT cost-share amount by a PARTICIPATING PHARMACY.
  4. Indications of a PARTICIPANT with multi-prescriber, multi-pharmacy and/or multi–prescription instances.

1. **Appeal Process Support**.
   1. The CONTRACTOR shall participate in all administrative hearings under Wis. Admin. Code Ch. ETF 11 to the extent determined to be necessary by the attorney(s) representing the DEPARTMENT.
   2. Participation means providing evidence and testimony necessary to explain the claim decisions made by the CONTRACTOR. The CONTRACTOR shall be responsible for any cost required for participation in the administrative hearings by the CONTRACTOR’S staff and any approved subcontractors, including but not limited to time spent at the hearing and travel time to and from the hearing.

### 150F 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. In addition to (and in accordance with) the provisions of section 24 of the Department Terms and Conditions, the CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within forty-eight (48) hours of discovering that the protected health information (PHI) and/or personally 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](http://docs.legis.wisconsin.gov/statutes/statutes/134/98), HIPAA, and GINA. The CONTRACTOR must provide the DEPARTMENT with the information required in Section 24.0(m) of the Department Terms and Conditions related to all such suspected or actual breaches.

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. At a minimum, the CONTRACTOR shall report to the DEPARTMENT the following:

1. A description of the incident(s).
2. The identified root cause(s).
3. The actual or estimated number of PARTICIPANTS impacted.

1. The actual impact list (as soon as known).
2. A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).
3. 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.

FIRST NOTICE: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer no less than two (2) BUSINESS DAYS before any CONTRACTOR releases any external communications regarding a data breach. See Section 24.0(m)(1) of the Department Terms and Conditions.

PRIVACY VIOLATION: The CONTRACTOR shall use or disclose PARTICIPANT PHI and/or PII only to perform functions, activities or provide the SERVICES specified in the CONTRACT, for or on behalf of the DEPARTMENT, provided that such use or disclosure would not violate state and federal law, including, where applicable, the requirements of the HIPAA, HITECH, or GINA. See Section 24.0 of the Department Terms and Conditions and Wis. Stat. §134.98.

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### 150G 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.

### 150H Contract Termination

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

1. If the BOARD terminates this CONTRACT, then all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination.
2. In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.
3. Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.
4. The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT’S approval.

### 150I Transition Plan

During the implementation period, 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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR’S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year of the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT’S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT’S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1. Participate in all DEPARTMENT requested meetings.
2. Provide all reports for program close out.
3. Report on performance standards specified in [Section 315](#_315_Performance_Standards).
4. Invoice the DEPARTMENT as specified in [Section 130A](#_130A_Financial_Provisions).
5. Transmit program data to the new vendor.
6. Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.
7. Transmit run-out claims data to the DEPARTMENT’S data warehouse as specified in [Section 150](#_150_Data_Integration).

# 200 Program Requirements

## 205 Enrollment

CONTRACTORS must participate in the annual IT’S YOUR CHOICE OPEN ENROLLMENT offering. The IT’S YOUR CHOICE OPEN ENROLLMENT period is scheduled for each fall prior to the covered program year. During the IT’S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR will accept any eligible EMPLOYEE or state retiree under [Wis. Stat. § 40.51 (16)](https://docs.legis.wisconsin.gov/statutes/statutes/40/IV/51/16) who enrolls.

Although the DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR shall maintain an enrollment/eligibility system to support the PHARMACY BENEFIT PLAN.

### 205A Enrollment Files

The daily and full file compare of the DEPARTMENT’S HIPAA 834 enrollment files must be fully tested and are ready for program operation no later than forty-five (45) calendar DAYS prior to the effective (i.e., “go-live”) date. Also see Section 145 Data Requirements

The CONTRACTOR shall cooperate with the DEPARTMENT to accommodate the DEPARTMENT’S benefit administration system (BAS) IT upgrade, which the DEPARTMENT anticipates would impact this program starting in year 2018. The BAS system will be the system of record for participant demographic and benefit information, and the upgrade may impact the formatting or data fields required for transmitting enrollment files and may also affect the way in which enrollment is communicated to the CONTRACTOR.

### 205B Identification (ID) Cards

The CONTRACTOR must provide PARTICIPANTS with ID which will list at minimum the SUBSCRIBER, each DEPENDENT of the SUBSCRIBER, and the SUBSCRIBER’s member identification number. The CONTRACTOR must issue new ID CARDS upon enrollment and BENEFIT changes that impact the information printed on the ID CARDS.

The CONTRACTOR shall issue the ID CARDS, along with a welcome packet for newly enrolled PARTICIPANTS, within the timeframes described below:

1. The CONTRACTOR shall issue ID CARDS within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 2) below.
2. For elections made during the IT’S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID CARDS by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT’S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID CARDS. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID CARDS were issued.

The CONTRACTOR must provide replacement cards upon request at no cost to the PARTICIPANT, including an expedited process to get a replacement card.

### 205C Participant Information

The CONTRACTOR must provide the following information, at a minimum, to PARTICIPANTS upon enrollment:

1. Information about PARTICIPANT requirements, including PRIOR AUTHORIZATIONS and appeals/grievance procedures.
2. An “Overview of Benefits” brochure that will include a description of how the formulary is developed, information about the web site, and a description of PHARMACY BENEFIT PLAN features.
3. A mail-order brochure.
4. The CONTRACTOR’S contact information, including the toll-free customer service phone number, business hours, and website address.

### 205D Termination of Coverage

The CONTRACTOR shall relay to the DEPARTMENT in a timely manner any information received from PARTICIPANTs regarding the PARTICIPANT’s request for termination of coverage.

### 205E Date of Death

The CONTRACTOR shall relay any information received regarding a PARTICIPANT’S death to the DEPARTMENT in a timely manner.

### 205F Coordination of Benefits (COB)

In the event the CONTRACTOR learns of a PARTICIPANT having other prescription drug coverage that may require COB, the CONTRACTOR shall collect any COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT in a timely manner. The CONTRACTOR will conduct ONLINE TRANSACTION PROCESSING of COVERED PRODUCTS for PARTICIPANTS that have one secondary insurance. The CONTRACTOR will report this information to the BOARD at least annually.

## 210 Pharmacy Benefit Management

The CONTRACTOR shall be responsible for ONLINE TRANSACTION PROCESSING of claims for COVERED PRODUCTS submitted by PARTICIPATING PHARMACIES, according to the benefit plan coverage parameters provided under Uniform Pharmacy Benefits. PARTICIPANT file information will be supplied by the BOARD. Such ONLINE TRANSACTION PROCESSING shall include eligibility and coverage determination, calculation of allowable costs and applicable DEDUCTIBLES, COINSURANCE or COPAYMENTS, and communication of payment disposition to PARTICIPATING PHARMACIES, and shall be subject to the terms and conditions of this CONTRACT, including but not limited to the procedures set forth in Section 230 Claims. In addition to administering pharmacy claims, the CONTRACTOR, with the consent of the BOARD, shall establish the collateral procedures and services necessary to provide PHARMACY BENEFITS under the BOARD’s PHARMACY BENEFIT PLAN in accord with the PROPOSAL and this CONTRACT, including enrollment and eligibility systems, according to Health Insurance PBM ANSI 834 Project Documents.

### 210A Pharmacy & Therapeutics Committee and Population Health Management

The CONTRACTOR shall collaborate and support activities related to population health management as directed by the BOARD.

The CONTRACTOR shall have utilization management processes that are evidence-based and focus on quality, positive PARTICIPANT outcomes, and cost savings. The CONTRACTOR shall use these processes for evidence-based policy development for coverage of new technologies and to provide input to the DEPARTMENT on benefit design changes, as appropriate. The CONTRACTOR shall provide these policies to PARTICIPANTS upon request.

Pharmacy & Therapeutics (P&T) Committee. The CONTRACTOR will create an independent P&T Committee to evaluate the safety, efficacy, and uniqueness of a PRODUCT to determine whether that PRODUCT should be included on the formulary. The DEPARTMENT will appoint at least one member who will serve on the P&T Committee. The DEPARTMENT, on behalf of the BOARD, will consider the recommendations of the P&T Committee to assist in making formulary or other coverage determinations, requests or recommendations. The DEPARTMENT agrees that the formulary recommended by the CONTRACTOR and approved by the DEPARTMENT, on behalf of the BOARD will be the only formulary in place during the term of this CONTRACT, and that changes to the formulary will be recommended by the P&T Committee and approved by the DEPARTMENT, on behalf of the BOARD.

Prior Authorization

For a select group of PRODUCTS, as identified by the CONTRACTOR or the DEPARTMENT, CONTRACTOR personnel will implement PRIOR AUTHORIZATION procedures to assist prescribers and PARTICIPANTS in obtaining coverage for otherwise non-covered PRODUCTS. The CONTRACTOR will provide the DEPARTMENT with the CONTRACTOR’s previously established PRIOR AUTHORIZATION procedures and will work with the DEPARTMENT to expand or modify previously established PRIOR AUTHORIZATION procedures as recommended by the DEPARTMENT.

The CONTRACTOR will accept PRIOR AUTHORIZATION requests from prescribers or PARTICIPANTS (EGWP only) and will approve or deny such requests in accordance with the approved process. The CONTRACTOR will notify the prescriber and/or the PARTICIPANT who submitted the PRIOR AUTHORIZATION request of the coverage determination for such request. Approvals will be entered into the CONTRACTOR claim adjudication system. PRIOR AUTHORIZATION approval and denial reports shall be furnished to the DEPARTMENT upon request.

Step Therapy Protocols

The CONTRACTOR may provide a step therapy program, pursuant to which limitations on drug coverage may be established for categories of drugs that are not otherwise covered by or included in the plan. Such coverage limitations are defined and established based upon agreement between the CONTRACTOR and the DEPARTMENT, on behalf of the BOARD. Claims for these drugs will be rejected if the coverage requirements established by applicable step therapy protocols are not satisfied.

Step therapy will involve an automated PRIOR AUTHORIZATION process developed by the CONTRACTOR and implemented upon agreement with the DEPARTMENT regarding certain drugs and drug classes. For selected PRODUCTS, the claims system will search the claims history to determine if step-therapy criteria for coverage have been met.

The BOARD acknowledges that the step therapy program is an automated, non-discretionary processing technique intended to provide better management of the BOARD’s PRESCRIPTION DRUG PLAN based on objective criteria agreed to with the DEPARTMENT, on behalf of the BOARD. The CONTRACTOR shall not undertake, and is not required, to determine medical necessity or appropriateness of therapy determinations, to make diagnoses, or to substitute the CONTRACTOR’s judgment for the professional judgment and responsibility of the prescribing physician.

The CONTRACTOR is required to implement and report on DEPARTMENT programs designed to manage cost. Programs are subject to change, as determined by the DEPARTMENT, to better serve the needs of the PHARMACY BENEFIT PLAN PARTICIPANTS.

The current DEPARTMENT programs are:

1. Access to Mail Order Services. The CONTRACTOR shall establish a fair and competitive process to identify, evaluate, and contract with a single vendor of mail order pharmacy services while this CONTRACT is in effect. The process and choice of vendor are subject to approval by the DEPARTMENT, on behalf of the BOARD.
   1. Distribution of Information. The contract with the mail order pharmacy vendor shall provide that a member may begin the mail order process with the chosen vendor by phone, online, or by filling out a mail order brochure. In addition, refills can be ordered online. The vendor will provide to PARTICIPANTS, on request, informational material explaining its services and the forms necessary for PARTICIPANTS to utilize the mail service.
   2. Delivery and Dispensing. Subject to, and in accordance with plan design, the CONTRACTOR’s Mail Order pharmacy will dispense new or refill prescription orders upon receipt from a PARTICIPANT of (i) a valid prescription order or a completed refill order form; and (ii) the applicable COPAYMENT, COINSURANCE, or DEDUCTIBLE amount. The CONTRACTOR’s Mail Order pharmacy will fill and mail to each PARTICIPANT via common carrier at the address set forth in the eligibility file, or as appearing on the face of the prescription, so long as such addresses are within the United States.
   3. The CONTRACTOR’S Mail Order pharmacy shall be subject to all provisions of this CONTRACT that apply to all other PARTICIPATING PHARMACIES.
2. Specialty Drug Management Program. The CONTRACTOR shall make available to the BOARD a SPECIALTY DRUG management program through the vendor or vendors chosen by the CONTRACTOR and in agreement with the BOARD to provide that service. After initial implementation, the BOARD agrees that it will provide incentives based on benefit design for PARTICIPANTS to use the SPECIALTY DRUG management program as the preferred channel for obtaining SPECIALTY DRUGS.
3. Contractor Standard Formulary Management. The BOARD agrees to cooperate and work with the CONTRACTOR to affect the adoption, distribution, and implementation of an evidence-based drug formulary designed to achieve the lowest overall net program cost consistent with the highest level of quality outcomes.
4. Generic Alternatives. The CONTRACTOR will implement a Generic Alternatives Program designed to offer generic alternatives to brand PRODUCTS to reduce costs for both the BOARD and the PARTICIPANT.
5. Dose Consolidation. The CONTRACTOR will implement a Dose Consolidation Program designed to identify opportunities for MEMBERS who are on multiple dose medications that can be safely administered in a single dose to reduce costs for both the BOARD and the PARTICIPANT.
6. Pill-Splitting Program. The CONTRACTOR will develop and implement a voluntary half-tablet program designed to encourage the use of half-tablet medications by reducing the COPAYMENT or COINSURANCE for certain PRODUCTS in accord with the provisions of the PHARMACY BENEFIT PLAN. The program will only be available for PRODUCTS that: (i) are COVERED DRUGS on the formulary; (ii) are recognized as an appropriate PRODUCT to split by the CONTRACTOR’s P&T Committee; (iii) the various strengths of the PRODUCT are comparably priced; and (iv) the PRODUCT has once-daily dosing. If the Half-Tablet Program is adopted by the BOARD, CONTRACTOR will provide pill splitting devices to PARTICIPANTS. These pill splitting devices may contain the CONTRACTOR logo or may be customized to carry the DEPARTMENT’s logo.
7. Web Site. The CONTRACTOR will maintain a publicly accessible website. The site will include but will not be limited to the formulary, benefit design, individual look-up capabilities, claims history, “contact us” information, information on pill splitting, mail order services and other programs offered. There will be direct access to the BOARD’s program functions.
8. Pharmacy Auditing Program. Each PARTICIPATING PHARMACY in the CONTRACTOR’s network shall be subject to audit. The BOARD may require use of an independent auditor rather than the CONTRACTOR. Auditing will be conducted in four phases starting at a high-level system audit and progressing through further drill-down and analysis to on-site audits if necessary. Desk-top audits will be conducted on a daily/weekly/monthly basis, depending on the type of audit report. On-site audits will be conducted as needed. Settlements that are the result of reversing or adjusting claims found to be processed in error will be passed back through to the BOARD for inclusion in the funds for the PHARMACY BENEFIT PLAN AND HEALTH BENEFIT PROGRAM.
9. Pharmacy Educational Services. The CONTRACTOR will conduct a program by which PARTICIPATING PHARMACIES are reimbursed for providing clinical and educational services to PARTICIPANTS. The CONTRACTOR shall report on the cost and effectiveness of the program and the BOARD shall have the opportunity to periodically review, suspend or cancel all or part of the program at its discretion.

## 215 Benefits

### 215A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Pharmacy Benefits (Section 400) to all PARTICIPANTS. Any BENEFIT changes must be implemented as directed by the BOARD. This shall include developing the necessary reporting and/or data transfers needed by the DEPARTMENT and other vendors to administer the change.

### 215B Benefit Plan Specifications

The CONTRACTOR acknowledges that the BOARD has provided, in the Uniform Pharmacy Benefits, specifications for the PHARMACY BENEFIT PLAN in sufficient detail to permit the CONTRACTOR to reasonably perform its duties under this CONTRACT. However, in the event of any changes to the details of the PHARMACY BENEFIT PLAN or if any future unanticipated circumstances arise for which the Uniform Pharmacy Benefits provide inadequate guidance, the CONTRACTOR may request a clarification from the DEPARTMENT via the PHARMACY BENEFIT PLAN program manager.

1. Because BOARD changes to the PHARMACY BENEFIT PLAN may require programming changes, such changes will be coordinated with the CONTRACTOR to assure timely implementation and minimal disruption of the ongoing PHARMACY BENEFIT PLAN. The time required for new PHARMACY BENEFIT PLAN changes will generally be as follows:
2. Two weeks for changes within the existing PHARMACY BENEFIT PLAN structure, which require minimal or no changes to the CONTRACTOR’s claims and/or eligibility processing systems.
3. Four to six weeks for changes for which functionality is currently available in the CONTRACTOR’s claims and/or eligibility processing systems, but not utilized within the PHARMACY BENEFIT PLAN structure.
4. Twelve to twenty-four weeks for changes for which functionality needs to be developed in the CONTRACTOR’s claims and/or eligibility processing systems.
5. The CONTRACTOR will notify the BOARD as promptly as reasonably possible following receipt of the request as to the feasibility and timing of the requested change. The CONTRACTOR shall not be responsible for implementing any changes to any previously established PHARMACY BENEFIT PLAN information until the CONTRACTOR has confirmed its agreement to and acceptance of implementation of such changes to the BOARD in writing, including a timetable for change implementation.

**Plan Design Information; Participant Eligibility**. The BOARD, at its own expense, will provide the CONTRACTOR all information concerning its plan design, health plans and employers participating in the PHARMACY BENEFIT PLAN, and PARTICIPANTS, which is necessary for the CONTRACTOR to perform its obligations under this CONTRACT, including any updates to this information as necessary. This information must be complete and accurate, provided timely, and in a format and media agreed to by the BOARD and the CONTRACTOR. The CONTRACTOR, PARTICIPANTS, PARITICIPATING PRESCRIBERS, and PARTICIPATING PHARMACIES are entitled to rely on the accuracy and completeness of this information and updates thereto.

### 215C Medicare Part D/EGWP Coverage

The CONTRACTOR will administer an EGWP and WRAP PLAN on behalf of the BOARD. The CONTRACTOR will maintain the contractual relationship with CMS, and will be responsible with ensuring that all aspects of the program are CMS compliant per 42 CFR 423. This includes, but is not limited to:

* Claims processing standards;
* Member and pharmacy call center standards;
* Pharmacy network access standards;
* Grievance and redetermination standards;
* Coordination of benefits;
* Member marketing materials;
* Reporting requirements;
* Prescription drug event (PDE) reconciliation;
* Records maintenance;
* Audit requirements; and
* Subsidy and REBATE processing.

In cases where CMS requirements and the non-Medicare Part D/EGWP requirements of this contract differ, the more rigorous standard shall supersede.

## 220 Quality

1. The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in encouraging and/or requiring PARTICIPATING PHARMACIES to participate in quality initiatives, including those identified by the DEPARTMENT. The CONTRACTOR must demonstrate their efforts in encouraging prescribers to participate in quality initiatives as well.
2. The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, its support for the DEPARTMENT’S initiatives in monitoring and improving quality of care. This may include providing actual contract language that specifies PARTICIPATING PHARMACY agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to pharmacy reimbursement.
3. The CONTRACTOR shall collaborate with the DEPARTMENT, HEALTH BENEFIT PROGRAM providers and other vendors contracted by the BOARD on quality initiatives to address current population health issues. The CONTRACTOR shall report to the DEPARTMENT semi-annually any initiatives and pilot programs offered by the CONTRACTOR or the PARTICIPATING PHARMACIES, including information on patient engagement and outcomes.
4. The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.
5. Prior to the DEPARTMENT holding the CONTRACTOR accountable for any of these measures, either through financial means and/or through publishing the measure results, the DEPARTMENT will provide the CONTRACTOR with an opportunity to review and validate the DEPARTMENT’S results within a specific timeframe, as determined by the DEPARTMENT.
6. The DEPARTMENT will collaborate with the CONTRACTOR to develop a final measure set. Measures agreed upon for the first year of this CONTRACT will not be associated with financial benefits or penalties, but may be subject to such financial penalties or benefits if the CONTRACT is extended benefits.

## 225 Pharmacy Network Administration

The CONTRACTOR has created a network of PARTICIPATING PHARMACIES, which will perform pharmacy services for PARTICIPANTS. The CONTRACTOR will adjudicate claims submitted by PARTICIPATING PHARMACIES in accordance with the PARTICIPATING PHARMACY’s agreement with the CONTRACTOR. Each PARTICIPATING PHARMACY shall exercise its professional judgment in the dispensing of COVERED PRODUCTS and may refuse to dispense any DRUG PRODUCT based upon the professional judgment of its pharmacists. The BOARD and its actuaries will have access to these agreements and the CONTRACTOR will notify the BOARD if the agreements change in a manner that materially affects this CONTRACT.

The CONTRACTOR’s creation and maintenance of a network of PARTICIPATING PHARMACIES is undertaken in the capacity of an independent contractor. The BOARD is not a party to the agreements between the CONTRACTOR and the PARTICIPATING PHARMACIES.

The CONTRACTOR shall conduct audits of the PARTICIPATING PHARMACIES in accordance with Subsection 150D, Audit and Other Services. If the CONTRACTOR becomes aware that any PARTICIPATING PHARMACY, pharmacy, or company that is authorized to represent one or more subsidiary, affiliated, or franchised pharmacies has engaged in any fraudulent practice or has violated any applicable standard of care or applicable law, including without limitation, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or the regulations promulgated thereunder, the CONTRACTOR shall immediately disclose such information to the DEPARTMENT. The CONTRACTOR and the DEPARTMENT shall consult and shall take such action as appears to them jointly to be reasonable under the circumstances, including but not limited to exclusion of that PARTICIPATING PHARMACY from the CONTRACTOR’s PARTICIPATING PHARMACY network.

The CONTRACTOR shall have staff solely dedicated to network management and pharmacy relations that includes a credentialing process, collaboration on quality initiatives, and pharmacy communications. The CONTRACTOR must engage in regular pharmacy negotiations to strategically realize cost savings to the PHARMACY BENEFIT PLAN. The CONTRACTOR must, at a minimum, provide an annual update on pharmacy discount negotiations efforts and outcomes to be included in the rate renewal reports. The DEPARTMENT reserves the right to require more frequent status updates on pharmacy negotiation strategies, efforts, and outcomes.

The CONTRACTOR will maintain a PARTICIPATING PHARMACY relations program that includes a communications plan with updated network information for new and on-going programs and processes. The program should also include assistance for PARTICIPATING PHARMACIES and their staff regarding pharmacy network issues. In addition, the program should actively consider suggestions and guidance from participating pharmacies about how the pharmacy network can best serve consumers. The CONTRACTOR must provide a copy of the current PARTICIPATING PHARMACY relations program administrative manual upon request by the DEPARTMENT.

The CONTRACTOR must submit provider data to the DEPARTMENT’S data warehouse as specified in Section 145. The DEPARTMENT will not amend its contract with the data warehouse vendor in a manner that directly or indirectly changes the terms of this section without prior notice to the CONTRACTOR. The DEPARTMENT’S notice to the CONTRACTOR will allow for comment by the CONTRACTOR, and when requested by the CONTRACTOR, discussion between the DEPARTMENT and the CONTRACTOR about the proposed changes.

The CONTRACTOR must certify annually that their pharmacy contracts meet the requirements in [Section 230](#_230_Provider_Contracts). The DEPARTMENT reserves the right to review any contracts with PARTICIPATING PHARMACIES that are IN-NETWORK for the PHARMACY BENEFIT PLAN.

### 225A Pharmacy Network Access

The CONTRACTOR must provide an annual pharmacy network submission to the DEPARTMENT containing the network of PARTICIPATING PHARMACIES for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly data submission as detailed in [Section 145C](#_150_Data_Integration).

The DEPARTMENT will use this data to ensure PARTICIPANT access to PARTICIPATING PHARMACIES is reasonable and adequate. The DEPARTMENT will also use this data to evaluate possible pharmacy network management changes.

### 225B Pharmacy Network Directory

The CONTRACTOR is required to have a current pharmacy directory easily accessible on their website at all times. If the PARTICIPATING PHARAMACIES change during the benefit period, an updated pharmacy directory must be provided by the CONTRACTOR and include a revision date. All past versions within a benefit period must be available and provided to the DEPARTMENT upon request for the purposes of resolving complaints.

The pharmacy network data submission and the published pharmacy network directory must be in alignment for the IT’S YOUR CHOICE OPEN ENROLLMENT for the upcoming benefit period.

### 225C Pharmacy Network Contracts Shall Include Compliance Plans

All new (and upon renewal of) PARTICIPATING PHARMACY contracts shall include requirements that PARTICIPATING PHARMACY staff be educated about health care laws, rules and regulations, applicable standards, and how to identify and report inappropriate behavior.

Examples of the types of contract provisions that should be in place include:

1. Effective internal controls to assure compliance with Federal and State laws, rules, regulations and internal policies and procedures; and
2. Establish procedures that allow the prompt, thorough investigation of possible misconduct by employees and independent contractors.

## 230 Claims

### 230A Claims Administration

With respect to claims for pharmacy benefits, the CONTRACTOR shall serve as third-party administrator, providing all necessary services to administer, process, and pay all pharmacy benefit claims as indicated in Uniform Pharmacy Benefits arising under the PHARMACY BENEFIT PLAN offered by the BOARD under Wisconsin Statutes Chapter 40. The CONTRACTOR shall not administer claims for any pharmacy benefits reserved to the health care coverage plans under the Uniform Pharmacy Benefits or the contracts between the BOARD and those health care coverage plans.

The CONTRACTOR shall administer claims in accord with the CONTRACT. The BOARD acknowledges that it has the sole authority to control and administer the PHARMACY BENEFIT PLAN and has contracted with the CONTRACTOR for assistance in administering claims. The BOARD further acknowledges that although CONTRACTOR has the authority to make initial determinations to approve or reject claims, the BOARD has the ultimate authority over such decisions, in the event the CONTRACTOR’s initial decision is challenged. Nothing in this CONTRACT shall be construed or deemed to confer on the CONTRACTOR any responsibility for or control over the terms or validity of the PHARMACY BENEFIT PLAN. Further, because CONTRACTOR is not an insurer, plan sponsor, or a provider of health services to PARTICIPANTS, the CONTRACTOR shall have no responsibility for (i) any funding of plan benefits; (ii) any insurance coverage relating to the BOARD, the HEALTH BENEFIT PROGRAM, or the PARTICIPANTS; or (iii) the nature or quality of professional health services rendered to PARTICIPANTS, except as otherwise expressly provided in Sections 210

### 230B Review of Claims Decisions

The CONTRACTOR shall make claims decisions according to its understanding of the PHARMACY BENEFIT PLAN. The CONTRACTOR’s decision to deny a pharmacy benefit claim, in whole or part, is subject to review only as described in Section 235 Grievances.

### 230C Claims Submitted by Participants

The CONTRACTOR will accept claims submitted directly by PARTICIPANTS when such PARTICIPANTS complete a standard claim form provided by the CONTRACTOR along with proof of payment. The CONTRACTOR will process such properly submitted claims and produce and mail, within thirty (30) calendar days of receipt of a request for reimbursement: (a) an explanation of benefits to PARTICIPANTS for allowable claims, together with checks for the agreed upon reimbursement amounts; or (b) requests for information for claims that are ineligible or incomplete; or (c) notification to the PARTICIPANT that the claims decision denied coverage or reimbursement of their claim.

## 235 Grievances

### 235A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT’S review and approval during the implementation process and upon request by the DEPARTMENT.

Any dispute about BENEFITS or claims arising under this AGREEMENT shall first be submitted for resolution through the CONTRACTOR’S internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT for administrative review.

Grievances regarding non-covered services or services excluded from coverage by the PHARMACY BENEFIT PLAN shall be handled like any other grievance. Written inquiries received by the CONTRACTOR not related to BENEFITS determinations shall be resolved by the CONTRACTOR within ten (10) BUSINESS DAYS following the CONTRACTOR’S receipt of the inquiry.

If any PARTICIPANT has a problem or complaint relating to a determination of BENEFITS, he/she should contact the CONTRACTOR. The CONTRACTOR shall assist the PARTICIPANT in trying to resolve the matter on an informal basis, and may initiate a claim review of the BENEFITS determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a formal grievance. A claim review is not a substitute for a grievance.

The following provides an overview of the steps in the PARTICIPANT grievance process. Details are provided in Sections 235B – H.

1. Claim review (optional for PARTICIPANT);
2. Participant notice;
3. Investigation and resolution;
4. Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD’s final decision to circuit court; or,
5. Federal external review (not all grievances eligible).

### 235B Claim Review

The CONTRACTOR shall perform a claim review when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, the CONTRACTOR shall notify the PARTICIPANT of the decision. If the decision is to uphold the denial of BENEFITS, the PARTICIPANT shall receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a grievance.

### 235C Participant Notice

The CONTRACTOR must provide the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar days to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based.

### 235D Investigation and Resolution Requirements

Investigation and resolution of any grievance will be initiated by the CONTRACTOR within five (5) DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within three (3) DAYS of the CONTRACTOR'S receipt of the grievance.

### 235E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee’s final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Pharmacy Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.

In the event the PARTICIPANT disagrees with the grievance committee’s final decision, they may submit a written request for review to the DEPARTMENT within sixty (60) calendar DAYS of the date of the final grievance decision letter. The DEPARTMENT will review and communicate the outcome of the review to the PARTICIPANT. In the event that the PARTICIPANT disagrees with the outcome, they may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within sixty (60) calendar DAYS of the date of the DEPARTMENT’S final review letter.

The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by [Wis. Stat. § 40.03 (6) (i)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/03/6) and [Wis. Adm. Code ETF 11.01 (3)](http://docs.legis.wisconsin.gov/code/admin_code/etf/11/01). However, the DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by [Wis. Stat. § 40.03 (6) (i)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/03/6) and [Wis. Adm. Code ETF 11.01 (3)](http://docs.legis.wisconsin.gov/code/admin_code/etf/11/01). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT’S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by [Wis. Stat. § 40.08 (12)](https://docs.legis.wisconsin.gov/statutes/statutes/40/I/08/12) and [Wis. Adm. Code ETF 11.15](http://docs.legis.wisconsin.gov/code/admin_code/etf/11/15).

### 235F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an Independent Review Organization (IRO) is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or the BOARD once the external review decision is rendered.

Within fourteen (14) calendar DAYS of the CONTRACTOR’S receipt of the notification of the external review’s determination, the CONTRACTOR must notify the DEPARTMENT of the outcome.

The CONTRACTOR shall not be in breach of this AGREEMENT solely because the external reviewer does not comply with the timeframes set forth in the statutes or regulations.

### 235G Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a CONTRACTOR shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the CONTRACTOR shall cooperate in obtaining the authorization and shall accept the DEPARTMENT’S form that complies with all applicable laws regarding patient privacy. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolve disputes or to formulate determinations. Such information must be provided at no charge within fifteen (15) BUSINESS DAYS, or by an earlier date as requested by the DEPARTMENT.

### 235H Department Request for Grievance

The DEPARTMENT may require the CONTRACTOR to treat and process a complaint received by the DEPARTMENT as a grievance and the DEPARTMENT will forward the complaint to the CONTRACTOR on behalf of the PARTICIPANT. The CONTRACTOR shall process the complaint as a grievance in compliance with the PHARMACY BENEFIT PLAN’S provisions regarding a formal grievance.

### 235I Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT’S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. This requirement does not extend to cases of subrogation.

### 235J Compliance with Departmental Determination

If a departmental determination overturns a CONTRACTOR’S decision on a PARTICIPANT’S grievance, the CONTRACTOR shall comply with the determination within ninety (90) calendar DAYS of the date of the determination. As used in this section, “comply” means to take action as directed in the departmental determination within ninety (90) calendar DAYS. Failure to either comply within ninety (90) calendar DAYS will result in penalties as described in Section 315 Performance Standards.

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## 255 Miscellaneous Program Requirements

### 255A 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 to any CONTRACTOR locations.

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

**Implementation Requirements Timeline**

| **Activity** | **Due Dates** |
| --- | --- |
| **Implementation Plan:** The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee. | Within ten (10) BUSINESS DAYS of execution of this CONTRACT |
| **Fraud and Abuse Review Plan:** The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT | Within thirty (30) DAYS of execution of this CONTRACT |
| **Program Information:** All program informational materials for the 2026 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval. | September 1, 2025 |
| **Web Content:** The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT’S YOUR CHOICE ENROLLMENT period for review and approval. | September 16, 2025 |
| **Employer Meeting:** The CONTRACTOR attends the IYC EMPLOYER Kick-Off meeting. | Fall 2025  (Date TBD) |
| **Customer Service:** The CONTRACTOR’S toll-free customer service telephone number is operational and customer service staff for the PHARMACY BENEFIT PLAN are trained. | September 30, 2025 |
| **Web Content Launch:** The web content dedicated to the PHARMACY BENEFIT PLAN and upcoming IT’S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched. | September 30, 2025 |
| **Informational Mailing:** The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT’S YOUR CHOICE OPEN ENROLLMENT period. | September 2025  (Date TBD) |
| **Employer Health Fairs:** The CONTRACTOR shall participate in IT’S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area. | October – November 2025 |
| **Enrollment File:** The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation according to pre-established timelines. | November 16, 2025 |
| **Financial Administration:** Financial administration requirements are operational, including but not limited to:   * Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. * Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). * ACH mechanism for EFT of claims payments and fees. | November 30, 2025 |
| **Grievance Procedure:** The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT’S review and approval. | November 30, 2025 |
| **ID CARDS:** The CONTRACTOR issues welcome packets that contain ID CARDS for SUBSCRIBERS with coverage effective January 1, 2018. | December 15, 2025 |
| **Claims Administrative Services:** All claims administrative services for the PHARMACY BENEFIT PLAN are fully operational. | January 1, 2026 |
| **Accumulator File Data:** The medical and pharmacy data transfer processes for accumulating PARTICIPANT out-of-pocket costs for deductibles and out-of-pocket limits is established, tested and working correctly according to pre-established timelines. | January 1, 2026 |
| **Web-Portal:** The CONTRACTOR’S web-portal tracking PARTICIPANT level information is launched. | January 1, 2026 |
| **Medical and Dental Data:** Themedical and dental data transfer process is established, tested, and working correctly. | January 15, 2026 |
| **Wellness and Disease Management Data:** The wellness and disease management data transfer process is established, tested, and working correctly. | January 31, 2026 |
| **Pharmacy Claims & Network Data:** The pharmacy claims and network data transfer process to the DEPARTMENT’S data warehouse has been established, tested, and working correctly. | February 28, 2026 |

### 255B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1. Manage the entire range of services specified in the CONTRACT;
2. Respond to DEPARTMENT requests and inquiries;
3. Provide daily operational support;
4. Implement the DEPARTMENT changes to benefit plan design and procedures; and,
5. Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR’S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the PHARMACY BENEFIT PLAN. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT’S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR’S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the PHARMACY BENEFIT PLAN. Meetings may be in person or by teleconference/webinar, as determined by the DEPARTMENT.

The CONTRACTOR must not modify any of the services or program content provided as part of this CONTRACT without prior written approval by the DEPARTMENT Program Manager.

The CONTRACTOR shall achieve a ninety-five percent (95%) satisfaction or better (defined as “top two-box” satisfaction/approval using an approved standard 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting PHARMACY BENEFIT PLAN services. The survey will be developed by the parties.

### 255C Customer Service

The CONTRACTOR shall operate a dedicated customer service department for the PHARMACY BENEFIT PLAN between 7:30 a.m. and 6:00 p.m., CST/CDT Monday through Thursday and 7:30 a.m. to 5:00 p.m. CST/CDT on Friday at a minimum, except for legal holidays. The CONTRACTOR will also have a sufficient number of customer service representatives available to members, pharmacists and prescribers 24 hours a day, seven days a week, excluding some holidays, via a toll-free customer service call center. PARTICIPANTS must also be able to submit questions using a secure website. The call center must be equipped with Telephone Device for the Deaf (TDD) in order to serve the hearing-impaired population. Calls and correspondence to customer services representatives shall be tracked, recorded, and retrieved when necessary by name or the DEPARTMENT’S eight (8)-digit member ID.

The CONTRACTOR must have a toll-free number for the PHARMACY BENEFIT PLAN and have customer service staff who are sufficiently trained to respond appropriately to PARTICIPANT inquiries, correspondence, complaints, and issues. The toll-free number must not have more than two (2) menu prompts to reach a live person.

The CONTRACTOR’S customer service staff will be able to respond to PARTICIPANTS’ questions regarding: plan design; coverage eligibility; DEDUCTIBLE and out-of-pocket limit status; required COPAY/COINSURANCE levels; clinical programs; the pharmacy network and alternative distribution channels; formulary related topics including alternate/equivalent drug options; and claims submission processes.

The CONTRACTOR shall notify the DEPARTMENT Program Manager of any disruption in customer service availability or toll-free access regardless of reason for disruption, within one (1) hour of realization that a problem exists.

The CONTRACTOR must monitor and report to the DEPARTMENT the performance standards for the PHARMACY BENEFIT PLAN that include call answer timeliness and call abandonment rate. Targets for the customer service performance standards and associated penalties are specified in Section 315D and are based on the toll-free number for the PHARMACY BENEFIT PLAN.

The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and/or website. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls shall be indexed and properly recorded to allow for reporting and analysis based on a distinct transaction.

The system must track and log, at a minimum, the following detail:

1. The PARTICIPANTS identifying information;
2. The date and time the inquiry was received;
3. The reason for the inquiry (including a reason code using a coding scheme);
4. The origin of the transaction (e.g., inbound call, the DEPARTMENT, EMPLOYER group);
5. The representative that handled the inquiry;
6. For phone inquiries, the length of call; and,
7. The resolution of the inquiry (open or closed).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT’S request.

At the DEPARTMENT’S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each month of a reasonable sample size of CONTRACTOR’S total book of business inquiries made by each submission type (e.g. phone, email, website) must be audited by the CONTRACTOR’S management staff (e.g. lead worker, supervisor, manager) to ensure accurate information was given to PARTICIPANTS and appropriate coaching and training is given to customer service representatives who failed to accurately respond to PARTICIPANTS. At the DEPARTMENT’S request, the CONTRACTOR must provide the audit results.

The CONTRACTOR must respond directly to PARTICIPANTS upon the DEPARTMENT’S request. For matters designated as urgent by the DEPARTMENT, the CONTRACTOR must contact the PARTICIPANT within one (1) BUSINESS DAY of receiving a request from the DEPARTMENT and actively communicate to the DEPARTMENT’S Program Manager or designee on issue resolution status until the issue is resolved.

### 255D Contractor Web Content and Web-Portal

The CONTRACTOR must provide dedicated web content (that may be via a microsite that meets all criteria below) and a web-portal as part of the AGREEMENT. Web content will provide basic program information. The web-portal will be used to present and track PARTICIPANT level information, such as claim status and out of pocket limit accumulation.

1. The CONTRACTOR must host and maintain customized web pages and a web-portal dedicated to PARTICIPANTS of the PHARMACY BENEFIT PLAN.
   1. The CONTRACTOR must submit the web content and web-portal design for review as directed by the DEPARTMENT.
   2. The DEPARTMENT must approve the content prior to publishing.
   3. The web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market which include Internet Explorer/Edge, Mozilla Firefox, Chrome and Safari.
   4. The web-portal must be simple, intuitive and easy to use and navigate.
   5. The web-portal must be able to render effectively on any form factor for mobile devices which include smartphones and tablets.
   6. The website and web-portal must have mobile capabilities. At a minimum the mobile capabilities must allow the PARTICIPANT to access program information.
   7. The website must ensure response time averaging two (2) seconds or better, and never more than three (3) second response time, from the time the CONTRACTOR receives the request to the time the response is sent, for all on-line activities. Response time will be measured from the time that the request is received by the website and a response is sent from the website.
   8. The solution must use SSL/TLS for end-to-end encryption for all connections between the user devices and the portal with the use of browsers or smartphone applications (apps).
   9. The portal must be SECURED with a minimum of SHA2-256 (or similar system such as SHA-256 as approved by the DEPARTMENT) bit EV certificates to provide the latest in encryption and cryptography.
   10. The portal must disable SSL/TLS negotiations which are using non-SECURE protocols and weak ciphers.
   11. The CONTRACTOR must provide the DEPARTMENT reports on the current security safeguards enabled for the website and web-portal, upon the DEPARTMENT’S request.
   12. After the initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website and web-portal test environment for the DEPARTMENT’S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website and web-portal. No less than two (2) weeks prior to the annual launch dates for each, the CONTRACTOR must have final content and functionality completed, as determined by the DEPARTMENT provided that eligibility and benefit setup information is received by CONTRACTOR in a timely manner.
   13. Prior to any launch of the CONTRACTOR website or web-portal, the CONTRACTOR must test the accessibility of the website and web-portal on multiple web browsers and from multiple internet carriers to ensure system capability.
   14. The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website content for the upcoming IT’S YOUR CHOICE OPEN ENROLLMENT period. The DEPARTMENT will annually communicate the due date for this submission. The CONTRACTOR will provide the website content to the DEPARTMENT for approval and implement any changes to the website content requested by the DEPARTMENT as soon as practicable after receiving all required information from the DEPARTMENT, with the goal of launching the updated website content at least two (2) weeks prior to the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.
   15. The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links from the website or web-portal to an external (governmental and non-governmental) website/portal or webpage.
   16. The CONTRACTOR will notify the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation.
2. Basic information must be available on the CONTRACTOR’S website without requiring log in credentials, including:
   1. General information about the PHARMACY BENEFIT PLAN and other programs offered by the BOARD;
   2. Directions on how to access the PHARMACY BENEFIT PLAN PARTICIPATING PHARMACY directory;
   3. Information about PARTICIPANT requirements, including PRIOR AUTHORIZATION requirements;
   4. Ability for PARTICIPANTS to access the PHARMACY BENEFIT PLAN abbreviated or quick reference formulary;
   5. A pharmacy benefit modeling tool for new members to project approximate cost sharing before electing to enroll; and,
   6. Contact information including the toll-free customer service phone number, business hours, and mailing address.
3. To ensure accessibility among persons with a disability, the CONTRACTOR’S website must comply with Section 508 of the Rehabilitation Act of 1973 (29 USC Section 794d) and implementing regulations at 36 CFR 1194 Subparts A-D. The website must also and conform to W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 (see <http://www.w3.org/TR/WCAG20/>).
4. The website must be hosted in a SECURE data center with system monitoring, managed firewall services and managed backup services within the United States and available twenty-four (24) hours a day, seven (7) DAYS a week, except for regularly scheduled maintenance.

The data center network shall include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of 9:30 p.m. and 5:00 a.m. CST/CDT or another time agreed to by the DEPARTMENT Program Manager and must be scheduled in advance with a notification on the program website/portal. Downtime for unscheduled maintenance is not to exceed six (6) incidents in a calendar year unless agreed to by the parties. Unscheduled disruption to the availability of the website or web-portal must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

The CONTRACTOR must have a regular patch management process defined for the infrastructure. The CONTRACTOR must have a defined maintenance time window for system patches, software upgrades. Outages in the system must be communicated through the web-portal or via alerts.

1. The CONTRACTOR must be able to link user profiles and site access permissions to the daily enrollment file provided by the DEPARTMENT and make updates based on current enrollment within three (3) BUSINESS DAYS of data receipt. The CONTRACTOR may utilize another process for validation if the process is pre-approved by the DEPARTMENT.
2. The CONTRACTOR will provide the web-portal content to the DEPARTMENT for approval and implement any changes to the web-portal content requested by the DEPARTMENT as soon as practicable after receiving all required information from the DEPARTMENT, with the goal of launching the web-portal with content and functionality updated, tested and approved by the DEPARTMENT Program Manager or designee at least fourteen (14) calendar DAYS prior to the benefit period start date. The web-portal will SECURELY authenticate the user. After the user is authenticated, all web-portal features must be available without the need for an additional login. Available features must include:
   1. User name and password creation and recovery;
   2. Enrollment confirmation;
   3. SECURE upload functionality for submitting program required documentation; and,
   4. Communication functions that allow users to submit SECURE questions to the CONTRACTOR and allow the CONTRACTOR to push general and targeted communications to users via USPS, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT.

### 255E Patient Rights and Responsibilities

The CONTRACTOR shall comply with and abide by the Patient’s Rights and Responsibilities as provided in the DEPARTMENT’S IYC materials. CONTRACTORS that have their own Patient’s Rights and Responsibilities may use them unless there is a conflict. In this case the Patient’s Rights and Responsibilities which are more favorable to the PARTICIPANT will apply.

### 255F Errors

Clerical errors made by the EMPLOYER, the DEPARTMENT or the CONTRACTOR shall not invalidate BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated, nor create eligibility for any BENEFITS where none otherwise existed under the PHARMACY BENEFIT PLAN.

Retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six (6) months of PREMIUMS paid, except in cases of fraud, material misrepresentation, resolution of a BOARD appeal, or when required by Medicare.

In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six (6) months and in accordance with Uniform Pharmacy Benefits.

No retroactive PREMIUM refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation.

Contractor / Provider / Subcontractor Errors

If the CONTRACTOR or a PARTICIPATING PHARMACY or subcontractor sends erroneous or misleading information to PARTICIPANTS, the DEPARTMENT may require the CONTRACTOR to send a corrected mailing at the cost of the CONTRACTOR to inform PARTICIPANTS.

### 255G Examination of Records

The DEPARTMENT, or its designee, shall have the right to examine any records of the CONTRACTOR relating to the PHARMACY BENEFIT PLAN in compliance with [Wis. Stat. § 40.07](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/07) and any applicable federal or other state laws and rules. The information shall be furnished within ten (10) BUSINESS DAYS of the request or as directed by the DEPARTMENT. All such information is the sole property of the DEPARTMENT.

Upon a showing satisfactory to the BOARD that the CONTRACTOR is required by law to maintain a copy of such information, the DEPARTMENT and the CONTRACTOR shall agree to terms, conditions and provisions permitting the CONTRACTOR to maintain information to the minimum extent and for the minimum time required by law. Any such agreement shall require the CONTRACTOR to:

1. Keep confidential and properly safeguard each “medical record” and all “personal information”, as those terms are respectively defined in [Wis. Admin. Code ETF 10.01 (3m)](http://docs.legis.wisconsin.gov/code/admin_code/etf/10/01/3m) and [ETF 10.70 (1)](http://docs.legis.wisconsin.gov/code/admin_code/etf/10/70/1), that are included in such information;
2. Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,
3. Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate [Wis. Stat. § 40.07 (1) or (2)](http://docs.legis.wisconsin.gov/statutes/statutes/40/I/07), respectively, if the disclosure was made by the DEPARTMENT.

### 255H Record Retention

The CONTRACTOR agrees that the BOARD, until the expiration of seven (7) years after the termination of this AGREEMENT, and any extensions, shall have access to and the right to examine any of the CONTRACTOR’S pertinent books, financial records, documents, papers, and records and those of any parent, affiliate, or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the CONTRACTOR involving transactions related to this AGREEMENT.

The period of access and examination described in the paragraph above, for records that relate to: (1) litigation or settlement of claims arising out of the performance of this AGREEMENT; or (2) costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions have been disposed.

The CONTRACTOR further agrees that the substance of this clause shall be inserted in any subcontract that the CONTRACTOR enters into with any subcontractor to carry out any of the CONTRACTOR’S obligations under this AGREEMENT.

### 255I 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.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD’S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR’S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD’S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house legal counsel of net dollars recovered by counsel, with those attorneys’ fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel’s or in-house legal counsel’s legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys’ fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys’ fees, legal costs and disbursements.

The CONTRACTOR’s subrogation obligations are limited to situations where, at the CONTRACTOR’s discretion, the circumstances in a particular subrogation matter warrant such a decision. This means that if the CONTRACTOR determines that the dollar amount of a subrogation lien is so low as to make recovery cost prohibitive, the CONTRACTOR is not obligated to pursue the BOARD’s subrogated interest.

### 255J Disaster Recovery and Business Continuity

The CONTRACTOR shall ensure that critical PARTICIPANT, provider and other web accessible and/or telephone-based functionality and information, including the website, are available to the applicable system users, except during periods of scheduled system unavailability agreed upon by the DEPARTMENT and the CONTRACTOR. Unavailability caused by events outside of the CONTRACTOR’S span of control is outside of the scope of this requirement. Any scheduled maintenance, which is anticipated to result in downtime, shall be scheduled in advance with notification by the CONTRACTOR directly to the DEPARTMENT and on the PARTICIPANT website and web-portal.

### 255K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the PHARMACY BENEFIT PLAN.

### 255L Gifts and/or Kickbacks Prohibited

No gifts from the CONTRACTOR or any of the CONTRACTOR’S subcontractors are permissible to any EMPLOYEES whose work relates to the PHARMACY BENEFIT PLAN, or members of the BOARD. Neither the CONTRACTOR nor any of its subcontractors shall request or receive kickbacks.

### 255M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR’S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

# 300 Deliverables

## 305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT’S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the PHARMACY BENEFIT PLAN, not general data from the CONTRACTOR’S book of business.

| **Report** | **Description** | **Frequency** |
| --- | --- | --- |
| 1. **Claims Invoicing**   **Pharmacy  Claims  Reimbursement** | The CONTRACTOR notifies the DEPARTMENT twice monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See [Section 130A](#_135A_Invoicing_and), 1, b. (1)   * Cycle I: Encompasses prescription claims processed day one (1) through day fifteen (15). CONTRACTOR will electronically send an invoice to DEPARTMENT two (2) DAYS after the end of the cycle. * Cycle II: Encompasses prescription claims processed day sixteen (16) through the last day of the month. CONTRACTOR will electronically send an invoice to DEPARTMENT two (2) DAYS after the end of the cycle. | Semi-Monthly |
| 1. **Claims Invoicing**   **Member  Claims  Reimbursement** | The CONTRACTOR notifies the DEPARTMENT monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See [Section 130A](#_135A_Invoicing_and), 2, b. (2)   * Direct Member Reimbursement cycles run on a weekly basis but are billed monthly. Each monthly cycles will include between 28 and 35 calendar days (four to five weeks). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle. | Monthly |
| 1. **Administrative Fee Invoicing** | The CONTRACTOR notifies the DEPARTMENT twice monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See [Section 130A](#_135A_Invoicing_and), 2, b. (1)   * Cycle I: Encompasses administrative fees for services provided from day one (1) through day fifteen (15). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle. * Cycle II: Encompasses administrative fees for services provided from sixteen (16) through the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle. | Semi-Monthly |
| 1. **Other Fees Invoicing** | The CONTRACTOR notifies the DEPARTMENT monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See [Section 130A](#_135A_Invoicing_and), 2, b. (2)   * Each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle | Monthly |
| 1. **Rebate Payments** | The DEPARTMENT will receive REBATE payments on at least a QUARTERLY basis. The CONTRACTOR will provide additional rebate reports as necessary. See [Section 130A](#_135A_Invoicing_and), 4. | QUARTERLY |
| 1. **Drug Manufacturer Revenue Payments** | The DEPARTMENT will receive drug manufacturer revenue payments on at least a QUARTERLY basis. The CONTRACTOR will provide additional revenue payment reports as necessary. See [Section 130A](#_135A_Invoicing_and), 5. | QUARTERLY |
| 1. **Claims Data Transfer to Data Warehouse** | The CONTRACTOR submits to the DEPARTMENT’S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. See [Section 145C](#_145C_Data_Warehouse) | Monthly |
| 1. **Bank Reconciliation Report** | The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. See [Section 130A](#_135A_Invoicing_and), 8 | Monthly |
| 1. **Claims Invoice Reconciliation Report** | The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the semi-monthly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT’S data warehouse. See [Section 130A](#_135A_Invoicing_and), 1, d.  The DEPARTMENT will collaborate with  the CONTRACTOR to implement changes to the claims extract  reports currently provided by the CONTRACTOR for claims invoice  reconciliation, within ninety (90) days of the CONTRACT effective  date. These claims extract reports will be used until claims invoice  reconciliation processes developed within the DEPARTMENT’s  data warehouse are functional. | Monthly |
| 1. **Participating Pharmacy Data Transfer to Data Warehouse** | The CONTRACTOR submits to the DEPARTMENT’S data warehouse in the file format specified by the DEPARTMENT in the most recent PARTICIPATING PHARMACY Data Specifications document See [Section 145C](#_145C_Data_Warehouse) | Monthly |
| 1. **Fraud and Abuse Review Results** | The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. See [Section 150E.](#_155E_Fraud_and) | QUARTERLY |
| 1. **Performance Standards Reports** | The CONTRACTOR submits all data and reports as required to measure performance standards specified in [Section 315](#_315_Performance_Standards). | QUARTERLY unless otherwise noted |
| 1. **Pilot Programs and Initiatives** | The CONTRACTOR reports to the DEPARTMENT any initiatives and pilot programs offered by the CONTRACTOR or the PARTICIPATING PHARMACIES, including information on patient engagement and outcomes. See [Section 220](#_225_Quality), 3. | Semi-Annually |
| 1. **Business Recovery Plan and Simulation Report** | The CONTRACTOR submits to the DEPARTMENT a business recovery plan that is documented and tested annually, at a minimum. See [Section 140](#_140_Information_Systems), 5. | Annually |
| 1. **Coordination of Benefits (COB) Report** | The CONTRACTOR collects from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and reports this information to the DEPARTMENT at least annually. See [Section 205F](#_205F_Coordination_of). | Annually |
| 1. **Financial and Utilization Data Submission** | The CONTRACTOR submits 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. See [Section 150A](#_150A_Reporting_Requirements), 1. | Semi-Annually |
| 1. **Grievance Summary Report** | The CONTRACTOR retains records of grievances and submits an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. See [Section 115](#_115_General_Requirements_1), 9 c. | Annually |
| 1. **Group Experience / Utilization Report** | The CONTRACTOR reports annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors, demonstrating support for technology and automation in the format as determined by the DEPARTMENT. The CONTRACTOR also includes details on the PHARMACY BENEFIT PLAN’S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends in a format as determined by the DEPARTMENT. See [Section 150A](#_155A_Reporting_Requirements). | Annually |
| 1. **Rate Renewal Reports** | To assist the DEPARTMENT and the BOARD’S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. See [Section 130](#_130_Premiums). | Annually |
| 1. **SOC 1, Type 2 Audit Report** | The CONTRACTOR agrees to a 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 SSAE 16 and provides a copy of the CPA’s report to the DEPARTMENT. See [Section 150D](#_155E_Audit_and). | Annually |
| 1. **SOC 2, Type 2 Audit Report** | The CONTRACTOR agrees to a SOC 2, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR’S expense that is in accordance with the SSAE 16 and provides a copy of the SOC2 report and bridge letter to the DEPARTMENT. See [Section 150D](#_155E_Audit_and). | Annually |

## 310 Deliverables

As required by the CONTRACT, the CONTRACTOR must provide deliverables specified in the sections below.

### 310A Deliverables to the Department

*Instructions on submitting the deliverable and specific due dates will be provided by the DEPARTMENT annually.*

| **Deliverable** | **Description** | **Frequency** |
| --- | --- | --- |
| 1. **Implementation Plan** | The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.See [Section 255A](#_255A_Implementation). | Within ten (10) BUSINESS DAYS of execution of this CONTRACT |
| 1. **Emergency Contact Numbers** | The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. See [Sections 255A](#_265A_Implementation) and [255B](#_255B_Account_Management). | Within ten (10) BUSINESS DAYS of execution of this CONTRACT |
| 1. **Fraud and Abuse Review Plan** | The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT.See [Section 155B](#_150B_Performance_Standards) and [255A](#_265A_Implementation). | Within thirty (30) DAYS of execution of this CONTRACT |
| 1. **Identification (ID) Card Issuance Delays** | The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID CARDS.See [Section 205B](#_205B_Identification_(ID)), 2. | Upon identification of issue |
| 1. **ID CARD Confirmation** | The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID CARDS were issued.See [Section 205B](#_205B_Identification_(ID)), 2. | January |
| 1. **Key Contacts Listing (ET-1728)** | The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. See [Section 255B](#_265B_Account_Management). | April  August |
| 1. **PARTICIPATING PHARMACY Submission for Upcoming Benefit Period** | The CONTRACTOR provides an annual submission to the DEPARTMENT containing their PARTICIPATING PHARMACY network for the upcoming benefit period. See [Section 225B](#_225B_Pharmacy_Network). | June |
| 1. **It’s Your Choice Information** | The CONTRACTOR submits 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:   * CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. * Content for the CONTRACTOR’S plan description page, including available features. * Information for PARTICIPANTS to access the CONTRACTOR’S PARTICIPATING PHARMACY directory on its web site, including a link to the pharmacy directory.   See [Section 135B](#_135B_It’s_Your). | July |
| 1. **It’s Your Choice Informational Materials Review** | The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT’S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. See [Section 135B](#_130B_Prohibited_Fees). | July |
| 1. **Copies of Materials** | The CONTRACTOR submits three (3) hard copies of all IT’S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT’S YOUR CHOICE OPEN ENROLLMENT period. See [Section 135B](#_135B_It’s_Your). | September |
| 1. **SUBSCRIBER Notification of Changes** | The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT’S YOUR CHOICE OPEN ENROLLMENT period identifying those providers PARTICIPATING PHARMACIES that will not be in-network for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. See [Section 135B](#_135B_It’s_Your). | September |
| 1. **SUBSCRIBER Notification Confirmation** | The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. See [Section 135B](#_135B_It’s_Your). | October |
| 1. **Enrollment Discrepancy Tracker** | The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. See [Section 145B](#_145B_Eligibility/834_File), d. | As directed by the DEPARTMENT |
| 1. **Enrollment Reconciliation Report** *Full File Compare (FFC)* | The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. See [Section 145B](#_145B_Eligibility/834_File), c. | As directed by the DEPARTMENT |
| 1. **Web Content and Web-Portal Design and Changes** | The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. See [Section 255D](#_255D_Contractor_Web), 1a and 1p. | As directed by the DEPARTMENT |
| 1. **Major Administrative and Operative System Changes** | The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred eighty (180) DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the PHARMACY BENEFIT PLAN. See [Section 140](#_145_Information_Systems), 8. | As needed |
| 1. **Notification of Account Manager or Key Staff Changes** | The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. See [Section 255B](#_265B_Account_Management). | As needed |
| 1. **Recovery of Overpayments** | The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR’S determination that such overpayment is uncollectible after using such recovery and collection procedures. See [Section 130C](#_130C_Recovery_of). | As needed |
| 1. **Notification of Legal Action** | If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT’S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. See [Section 235I](#_235I_Notification_of). | As needed |
| 1. **Notification of Legal Action Against PARTICIPANT in Dispute over Charges** | If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit’s status in a mutually agreeable format. See [Section 130C](#_130C_Recovery_of), 5. | As needed |
| 1. **Notification of Privacy Breach** | [See Section 150F](#_155F_Privacy_Breach) above. See Department Terms and Conditions for requirements. | As required |
| 1. **Notification of Significant Events** | The CONTRACTOR provides notification of all significant events as described in [Section 115](#_115_General_Requirements_1), 14. | As needed |
| 1. **External Review Determination** | Within fourteen (14) calendar DAYS of the CONTRACTOR’S receipt of the notification of the external review’s determination, the CONTRACTOR notifies the DEPARTMENT of the outcome. See [Section 235F](#_235F_External_Review). | See description |
| 1. **Medicare Enrollment Denial** | The CONTRACTOR notifies the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT’S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT’S enrollment file or notification by Medicare. See [Section 215C](#_220G_Medicare). | See description |
| 1. **Transition Plan** | The CONTRACTOR provides a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. See [Section 150I](#_150I_Transition_Plan). | During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination |

### 310B Deliverables to Participants

| **Deliverable** | **Description** | **Frequency** |
| --- | --- | --- |
| 1. **ID CARDS** | The CONTRACTOR provides PARTICIPANTS with ID CARDS indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. See [Section 205B](#_205B_Identification_(ID)). | Upon enrollment and BENEFIT changes that impact the information printed on the ID CARDS |
| 1. **Participant Enrollment Information** | The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment:   * Information about PARTICIPANT requirements, including PRIOR AUTHORIZATIONS and referrals. * The PARTICIPATING PHARMACY directory or directions on how to request a printed copy of the provider directory. * Directions on how to access the PARTICIPATING PHARMACY directory on the CONTRACTOR’S website. * The CONTRACTOR’S contact information, including the toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address.   See [Section 205C](#_205C_Participant_Information). | Upon enrollment |
| 1. **SUBSCRIBER Notification of Changes** | The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT’S YOUR CHOICE OPEN ENROLLMENT period identifying those PARTICIPATING PHARMACIES that will not be in-network for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other PHARMACY BENEFIT PLAN changes. See [Section 135B](#_135B_It’s_Your). | September |
| 1. **PARTICIPANT Notification of Terminated Pharmacy Agreement** | At least thirty (30) DAYS prior to the termination of a pharmacy agreement during the benefit period (excluding terminations for violations of law), the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that pharmacy in the past twelve (12) months that includes the following information:   * How to find a new IN-NETWORK PARTICIPATING PHARMACY, * The continuity of care provision as it relates to this situation, and * Contact information for questions.   See [Section 225](#_225_Pharmacy_Network). | See description |
| 1. **PARTICIPANT Notification of Grievance Rights** | The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. See [Section 235A](#_235A_Grievance_Process). | See description |
| 1. **PARTICIPANT Notification of DEPARTMENT Administrative Review Rights** | In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee’s final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. See [Section 235D](#_235D_Investigation_and). | See description |

## 315 Performance Standards and Penalties

Performance standards are specific to data from the PHARMACY BENEFIT PLAN, not general data from the CONTRACTOR’S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT – RFP ETC0049 Appendix 2 – Pharmacy Performance Guarantees. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 145 and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR’S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

|  |  |  |
| --- | --- | --- |
| **Section** | **Performance Category** | **Maximum Penalty** |
| [315A](#_315A_Implementation) | Implementation | Three (3%) percent |
| [315B](#_315B_Account_Management_1) | Account Management | Three (3%) percent |
| [315C](#_315C_Claims_Processing_1) | Claims Processing | Four (4%) percent |
| [315D](#_315D_Customer_Service_1) | Customer Service | Four (4%) percent |
| [315E](#_315E_Data_Management_1) | Data Management and Privacy Breach Notification | Four (4%) percent |
| [315F](#_315F_Enrollment) | Eligibility/Enrollment | Four (4%) percent |
| [315G](#_315G_Other_1) | Other | Three (3%) percent |
|  | TOTAL | Twenty-five (25%) percent |

### 315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

| **Performance Standards – three (3%) percent Penalty** | **Penalties** |
| --- | --- |
| 1. **Program Information:** All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Web Content:** The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT’S YOUR CHOICE OPEN ENROLLMENT period for review and approval. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Customer Service:** The CONTRACTOR’s toll-free customer service telephone number is operational and customer service staff for the PHARMACY BENEFIT PLAN are trained no later than September 30, 2017. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Web Content Launch:** The web content dedicated to the HEATLH BENEFIT PROGRAM and upcoming IT’S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Informational Mailing:** The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT’S YOUR CHOICE OPEN ENROLLMENT period. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Enrollment File:** The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Financial Administration:** Financial administration requirements are operational no later than November 30, 2017. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Grievance Procedure:** The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT’S review and approval. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **ID CARDS:** No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID CARDS for SUBSCRIBERS with coverage effective January 1, 2018. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Claims Administrative Services:** All claims administrative services for the PHARMACY BENEFIT PLAN shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018.See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Outbound Pharmacy Data:** The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. See [Section 255A](#_265A_Implementation). | One thousand ($1,000) dollars per DAY for which the standard is not met |

### 315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| **1) CONTRACTOR Services:** The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as “top two-box” satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). See Section 255B. | Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey |
| **2) Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and employers of the PHARMACY BENEFIT PLAN. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of benefits, summary plan descriptions, claim denials and appeals, and summary of benefits and coverage. See Section 135A. | Five thousand ($5,000) dollars per incident |

### 315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| 1. **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. See [Section 230](#_230_Claims). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |
| 1. **Processing Accuracy:** At least ninety-nine and one-half percent (99.5%) level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. See [Section 230](#_235_Claims). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |
| 1. **Accumulator File:** At least ninety-five percent (95%) accuracy in health plan file processing, accumulation, and file return to health plans within twenty-four (24) hours. | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |
| 1. **Direct Member Reimbursement:** At least ninety-nine percent (99%) of clean claims adjudicated within 30 days. | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |
| 1. **Claims Processing Time:** At least ninety-nine and one-half percent (99.5%) of the time claims are paid (including reversals and adjustments) in accordance with the pharmacy contract reimbursement provisions effective at the time the claim is adjudicated. See Section 230. | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |
| 1. **Claims Processing System Availability:** At least ninety-nine (99%) percent of the time the claims processing system is available for adjudication of online claims submitted by network pharmacies. This includes downtime for system maintenance. | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month |

### 315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| 1. **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization’s customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. See [Section 255C](#_255C_Customer_Service). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month) |
| 1. **Call Abandonment Rate:** Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. See [Section 255C](#_265C_Customer_Service). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month) |
| 1. **Open Call Resolution Turn-Around-Time:** At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. See [Section 255C](#_265C_Customer_Service). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month) |
| 1. **Inquiry Resolution Tracking Document/Log:** Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT’S request.See [Section 255C](#_265C_Customer_Service). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month) |
| 1. **Electronic Written Inquiry Response:** At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. See [Section 255C](#_265C_Customer_Service). | Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month) |
| 1. **Key Stakeholder Satisfaction:**  See 315B (1) above. |  |

### 315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| 1. **Claims Data Transfer:** 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, all claims processed for PARTICIPANTS. See Section 145. | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Data File Corrections:** 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. See Sections 145 | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Notification of Data Breach:** The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within forty-eight (48) hours of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR must provide the DEPARTMENT with the information required in Section 24.0 (m) of the Department Terms and Conditions related to all such suspected or actual breaches. See [Section 150F](#_150F_Privacy_Breach). | $2,500 - first violation  $5,000 - second violation  $10,000 - third and any additional violations  $100,000 annual maximum |
| 1. **First Notice:** The Contractor must notify the Department Program Manager and Department Privacy Officer no less than two (2) Business Days before Contractor releases any external communications regarding a data breach. See Section 24.0(m)(1) of the Department Terms and Conditions. | $2,500 - first violation  $5,000 - second violation  $10,000 - third and any additional violations  $100,000 annual maximum |
| 1. **Privacy Violation:** The CONTRACTOR shall use or disclose PARTICIPANT PHI and/or PII only to perform functions, activities or provide the SERVICES specified in the CONTRACT, for or on behalf of the DEPARTMENT, provided that such use or disclosure would not violate state and federal law, including, where applicable, the requirements of the HIPAA, HITECH, or GINA. See Section 24.0 of the Department Terms and Conditions and Wis. Stat. §134.98. | $10,000 – First violation, plus $1,000 per record affected by each breach or disclosure.  $15,000 – Second violation, plus $1,000 per record affected by each breach or disclosure.  $20,000 – Third and any additional violations, plus $1,000 per record affected by each breach or disclosure. |

### 315F Eligibility/Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| 1. **Enrollment File:** 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. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. See [Section 145B.](#_145B_Eligibility/834_File) | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Enrollment Discrepancies:** 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. See [Section 145B](#_145B_Eligibility/834_File). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **ID CARDS:** The CONTRACTOR shall issue ID CARDS within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. See [Section 205B](#_205B_Identification_(ID)), 1. | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **ID CARDS for elections made during the IT’S YOUR CHOICE OPEN ENROLLMENT Period:** The CONTRACTOR shall issue ID CARDS by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the IT’S YOUR CHOICE OPEN ENROLLMENT period through December 10. See [Section 205B](#_205B_Identification_(ID)), 2. | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Removed** |  |

### 315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

| **Performance Standards** | **Penalties** |
| --- | --- |
| 1. **Audit:** The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. See [Section 150D](#_155E_Audit_and). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Grievance Resolution:** Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. See [Section 235D](#_245C_Investigation_and). | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **Major System Changes and Conversions:** 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 PHARMACY BENEFIT PLAN without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. See [Section 140](#_145_Information_Systems), 8. | One thousand ($1,000) dollars per DAY for which the standard is not met |
| 1. **REMOVED** |  |
| 1. **Non-Disclosure:** The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. See [Section 115](#_115_General_Requirements_1), 18. | Five thousand ($5,000) dollars per incident |
| 1. **Reporting and Deliverables Requirements:** The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must:  * Be verified by the CONTRACTOR for accuracy and completeness prior to submission; * Be delivered on or before scheduled due dates; * Be submitted as directed by the DEPARTMENT; * Fully disclose all required information in a manner that is responsive and with no material omission; and * Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report.   See [Section 150A](#_155A_Reporting_Requirements), 2. | Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met |
| 1. **Mail Order Dispensing Accuracy:** At least ninety-nine (99%) percent of the time, prescriptions are dispensed accurately with no errors. | Twenty-five hundred ($2,500) dollars for each percentage point below the Performance Standard listed, assessed on a monthly basis. |
| 1. **Mail Order Shipping Time:** At least ninety (90%) percent of clean prescriptions are shipped within two (2) business days. At least ninety-nine (99%) percent of prescriptions requiring intervention are shipped within five (5) business days. | Twenty-five hundred ($2,500) dollars for each percentage point below the Performance Standard listed, assessed on a monthly basis. |

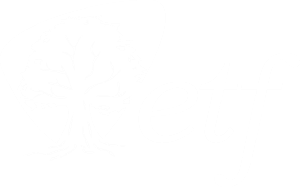
# 400 Uniform Pharmacy Benefits

**NOTE: Uniform Pharmacy Benefits are reviewed and updated annually. These Uniform Pharmacy Benefits will be updated with any benefit changes approved by the Group Insurance Board for future plan years.**

These are the Uniform Pharmacy Benefits or “Summary Plan Description” offered under the Health Benefit Program, specific to Pharmacy Benefits.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Pharmacy Benefits are provided to SUBSCRIBERS on the Department’s website. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Pharmacy Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.



Plan Year 2024

Uniform Pharmacy Benefits

**Certificate of Coverage**

**Unform Pharmacy Benefits Certificate of Coverage**

For all State of Wisconsin and Wisconsin Public Employers Group Health Insurance Programs

Effective January 1, 2024

24ET-2107upb (Revised 8/25/2023)

Certificate of Coverage

This Certificate of Coverage is your Summary Plan Description and contains the Uniform Pharmacy Benefits (UPB) offered under the **Group Health Insurance Program** (**GHIP**).

Keep this document with your insurance papers. The purpose of this document is to help you (the **Member**) and your **Dependents** understand the **Benefits** covered under this policy.

**Navitus Health Solutions, LLC**. (**Navitus**) the **Pharmacy Benefit Manager (PBM)** contracted with Wisconsin **Group Health Insurance Board** (**Board**) to provide pharmacy coverage for **Members** and their **Dependents** must offer the coverage described in this document.

If any part of this policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

These **Benefits** comply with state and federal minimum **Benefits** requirements, and any additional coverage requirements made by **the Group Insurance Board (Board)**.

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The **Pharmacy Benefit Manager** offering coverage in the State of Wisconsin and the Wisconsin Public Employers Group Health Insurance Program must include the Uniform Pharmacy Benefits. The **Pharmacy Benefit Manager** may not alter the language, **Benefits**, or exclusions and limitations of the Uniform Pharmacy Benefit.

# Definitions

The following terms, when used and capitalized in this **Pharmacy Benefit** description, are defined and limited to that meaning only:

**Allowed Amount**: Means the maximum dollar amount the **PBM** will pay a pharmacy for your prescription and is based upon the contract agreement between the **PBM** and the Pharmacy.

**Benefit Plan**:Means pharmacy benefit coverage including drug **Tiers**, copays, and co-insurance that you are enrolled in under the State of Wisconsin **Group Health Insurance Program**.

**Brand Name Drugs:** Means a drug sold by a drug company under a specific name or trademark, protected by a patent, and available by prescription or over the counter.

**Clear Bagging**: Means the process in which a **Provider’s** internal specialty pharmacy dispenses a **Participants** **Level** 4 specialty drug and transports the drug to where the drug is going to be administered to the **Participant** by a medical professional. Drugs administered in ETF’s **Clear Bagging** program are paid for through the pharmacy benefit.

**Confinement/Confined:** Means the period of time between admission as an inpatient or outpatient to a **Hospital**, **Covered** residential center, skilled nursing, or licensed ambulatory surgical center on the advice of the **Participant’s** physician; and discharge

therefrom, or the time spent receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**. **Hospital** swing bed **Confinement** is considered the same as **Confinement** in a skilled nursing facility.

**Coinsurance:** Means a specified percentage of the Drug costs that the **Participant** or family must pay each time those **Covered** services are provided, subject to any limits specified in the **Schedule of Benefits**.

**Copayment**:Means a specified dollar amount that the **Participant** or family must pay each time those **Covered** services are provided, subject to any limits specified in the **Uniform Pharmacy Benefits**. In maximum quantities, **Copayments** do not exceed a 30 consecutive day supply.

**Cover**//**Covers**/**Benefits**: Means the pharmacy or medical services that are paid for as a part of your coverage under the State of Wisconsin Group Health Insurance Program.

**Dispense as Written-1/DAW-1:**  Is a term used on a prescription by a **Prescriber** to fill the prescription as written, with no **Generic Drug** substitution.

**Deductible:** Means the amount the **Participant** owes for pharmacy drug coverage the **Participants** pharmacy **Benefit Plan** **Covers** before the pharmacy **Benefit Plan** begins to pay. For example, if the **Participants** **Deductible** is $1,600, the pharmacy **Benefit Plan** will not pay anything until the **Participant** has incurred $1,600 in **Out-Of-Pocket** expenses for covered pharmacy services subject to the **Deductible**. The **Deductible** may not apply to all services.

**Department/ETF**: Means the State of Wisconsin Department of Employee Trust Funds.

**Dependent**: Means any **Member** or beneficiary of the **GHIP** who is not the **Subscribe**r.

**Direct Member Reimbursement (DMR)**: Is when a **Member** pays full price for a drug at the pharmacy and then submits a **DMR** form to the **PBM** for reimbursement. If approved, the **Member** is reimbursed from the **PBM** the negotiated rate with the pharmacy minus the drug’s copay.

**Effective Date:** Means the date, as certified by **ETF** (or as shown on the **Health Plan** and/or **PBM** records for **Participants** who pay their pharmacy premium directly a **GHIP** **Health Plan**) on which the **Participant** becomes enrolled and entitled to the **Benefits** specified in the contract.

**Eligible Employee**:Is as defined under [Wis. Stat. § 40.02 (25)](https://docs.legis.wisconsin.gov/statutes/statutes/40/i/02/25) ,§[40.02 (46)](https://docs.legis.wisconsin.gov/statutes/statutes/40/i/02/46), or [§ 40.19 (4) (a)](https://docs.legis.wisconsin.gov/statutes/statutes/40/i/19/4), of an employer as defined under [Wis. Stat. § 40.02 (28)](https://docs.legis.wisconsin.gov/statutes/statutes/40/i/02/28). Employers, other than the State, must also have acted under [Wis. Stat. § 40.51 (7)](https://docs.legis.wisconsin.gov/statutes/statutes/40/iv/51/7), to make health care coverage available to their employees.

**Embedded**: Means when a **Participant** within a family plan meets the individual portion of **Participant** financial responsibility (**Deductible**, **Out-Of-Pocket-Limit**, **Maximum-Out-Of-Pocket)** within the family’s total financial responsibility, that **Participant** is no longer responsible for any further out of pocket costs. The remaining family **Deductible** will still apply to other family **Participants**.

**Emergency:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:

1. Serious jeopardy to the **Participant’s** health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
2. Serious impairment to the **Participant’s** bodily functions
3. Serious dysfunction of one or more of the **Participant’s** body organs or parts.

**Experimental**: Means the use of any service, treatment, procedure, facility, equipment, drug, device, or supply for a **Participant’s** **Illness** or **Injury** that, as determined by the **PBM** requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used, or isn't yet recognized as an acceptable medical practice to treat that **Illness** or **Injury** for a **Participant’s** **Illness** or **Injury**

**Food and Drug Administration (FDA):** Means the United States Food and Drug Administration is a federal agency of the Department of Health and Human Services responsible for, among other things, protecting public health by ensuring the safety, efficacy, and security of drugs, biological products, and medical devices.

**Formulary**:Means a list of prescription drugs, developed by a committee established by the **PBM**. The committee is made up of physicians and pharmacists. The **PBM** may require **Prior Authorization** for certain **Preferred** and **Non-Preferred Drugs** before coverage applies. Drugs that are not included in the **Formulary** are not **Covered** by the **Benefits** of this program.

**Generic Drugs:** Means a prescription drug that has the same active-ingredient formula as a brand-name drug. **Generic drugs** usually cost less than brand-name drugs. The **FDA** rates these drugs to be as safe and effective as brand-name drugs.

**Generic Equivalent:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

**Grievance**:Means a written complaint filed with the **Health Plan** and/or **PBM** concerning some aspect of the **PBM**. Some examples would be a rejection of a claim, denial of a formal Referral, etc.

**Group Health Insurance Program (GHIP)**:Means the Benefit Program offered by the **Group Insurance Board** that provides medical, pharmacy, and dental **Benefits** to enrolled public workers and their **Dependents**.

**Group Insurance Board (Board)**: Means the governing body that oversees the **Group Health Insurance Program**.

**Health Plan**:Means the **Health Plan** entity that is under contract with the **Group Insurance Board** to provide **Benefits** and services to **Participants** of the **Group Health Insurance Program**.

**High Deductible Health Plan (HDHP):** Means a **Benefit Plan** that, under federal law, has a minimum annual **Deductible** and a maximum annual **OOPL** set by the IRS. An **HDHP** does not pay any health care costs until the annual **Deductible** has been met (except for preventive services mandated by the Patient Protection and Affordable Care Act). The **HDHP** is designed to offer a lower monthly premium in turn for more shared health care costs.

**Hospital:** Means an institution that:

a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to **Hospitals**;

b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, **Injury** and **Illness**;

c) provides this care for fees;

d) provides such care on an inpatient basis;

e) provides continuous 24-hour nursing services by registered graduate nurses, or qualifies as a psychiatric or tuberculosis **Hospital**;

f) is a **Medicare** Provider; and

g) is accredited as a **Hospital** by the Joint Commission of Accreditation of **Hospitals**.

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

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

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

**Internal Revenue Service (IRS)**: Means the federal agency that is responsible for collecting taxes and administering the Internal Revenue Code

**Medically Necessary:** A service, treatment, procedure, equipment, drug, device, or supply provided by a **Hospital**, physician or other health care **Provider** that is required to identify or treat a **Participant’s** **illness** or **Injury** and which is, as determined by the **Health Plan** and/or **PBM**:

1. Consistent with the symptom(s) or diagnosis and treatment of the **Participants** **Illness** or **Injury**, and
2. appropriate under the standards of acceptable medical practice to treat that **Illness** or **Injury**, and
3. not solely for the convenience of the **Participant**, physician, **Hospital**, or other health care **Provider**, and
4. the most appropriate service, treatment, procedure, equipment, drug, device, or supply which can be safely provided to the **Participant** and accomplishes the desired end result in the most economical manner.

**Medicare:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended. **Medicare** Part A refers to coverage for **Hospital** services, and **Medicare** Part B refers to coverage for outpatient services.

**Medicare Prescription Drug Program/Medicare Part D:** Means the prescription drug coverage provided by the **PBM** to Covered Individuals who are enrolled in **Medicare** Parts A and B, and eligible for **Medicare Part D**; and who are covered under a **Medicare** coordinated contract in the **GHIP**.

**Non-Participating Pharmacy:** Means a pharmacy that does not have a signed written agreement and is not listed on the most current listing of the **PBM’S** directory of **Participating Pharmacies**.

**Non-Preferred Drug (Non-Preferred):** Means a drug the **PBM** has determined offers less value and/or cost-effectiveness than **Preferred Drugs**. This would include **Non-Preferred Generic Drugs, Non-Preferred Brand Name Drugs**, and **Non-Preferred Specialty Drugs** included on the **Formulary**, which are covered by the **Benefits** of this program with a higher **Copayment**.

**Maximum Out-Of-Pocket Limit (MOOP):** Means the most a **Participant** pays during a policy period (usually a calendar year) before the **Pharmacy Benefit** or **Health Plan** begins to pay 100% of the **Allowed Amount**. This limit never includes premium, balance-billed charges, or charges for health care that the **Pharmacy Benefit** or **Health Plan** does not **Cover**. Note: payments for prescription drugs obtained at a **Non-Participating Pharmacy**, out-of-network services, or other expenses do not accumulate toward this limit.

**Out-Of-Pocket Limit (OOPL):** The most the **Participant** pays during a policy period (usually a calendar year) for essential health **Benefits** as defined by the Affordable Care Act before the Pharmacy Benefit or **Health Plan** begins to pay 100% of the **Allowed Amount**. This limit never includes premium, balance-billed Charges, or Charges for health care the **Benefit Plan** does not **Cover**. Payments for out-of-network services or other expenses do not accumulate toward this limit.

**Participant:** Means the **Subscriber** or any of their **Dependents** who have been specified for enrollment and are entitled to **Benefits**.

**Participating Pharmacy:** Means a pharmacy that has agreed in writing to provide the services to **Participants** that are administered by the **PBM** and covered under the policy. The pharmacy’s written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a **Participan**t.

**Payer/Payor**: Means the person or company making the payment, satisfying the claim, or settling a financial obligation

**Pharmacy Benefit Manager (PBM)/Navitus Health Solutions, LLC. (Navitus):** The **PBM** is a third-party administrator that is contracted with the **Group Insurance Board** to administer the prescription drug **Benefits** under this health insurance program. Its primarily responsible for processing and paying prescription drug claims, developing and maintaining the **Formulary**, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. **Navitus** is the **Board’s** **PBM** for 2024.

**Preferred Drug (Preferred):** Means a drug the **PBM** has determined offers more value and/or cost-effective treatment options compared to a **Non-Preferred Drug**. This would include **Preferred Generic Drugs**, **Preferred Brand Name Drugs**, and **Preferred Specialty Medications** included in the **Formulary**, which is covered by the **Benefits** of this program.

**Preferred Specialty Pharmacy:** Means a **Participating Pharmacy** that meets criteria established by the **PBM** to specifically administer **Specialty Medications** services, with which the **PBM** has executed a written contract to provide services to **Participants**, which are administered by the **PBM** and covered under the policy. The **PBM** may execute written contracts with more than one **Participating Pharmacy** as a **Preferred Specialty Pharmacy**.

**Prescriber**: Means the medical professional who writes a prescription for a **Participant**.

**Preventive Drug**: The Affordable Care Act (ACA) requires that eligible people receive certain drugs and services at no cost. **Preventive Drugs** fall are used for breast cancer prevention, cardiovascular disease primary prevention, colorectal cancer screening, heart attack prevention, human immunodeficiency virus (HIV) pre-exposure prophylaxis, smoking cessation, and vitamins and minerals for children and women planning or capable of pregnancy.

**Prior Authorization:** Means obtaining approval from the **PBM** before obtaining the drug. **Prior Authorizations** are at the discretion of the **PBM** and are indicated on the **Formulary**.

**Provider:** Means (a) a doctor, **Hospital**, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more **Benefits**.

**Quantity Limits**: The highest amount of a prescription drug that can be given by a pharmacy in a period of time.

**Schedule of Benefits:** The document that is issued to accompany this document which details specific **Benefits** for covered services provided to **Participants** by the **PBM**.

**Self-Administered Injectable:** Means an injectable that is administered subcutaneously and can be safely self-administered by the **Participant** and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections, or any drug administered through infusion.

**Specialty Medications:** Means medications that are used to treat complex chronic and/or life-threatening conditions; are more costly to obtain and administer; may not be available from all Participating Pharmacies; require special storage, handling, and administration; and involve a significant degree of patient education, monitoring, and management.

**Subscriber:** An **Eligible Employee** or retiree who is enrolled for (a) single coverage; or (b) family coverage and whose **Dependents** are eligible for **Benefits**.

**Tier/Level**: The **ETF’s** pharmacy benefit has four **Tiers**. Each **Tier Covers** a different type of drug and has its own **Coinsurance**/copay rate.

**Urgent Care:** Means care for an accident or **Illness** which is needed sooner than a routine doctor's visit. This does not include follow-up care unless such care is necessary to prevent a **Participant’s** health from getting seriously worse before they can reach their primary care **Provider**. It also does not include care that can be safely postponed until the **Participant** can obtain a prescription from a **Participating Pharmacy**.

**Usual and Customary Charge:** An amount for a treatment, service, or supply provided by **Non-Participating Pharmacy** that is reasonable, as determined by the **PBM**, when taking into consideration, among other factors determined by the **PBM**, amounts charged by **Non-Participating Pharmacies** for similar prescription drugs when provided in the same general area under similar or comparable circumstances and amounts accepted by the **PBM** as full payment for similar Prescription Drugs. In some cases, the amount the **PBM** determines as reasonable may be less than the amount billed. In situations where the prescription drug is provided by a **Participating Pharmacy** or a **Non-Participating Pharmacy**, the **Participant** is held harmless for the difference between the billed and paid Charge(s), other than the **Copayments**, **Coinsurance**. **Participants** may be responsible for costs beyond **Usual and Customary Charges** for prescription drugs obtained from **Non-Participating Pharmacy** for prescription drugs that are non-**Emergency** or non-Urgent and which are not on the **Formulary**. **Emergency** or **Urgent Care** prescription drugs from a **Non-Participating Pharmacy** may be subject to **Usual and Customary Charges**, however, the **PBM** must hold the **Participant** harmless from any effort(s) by third parties to collect from the **Participant** the amount above the **Usual and Customary Charges** for the Pharmacy Benefit.

# How the Pharmacy Benefit Works

## Benefits and Services

**Pharmacy Benefits** are provided under a contract between **Navitus Health Solutions, LLC**. (**Navitus**) and **The Group Insurance Board**. **Navitus** is responsible for the prescription drug **Benefits** under the terms and conditions as laid out in the contract with the **Group Insurance Board**.

The **Group Insurance Board** contracts with **Navitus** to provide prescription drug **Benefits**. **Navitus** is responsible for the prescription drug benefit as provided for under the terms and conditions of the **Pharmacy Benefits** for those who are **Covered** under the State of Wisconsin Health Benefit Program.

All **Pharmacy Benefits** are paid per the terms of this contract between **Navitus** and the **Group Insurance Board**. **Pharmacy Benefits** are entirely incorporated in the contract.

This section describes the **Benefits** and services provided under the Uniform Pharmacy Benefit. All **Benefits** are available to you and your enrolled **Dependents** if they are received after the date your health insurance policy becomes effective and your Premium is paid.

## Pharmacy Premium Payment

The Pharmacy Premium is combined with the Health Insurance premium for one payment each month. For most **Subscribers**, your Pharmacy Premium payments will be arranged through deductions from salary, your accumulated sick leave accounts (State Employees only), your annuity, or by converting your life insurance under certain circumstances. If a **Subscribe**r is longer working and does not have an annuity, sick leave, or converted life insurance plan, they must pay their Premium directly to their **Health Plan**. If you are paying your Premium directly to your **Health Plan** and you either stop paying or tell your **Health Plan** you no longer want coverage, your **Health Plan** will notify **ETF** and **ETF** will notify the **PBM**.

## Drug Formulary

Drugs that are not included on the **Formulary** are not **Covered** by this pharmacy benefit unless approved through an exceptions process.

The IYC plans, **HDHP** plans, and **Medicare Part D** all have drug formularies. These formularies can be found at the public facing **Navitus**/**ETF** website at <https://etf.benefits.navitus.com>. To find the formularies just click on the name of the plan’s **Formulary** you are looking for and then on the word **Formulary** on the left side of the screen. The option to view the most current **Formulary** should then appear on your screen.

A **Member** can also view a **Formulary** through **Navitus’s** website at <https://www.navitus.com/>members through the **Member** portal. To view the **Formularies**, you will need to have a portal login and password established with **Navitus**. A **Member** can create a portal login and password through the **Navitus** website.

## Participating Pharmacies vs. Non-Participating Pharmacies

This Summary Plan Description applies to services received from Participating Pharmacies. Services received from Non-Participating Pharmacies are not **Covered** except for **Emergency** or Urgent situations.

**Members** may submit paper claims and a completed **Direct Member Reimbursement** form for prescriptions filled at Non-Participating Pharmacies in Urgent or **Emergency** situations. **Members** may receive reimbursement for these drugs at the pharmacy contracted rate minus the drug copay/**Coinsurance**.

For example, a **Member** fills a prescription in an **Emergency** or Urgent situation and pays $100 for the drug. The **PBM’s** contracted rate for the **Level** 1 drug is $50. The contracted rate ($50) minus the copay for the **Level** 1 drug ($5) is $45. The **Member** would be reimbursed $45 for the drug they obtained.

If a **Member** fills a prescription at a **Non-Participating Pharmacy** and they are not experiencing an **Emergency** or urgent situation they will need to pay the full price of the drug out of their pocket and not expect to be reimbursed anything.

A searchable list of in-network participating pharmacies can be found at <https://etf.benefits.navitus.com/>, <https://www.navitus.com/>members, or by contacting **Navitus** Customer Care at 866-333-2757 (non-**Medicare**)/ 866-270-2877 (**Medicare**).

## How to Fill a Prescription

When filling a prescription at a **Participating Pharmacy** you must show your **Navitus** identification card at the pharmacy.

### What if I lost my Navitus card and I need my prescription now?

If you cannot show your identification card, you may have your pharmacy call Navitus Customer Care to obtain the necessary processing information to submit your claim. Otherwise, you may need to pay the full amount and submit to the **PBM** for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient’s name, patient’s identification number, the drugs national drug classification (NDC) code, prescription name, and retail price (in U.S. currency). The **Member** may be responsible for more than the **Copayment** amount in these situations. The **PBM** will determine the benefit amount based on the network price. To request replacement ID cards, **Member** may contact Navitus Customer Care.

## Participant Cost Share for Prescription Drugs

Prescription Drug **Copayments** or **Coinsurance** are required for all **Members** for all services unless otherwise required under federal and state law. Here is a chart to help describe each **Level** of drug coverage under the pharmacy benefit.

|  |  |  |
| --- | --- | --- |
| **Level** | **Copay/Coinsurance** | **Drug Description** |
| Level 1 | $5 copay | Preferred **Generic Drugs** and certain lower-cost preferred **Brand Name Drugs** |
| Level 2 | 20% **Coinsurance** ($50 max) | Preferred **Brand Name Drugs** and certain higher cost preferred **Generic Drugs** |
| Level 3 | 40% **Coinsurance** ($150 max)  **Dispense as Written** drugs are 40% **Coinsurance** plus the cost difference between the brand and **Generic Drugs** applied unless the **Member** has a medical need, and their doctor has submitted a one-time **FDA** MedWatch form. | **Non-preferred** **Brand Name Drugs** and certain high-cost **Generic Drugs** which alternative/equivalent preferred generic and **Brand Name Drugs** are **Covered** |
| Level 4 | $50 copayment | Includes only specialty drugs filled at a **Preferred** **Specialty Pharmacy**. This is mandatory for non-**Medicare** **Participants**. |
| 40% **Coinsurance** ($200 max) | Only applies to those with **Medicare**. These specialty drugs are filled at a pharmacy other than a **Preferred** **Specialty Pharmacy**. |

This chart describes each plan’s Deductibles and Out-Of-Pocket Limits (OOPLs).

|  |  |  |  |
| --- | --- | --- | --- |
|  | **IYC Health Plan** | **IYC HDHP** | **Medicare Part D** |
| **Plan Deductibles** | | | |
| All Levels | None | $1,600/$3,200 combined medical and pharmacy | None |
| **OOPLs** |  |  |  |
| Level 1 & 2 Combined | $600/$1,200 | $2,500/$5,000 combined medical and pharmacy | $600/$1,200 |
| Level 3 | $9,450/$18,900 | $9,450/$18,900 |
| Level 4 | $9,450/18,900 | $1,200/$2,400 |

## Special Note for High Deductible Health Plan Members

Unless noted otherwise all **Members** with **HDHP** will need to meet their combined medical and pharmacy **Deductible** before any copay or **Coinsurance** rates begin. For example, if an individual with **HDHP** is prescribed a **Level** 3 drug that costs $400 the **Member** will need to pay $1,600 for that drug, any other prescriptions they may be on, and medical costs. After the $1,600 threshold is met the **Member** would then pay no more than $150 for that **Level** 3 drug.

## PBM Drug Coverage vs. Medical Plan Drug Coverage

A **Member’s** prescription drug will be **Covered** under their medical insurance, rather than their pharmacy insurance, if the prescription drug is administered during home care, in a medical professional’s office, during **Confinement**, during an **Emergency** room visit, or in an **Urgent Care** setting.

However, if a prescription is written for a **Covered** drug during home care, in a medical professional’s office, during **Confinement**, during an **Emergency** room visit, or in an **Urgent Care** setting that prescription will be **Covered** by a **Member’s** pharmacy benefit. An example of this would be a **Self-Administered Injectable** drug.

The one exception to **PBM** drug coverage and Medical Plan Drug Coverage is the **Clear Bagging Program**. Those who have some **Level** 4 drugs administered in a medical professional’s office, clinic, or **Hospita**l could have their drug paid for through the pharmacy benefit. If this is the case a **Member** will receive two **Explanations of Benefits (EOBs)** and two bills, one from the **PBM** for the drug and one from the Medical Insurance **Provider** for the administration of the drug.

## Vaccinations at Pharmacies

### Non-Medicare Members

Non-**Medicare** **Members** can receive vaccines for Influenza, Pneumonia, Tetanus, Hepatitis, Shingles, Measles, Mumps, Human Papillomavirus (HPV) Pertussis, Varicella, Meningitis, Covid-19 at any in-network pharmacy at no cost. If Non-**Medicare** **Members** receive these vaccinations at their doctor’s office the vaccine will be **Covered** under their Medical Insurance.

### Medicare Members

Vaccinations for **Medicare** **Members** are **Covered** under **Medicare Part D**. **Medicare** **Members** can receive vaccines at the pharmacy at no cost. If a **Medicare Part D** **Member** receives a vaccination at the medical **Provider’s** office, they will need to pay the full price of the vaccine to their medical **Provider** and then submit a **Direct Member Reimbursement** form to **Navitus**. **Navitus** will reimburse **Members** the negotiated price they pay pharmacies to administer the vaccine. For example, a **Medicare Part D** **Member** pays $300 to their medical **Provider’s** office for a Shingles vaccination. **Navitus’s** negotiated rate with pharmacies for the Shingles vaccine is $200. The **Member** will be reimbursed $200 and the remaining $100 the **Member** paid will be the **Member’s** **Out-Of-Pocket** expense.

All Non-**Medicare** and **Medicare** **Members** should call ahead to a pharmacy ahead getting vaccinated to make sure the pharmacy:

1. Has the vaccine/immunization in stock
2. Find out if the pharmacy requires an appointment for vaccines/immunization
3. If vaccinating/immunizing a child, make sure the pharmacy does vaccinate children

## Medicare Part D Dual Enrollment

**Medicare**-eligible **Members** will be **Covered** by the **PBM’s** **Medicare Part D** prescription drug plan (PDP). If a **Member** chooses to be enrolled in another **Medicare Part D** PDP other than the **PBM’s** they will not have duplicate **Benefits**.

## PBM Restrictions on Medications

The **PBM** may apply **Quantity Limits** to medications in certain situations. The **PBM** may also require the **Prescribe**r to file a **Prior Authorization** form and the **PBM** approves the form before allowing any prescription to be **Covered** under the pharmacy benefit.

## Drug Packaging

Single packaged items are limited to two items per **Copayment** or up to a 30-day supply, whichever is more appropriate as determined by the **PBM**.

Oral contraceptives are not subject to the 30-day supply and will be dispensed at one **Copaymen**t per package or a 28-day supply, whichever is less.

## Brand Name Vs. Generic

Cost-effective **Generic Equivalent** will be dispensed unless the **Prescriber** specifies on the prescription the Brand Name Drug and indicates that no substitutions may be made. In those cases, the Brand Name Drug will be **Covered** at whatever **Tier** the drug is at on the **Formulary**.

## Tablet Splitting

This is a voluntary program where the **PBM** designates certain medications that **Members** can split the tablet of a higher strength dosage at home. In this program, the **Member** gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. **Members** who use table splitting will pay half the normal **Copayment** amount. Medications eligible for tablet splitting are designated on the **Formulary.**

## Over-The-Counter Drugs

The **PBM** reserves the right to cover certain over-the-counter drugs on the **Formulary**. Over-the-counter drugs are shown on the **Formulary** with the Special Code of OTC.

## Preventive Prescription Drugs

The Affordable Care Act (ACA) requires that all non-**HDHP** and **HDHP** **Members** receive certain drugs on the drug **Formulary** and services at no cost. **Preventive Drugs** fall that are used for breast cancer prevention, cardiovascular disease primary prevention, colorectal cancer screening, heart attack prevention, human immunodeficiency virus (HIV) pre-exposure prophylaxis, smoking cessation, and vitamins and minerals for children and women planning or capable of pregnancy.

## Discount Eligible Medications

There are some drugs used to treat weight loss, infertility, hair loss, and erectile dysfunction that are not **Covered** by a **Member’s** pharmacy benefit, but a **Member** can still buy them at a discount. A **Member** will pay 100% of the discounted rate and the amounts will not count towards any **OOPL**. To see the complete Discount Drug List visit <https://etf.benefits.navitus.com/>and click on the name of the plan’s **Formulary** and then on the word **Formulary** on the left side of the screen. The option to view the **ETF** Discount Drug List will appear on the list in the middle of your screen.

## Insulin, Disposable Diabetic Supplies, Glucometers and Continuous Glucose Monitors

The **Formulary** will list all approved diabetic related products. **Prior Authorization** is required for any product or drug not listed on the **Formulary**. Diabetic supplies are not **Covered** under **Medicare Part D**

1. Insulin is **Covered** as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug **Copayment**
2. Disposable Diabetic Supplies and Glucometers will be **Covered** on **Level** 2 with a 20% **Coinsurance** ($50 max). **Members** with **HDHP** coverage must meet their **Deductible** before the **Level** 2 coverage begins. All **Members** **Coinsurances** will be applied to the annual **OOPL** for prescription Drugs.
3. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood, or urine test strips.
4. Continuous Glucose Monitors for non-**Medicare** **Members** certain brands of Continuous Glucose Monitors (CGMs) are **Covered** under your pharmacy benefit. CGMs are **Covered** on **Level** 3 with a 40% **Coinsurance** ($150 max). Certain brands for CGMs are also **Covered** under your medical benefit. The brand of CGM coverage varies from insurer to insurer. CGMs are not **Covered** under **Medicare Part D**.

## Other Devices and Supplies

Other devices and supplies administered by the **PBM** that are subject to a 20% **Coinsurance** and applied to the annual **OOPL** for prescription drugs are:

1. Diaphragms
2. Syringes/Needles
3. Spacers/Peak Flow Meters

\*\*NOTE: If a **Member** is in the **HDHP** program they must satisfy the **Deductible** before the pharmacy benefit begins coverage, except for preventive prescription drugs. \*\*

## Smoking Cessation

Two ninety (90)-day courses of pharmacotherapy products that by law require a written prescription and filled at a **Participating Pharmacy** are **Covered** per calendar. This coverage includes all **FDA**-approved prescription and over-the-counter smoking cessation products that are on the **Formulary**. Only one 30-day supply of medication may be obtained at a time. A **Member’s** treating physician must file a **Prior Authorization** form to the **PBM** if they extend the first quit attempt.

## No Lifetime Maximum on Pharmacy Benefits

There is no lifetime maximum benefit on all **Pharmacy** **Benefits**.

## Specialty Medications

**Specialty Medications** are also known as **Level** 4 drugs are medications that traditionally treat complex, chronic, or rare conditions including investigational drugs for the treatment of HIV, as required by Wis. Stat. [§ 632.895 (9)](https://docs.legis.wisconsin.gov/statutes/statutes/632/vi/895/9).

**Specialty medications** are usually the most expensive drugs on the pharmaceutical market.

In some cases, the **PBM** may limit availability to specific pharmacies.

## Preferred Specialty Pharmacies

### Non-Medicare Members:

For a specialty drug to be **Covered** under your pharmacy benefit, which means you a **Member** would pay a $50 copay for the drug, with **HDHP** **Members** paying $50 for the drug after meeting their **Deductible**, the prescription must be filled at either [Lumicera Health Services](https://www.lumicera.com/) specialty pharmacy or [UW Specialty Pharmacies](https://www.uwhealth.org/pharmacy-services). Outside of an **Emergency** or urgent situation if a specialty drug prescription is filled at another specialty pharmacy the drug won’t be **Covered** by the Pharmacy Benefit.

### Medicare Members:

If you are on **Medicare Part D** you will pay a $50 copy for a specialty drug filled at [Lumicera Health Services](https://www.lumicera.com/) specialty pharmacy or [UW Specialty Pharmacies](https://www.uwhealth.org/pharmacy-services). If you do not fill your **Level** 4 prescription at one of these pharmacies, you will pay 40% of the total cost of the prescription with a $200 maximum payment. The amount you pay for the drug to out-of-network pharmacy will not apply to the **Level** 4 **OOPL** but, will go towards the federal limit of $9,450 individual/$18,900 family.

# Exclusions and Limitations

The following is a list of services, treatments, equipment, or supplies that are excluded or have some limitations on the benefit provided under the pharmacy benefit. All exclusions listed below apply to **Benefits** offered by the **PBM**. Some of the listed exclusions may be **Medically Necessary**, but still are not **Covered** under the Pharmacy Benefit, while others may be examples of services that are not **Medically Necessary** or not medical in nature, as determined by the **PBM**.

## Outpatient Prescriptions Drugs Administered by the PBM

1. Charges for supplies and medicines with or without a doctor’s prescription, unless otherwise specifically **Covered**.
2. Charges for prescription drugs that require a **Prior Authorization** unless approved by the **PBM**.
3. Charges for cosmetic drug treatments such as Retin-A and Rogaine.
4. Any diet control program, treatment, or supplies for weight reduction including any **FDA** medications approved for weight loss such as Wegovy, Saxenda, and,Xenical
5. Anorexic agents
6. Non-**FDA** approved prescriptions, including compounded estrogen, progesterone, or testosterone products, excepted as authorized by the **PBM**
7. All over-the-counter drug items, except those designated as **Covered** by the **PBM**
8. Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
9. Charges for injectable medications, except for **Self-Administered Injectable** medications.
10. Charges for supplies and medications purchased from a **Non-Participating Pharmacy**, except when there is an **Emergency** or **Urgent Care** is required
11. Drugs approved by the **FDA** may be excluded until reviewed and approved by the **Navitus’s Pharmacy** and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
12. Charges for infertility and fertility treatment
13. Charges for drugs prescribed for erectile dysfunction
14. Charges for medications obtained through a discount program or over the internet, unless **Prior Authorized** by the **PBM**
15. Charges to replace expired, spilled, stolen, or lost prescription drugs

## General

1. Any additional exclusion as described in this document
2. Services to the extent the **Member** is eligible for all **Medicare** benefits, regardless of whether the **Member** is enrolled in **Medicare**. This exclusion only applies if the **Member** is enrolled in a **Medicare** coordinated coverage and does not enroll in **Medicare** Part B when it is first available as the primary **Payor** or who subsequently cancels **Medicare** coverage or is not enrolled in a **Medicare Part D** Plan.
3. Treatment, services, and supplies for which the **Member**: (a) has no obligation to pay or which would be furnished to the **Member** without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulations, or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.
4. Treatment, services, and supplies for any **Injury** or **Illness** as the result of war declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.
5. Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which under the policy the **PBM** is the primary **Payor**, and the VA is the secondary **Payor** under applicable federal law. **Benefits** are not coordinated with the VA unless specific federal law requires such coordination.
6. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
7. Treatment, services or supplies used in educational or vocational training.
8. Treatment or service in connection with an **Illness** or **Injury** caused by engaging in an illegal occupation or in the commission of or attempt to commit a felony.
9. Charges for injectable medications administered in nursing when the nursing home stay is not **Covered** by the Medical Insurance Plan.
10. Expenses incurred prior to the **Effective Date** of coverage by the Pharmacy Benefit or services received after the Pharmacy Benefit coverage or eligibility terminates. Except when a **Member’s** coverage is terminated because of **Member** cancellation or nonpayment of premium, **Benefits** shall continue to the **Member** if they are **Confined** as an inpatient on the coverage termination date but only until the attending physician determines that **Confinement** is no longer **Medically Necessary**; the contract maximum is reached; the end of 12 months after the date of termination; or **Confinement** ceases, whichever occurs first.
11. Any service, treatment, procedure, equipment, drug, device, or supply which is not reasonable and **Medically Necessary** or not required in accordance with accepted standards of medical, surgical, or psychiatric practice.
12. **Experimental** services, treatments, procedures, equipment, drugs, devices, or supplies Any service considered to be **Experimental**, except drugs for the treatment of an HIV infection, as required by Wis. Stat. [§ 632.895 (9)](https://docs.legis.wisconsin.gov/statutes/statutes/632/vi/895/9) and routine care administered in a cancer clinical trial as required by Wis. Stat. [§ 632.87 (6)](https://docs.legis.wisconsin.gov/statutes/statutes/632/vi/87/6).
13. Services or medications provided by non-participating pharmacies. Exceptions to this exclusion:
14. Prescriptions related to **Emergency** or **Urgent Care** services outside the Service Area
15. Food or food supplements except when provided during a **Covered** outpatient or inpatient **Confinement**.
16. Services to the extent a **Member** receives or is entitled to receive, any **Benefits**, settlement, award, or damages for any reason of, or following any claim under, any Worker’s Compensation Act, employer’s liability insurance plan, or similar law or act. Entitled means the **Member** is actually insured under Worker’s Compensation.
17. Services related to an **Injury** that was self-inflicted for the purpose of receiving Medical Insurance and/or **Pharmacy Benefits**.
18. Treatment, services, and supplies for cosmetic or beautifying purposes, except when associated with a **Covered** service to correct a functional impairment related to congenital bodily disorders or conditions or when associated with reconstructive surgery due to an **Illness** or accidental **Injury**.
19. Any charges for, or in connections with travel. However, most travel vaccines are **Covered** under the pharmacy benefit.
20. Services that a child’s school is legally obligated to provide, whether or not the school actually provides the services and whether or not a **Member** chooses to use those services.

# Limitations

1. Major Disaster or Epidemic: If a major disaster or epidemic occurs, the **PBM** must allow **Members** to receive drugs and supplies on the **Formulary** from out-of-network **Providers** and/or non-participating pharmacies.
2. Circumstances Beyond the **PBM’s** Control: If due to circumstances not reasonable with the contract of the **PBM**, such as a complete or partial insurrection, labor disputes not under the control of the **PBM**, the rendition or provision of drugs and supplies **Covered** are delayed or rendered impractical, the **PBM** will use their best efforts to provide **Covered benefits**. In this case, **Members** may receive drugs and supplies from non-participating pharmacies.

# Coordination of Benefits

## Applicability

This Coordination of Benefits (COB) provision applies to the State **Pharmacy Benefits** which is part of the Wisconsin **Group Health Insurance Plan (GHIP**) when a **Participant** has health care and/or pharmacy coverage under more than one Plan at the same time.

If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the **Benefits** of the **GHIP** are determined before or after those of another plan. The **Benefits** of the **GHIP**:

a) Shall not be reduced when, under the order of benefit determination rules, the **GHIP** determines its **Benefits** before another Plan, but

b) May be reduced when, under the order of benefit determination rules, another Plan determines its **Benefits** first.

## Order of Benefit Determination Rules

When there is a basis for a claim under the **GHIP** and another Plan, the **GHIP** is a Secondary Plan that has its **Benefits** determined after those of the other Plan, unless:

a) The other Plan has rules coordinating its **Benefits** with those of the **GHIP**,

and

b) Both those rules and the **GHIP’s** rules described in the Rules subsection below require that the **GHIP’s** **Benefits** be determined before those of the other Plan.

## Rules

The **GHIP** determines its order of **Benefits** using the first of the following rules:

1. Non-**Dependent**/**Dependent**

The **Benefits** of the Plan which **Covers** the person as an employee or **Participant** are determined before those of the Plan which **Covers** the person as a **Dependent** of an Employee or **Participant**.

1. **Dependent** Child/Parents Not Separated or Divorced

Except as stated in paragraph c) below, when the **GHIP** and another Plan **Cover** the same child as a **Dependent** of different persons, called "parents":

1. The **Benefits** of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year, but
2. If both parents have the same birthday, the **Benefits** of the Plan which **Covered** the parent longer are determined before those of the Plan which **Covered** the other parent for a shorter period of time.

If the other Plan does not have the rule described in i) above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of **Benefits**, the rule in the other Plan shall determine the order of **Benefits**.

1. Dependent Child/Separated or Divorced Parents

If two or more Plans **Cover** a person as a **Dependent** child of divorced or separated parents, **Benefits** for the child are determined in this order:

1. First, the Plan of the parent with custody of the child,
2. Then, the Plan of the spouse of the parent with the custody of the child, and ET-2180 (Rev 1/13/2022) Page 58 of 63
3. Finally, the Plan of the parent not having custody of the child. Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the **Benefits** of the respective parents' Plans have actual knowledge of those terms, **Benefits** for the **Dependent** child shall be determined according to paragraph b) above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the **Benefits** of the Plan of that parent has actual knowledge of those terms, the **Benefits** of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any **Benefits** are actually paid or provided before the entity has that actual knowledge.

1. Active/Inactive Employee

The **Benefits** of a Plan which **Covers** a person as an employee who is neither laid off nor retired nor as that employee's **Dependent** are determined before those of a Plan which **Covers** that person as a laid off or retired employee or as that employee's **Dependent**. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of **Benefits**, this paragraph d) is ignored.

1. Continuation Coverage

If a person has continuation coverage under federal or state law and is also **Covered** under another Plan, the following shall determine the order of **Benefits**:

1. First, the **Benefits** of a Plan **Cover** the person as an employee, **Member**, or **Subscriber** or as a **Dependent** of an employee, **Member**, or **Subscriber**.
2. Second, the **Benefits** under the continuation coverage.

If the other Plan does not have the rule described in subparagraph i), and if, as a result, the Plans do not agree on the order of **Benefits**, this paragraph e) is ignored.

1. Longer/Shorter Length of Coverage

If none of the above rules determines the order of **Benefits**, the **Benefits** of the Plan which **Covered** an employee, **Member**, or **Subscriber** longer are determined before those of the Plan which **Covered** that person for the shorter time.

## Effect on the Benefits of the GHIP

This section applies when, in accordance with Section B. Order of Benefit Determination Rules, the **GHIP** is a Secondary Plan as to one or more other Plans. In that event, the **Benefits** of the **GHIP** may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

The **Benefits** of the **GHIP** will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

a) The **Benefits** that would be payable for the Allowable Expenses under the **GHIP** in the absence of this COB provision, and

b) The **Benefits** that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether a claim is made. Under this provision, the **Benefits** of the **GHIP** will be reduced so that they and the **Benefits** payable under the other Plans do not total more than those Allowable Expenses.

When the **Benefits** of the **GHIP** are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the **GHIP**.

## Right to Receive and Release Needed Information

The **Health Plan** has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming **Benefits** under the **GHIP** must give the **Health Plan** any facts it needs to pay the claim.

## Facility of Payment

A payment made under another Plan may include an amount that should have been paid under the **GHIP**. If it does, the **Health Plan** may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under the **GHIP**. The **Health Plan** will not have to pay that amount again. The term "payment made" means reasonable cash value of the **Benefits** provided in the form of services.

## Right of Recovery

If the amount of the payments made by the **Health Plan** is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a) The persons it has paid or for whom it has paid,

b) Insurance companies, or

c) Other organizations.

The "amount of payments made" includes the reasonable cash value of any **Benefits** provided in the form of services.

## Right to Obtain and Provide Information

Each **Participant** agrees that the **PBM** may obtain from the **Participant’s** health care **Provider** information, including medical records, that are reasonably necessary, relevant, and appropriate from the **PBM** to evaluate in connection with treatment(s), payment, or health care operations.

Each **Participant** must, upon request by the **PBM**, provide any relevant and reasonably available information which the **PBM** believes is necessary to determine payable **Benefits**. Failure to provide this information may result in denial of the claim at issue.

**Participants** agree that information, including medical records, may be as reasonably necessary, relevant, and appropriate to be disclosed as part of treatment, payment, or health care operations maybe disclosure not only within the **PBM** but also to:

1). Health Care Providers as necessary and appropriate for treatment

2). Appropriate **ETF** employees as part of conducting quality assessment and improvement activities, or reviewing the **PBM’s** claims determination for compliance with contract requirements, or other necessary health care operations

3). External review of organization and parties to any appeal concerning a claim denial.

## Case Management/Alternate Treatment

The **PBM** may employ professional staff to provide case management services. As part of this case management, the **PBM** may recommend that a **Participant** consider receiving treatment for an **Illness** or **Injury** which differs from the current treatment if it appears that:

1. The recommended treatment offers at least equal medical therapeutic value, and
2. The current treatment program may be changed without jeopardizing the **Participant’s** health, and

3) The pharmacy charges incurred for drugs or supplies provided under the recommended treatment will probably be less.

If the **PBM** agrees to the attending physician’s recommendation or if the **Participant** or his/her authorized representative and the attending physician agree to the **PBM’S** recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which **Benefits** are not otherwise payable payment of **Benefits** will be as determined by the **PBM**.

## Disenrollment

No person other than a **Participant** is eligible for health **Benefits**. The **Subscriber’s** rights to group health benefits coverage 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 fraudulently attempts to obtain **Benefits**.

Coverage terminates at the beginning of the month following the action of the **Board**.

Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It’s Your Choice open enrollment period. Re-enrollment options may be limited under the **Board’s** authority.

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**.

The **Subscriber’s** disenrollment is effective the first of the month following completion of the **Grievance** process and approval of the **Board**. Coverage and enrollment options may be limited by the **Board**.

## Recovery of Excess Payments

The **PBM** might pay more than the **PBM** owes under the policy. If so, the **PBM** can recover the excess from the **Subscriber**. The **PBM** can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the **PBM**.

Each **Participant** agrees to reimburse the **PBM** for all payments made for **Benefits** to which the **Participant** was not entitled. Reimbursement must be made immediately upon notification to the **Subscriber** by the **PBM**. At the option of the **PBM**, **Benefits** for future claims may be reduced by the **PBM** as a set-off toward reimbursement.

## Subrogation

Each **Participant** agrees that the **Payor** under the **Pharmacy Benefit**, whether that is a **PBM** or **ETF**, shall be subrogated to a **Participant’s** rights to damages, to the extent of the **Benefits** the **PBM** provides under the policy, for **Illness** or **Injury** a third party caused or is liable for. It is only necessary that the **Illness** or **Injury** occurs through the act of a third party. The **PBM’s** or **ETF’s** rights of full recovery may be from any source, including but not limited to:

a) The third party or any liability or other insurance covering the third party.

b) The **Participant’s** own uninsured motorist insurance coverage.

c) Under-insured motorist insurance coverage.

d) Any pharmacy-related payments, no-fault, or school insurance coverages that are paid or payable.

A **Participant’s** rights to damages shall be, and they are hereby, assigned to the **PBM** or **ETF** to such extent.

The **PBM’s** or **ETF’s** subrogation rights shall not be prejudiced by any **Participant**. Entering into a settlement or compromise arrangement with a third party without the **PBM’s** or **ETF’s** prior written consent shall be deemed to prejudice the **PBM’s** or **ETF’s** rights. Each **Participant** shall promptly advise the **PBM** or **ETF** in writing whenever a claim against another party is made on behalf of a **Participant** and shall further provide to the **PBM** or **ETF** such additional information as is reasonably requested by the **PBM** or **ETF**. The **Participan**t agrees to fully cooperate in protecting the **PBM’s** or **ETF’s** rights against a third party. The **PBM** or **ETF** has no right to recover from a **Participant** or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the **Participant’s** or insured's comparative negligence. If a dispute arises between the **PBM** or **ETF** and the **Participant** over the question of whether or not the **Participan**t has been "made whole", the **PBM** or **ETF** reserves the right to a judicial determination of whether the insured has been "made whole."

In the event, the **Participant** can recover any amounts, for an **Injury** or **Illness** for which the **PBM** or **ETF** provides **Benefits**, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefits act, or other employee **Benefit** act, the **Participant** shall either assert and process such claim and immediately turn over to the **PBM** or **ETF** the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the **PBM** or **ETF** in writing to prosecute such claim on behalf of and in the name of the **Participant**, in which case the **PBM** or **ETF** shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a **Participant** fails to comply with the subrogation provisions of this Agreement, particularly, but without limitation, by releasing the **Participant’s** right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefits act, or other employee **Benefit** act, as part of the settlement or otherwise, the **Participant** shall reimburse the **PBM** or **ETF** for all amounts theretofore or thereafter paid by the **PBM** or **ETF** which would have otherwise been recoverable under such acts and the **PBM** or **ETF** shall not be required to provide any future **Benefits** for which recovery could have been made under such acts but for the **Participant’**s failure to meet the obligations of the subrogation provisions of this Agreement. The **Participant** shall advise the **PBM** or **ETF** immediately, in writing, if and when the **Participant** files or otherwise asserts a claim for **Benefits** under any workmen's or worker's compensation act, disability benefits act, or other employee Benefit act.

# Grievances and Appeals

## Grievance Process

The **PBM** is required to make a reasonable effort to resolve **Participants**’ problems and complaints. If the **Participant** has a complaint regarding the **PBM’s** administration of these **Benefits** (for example, denial of claim), the **Participant** should contact the **PBM** and try to resolve the problem informally. If the problem cannot be resolved in this manner, the **Participant** may file a written **Grievance** with the **PBM**. Contact the **PBM** for specific information on its **Grievance** procedures.

If the **Participant** exhausts the **PBM’s** **Grievance** process and remains dissatisfied with the outcome, the **Participant** may appeal to the **ETF** by completing an **ETF** complaint form. The **Participant** should also submit copies of all pertinent documentation including the written determinations issued by the **PBM**. The **PBM** will advise the **Participant** of their right to appeal to the **ETF** within sixty (60) calendar days of the date of the final **Grievance** decision letter from the **PBM**.

However, the **Participant** may not appeal to **ETF** issues that do not arise under the terms and conditions of this Certificate of Coverage, for example, coverage of a drug, not the **Formulary**, **Experimenta**l treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. The **Participant** may request an external review. In this event, the **Participant** must notify the **PBM** of their request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. The **Participant** has no further right to administrative review once the external review decision is rendered.

## Appeals to the Group Insurance Board

After exhausting the **PBM’s** **Grievance** process and review by **ETF**, the **Participant** may appeal **ETF’s** determination to the **Board**, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The **Board** does not have the authority to hear appeals relating to issues that do not arise under the terms and conditions of this Certificate of Coverage, for example, determination of medical necessity, appropriateness, the effectiveness of a **Covered** drug/supply, **Experimental** treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the **PBM** breached its contract with the **Board**.