State of Wisconsin
Department of Employee Trust Funds
4822 Madison Yards Way
Madison, WI 53705-9100

P. O. Box 7931
Madison, WI 53707-7931

Contract by Authorized Board

Commodity or Service:
IYC Medicare Advantage Plan (Contract ETD0050)
Medicare Plus Plan (Contract ETD0051)

Requests for Proposals:
ETD0050-51

Authorized Board: Group Insurance Board

Contract Period: This Contract covers the period January 1, 2026 – December 31, 2027 with the option to extend for five (5) additional years.

1. This Contract is for IYC Medicare Advantage and Medicare Plus Plans and is entered into by the State of Wisconsin Department of Employee Trust Funds (Department or ETF) on behalf of the State of Wisconsin Group Insurance Board (Board), and **Sierra Health and Life Insurance Company, Inc. dba UnitedHealthcare** (Contractor), whose address and principal officer appear below. The Department is the sole point of contact for this Contract.

2. Whereby the Department agrees to direct the purchase, and Contractor agrees to supply the Contract requirements in accordance with the documents specified in the order of precedence below, which, if not attached hereto, are hereby made a part of this Contract by reference.

3. For purposes of administering this Contract, the order of precedence is:
   a. This Contract cover page;
   b. Certification to Health Insurance Issuer for Disclosure of Personal Health Information (PHI) to Department (rev. March 20, 2025) attached hereto;
   c. Requests for Proposals (RFP) ETD0050 and ETD0051 Exhibit 5 – Department Terms and Conditions (revised March 17, 2025) attached hereto;
   d. RFPs ETD0050 and ETD0051 Exhibit 1 – State of Wisconsin Group Health Program – Medicare Advantage and Medicare Plus Program Agreement revised and renamed as State of Wisconsin Group Health Insurance Program Agreement for UnitedHealthcare, with the release date of April 16, 2025, attached hereto, including the following revised documents all attached hereto:
      - 2026 Certificate of Coverage (ET-2180) revised April 15, 2025;
      - 2026 Certificate of Coverage for Medicare Plus (ET-4113) revised April 3, 2025;
      - 2026 Schedule of Benefits: GHIP for Members-State of Wisconsin Retirees with Medicare; Local Traditional Plan for Employees/Retirees/COBRA; Local Retirees with Medicare including LAHP (ET-2108sb);
      - 2026 Schedule of Benefits: GHIP for Members in the Local Deductible Plan-Employees, Retirees and COBRA Continuants (ET-2158sb);
      - 2026 Medicare Plan Design Scenario Workbook
   e. RFPs ETD0051 and ETD0052 with the release date of March 7, 2024, as amended by Addendum 1 dated April 26, 2024, Addendum 2 dated May 14, 2024, and Addendum 3 dated May 30, 2024;
   f. Contractor's pricing received by the Department on May 2, 2025; and
   g. Contractor's proposal dated July 11, 2024.

Continued on next page.

Contracts ETD0050 and ETD0051 shall become effective upon the date of last signature below (the "Effective Date").

State of Wisconsin Department of Employee Trust Funds
Authorized Board: State of Wisconsin Group Insurance Board
By *(Name):* Herschel Day, Chair, Group Insurance Board
Signature: /s/
Date of Signature: 5/29/2025
Email ETFsmbProcurement@etf.wi.gov should questions arise regarding this document.

Contractor
Legal Company Name: Sierra Health and Life Insurance Company, Inc.
Trade Name: UnitedHealthcare
Taxpayer Identification Number: 94-0734860
Contractor Address (Street Address, City, State, Zip): UnitedHealthcare Insurance Company 185 Asylum Street Hartford, CT 06103-3408
Name & Title (print name and title of person authorized to legally sign for and bind Contractor): David Myers, Chief Financial Officer, UnitedHealthcare Retiree Solutions (URS)
Signature: /s/
Date of Signature: 5/7/2025

2026 UnitedHealthcare Contracts ETD0050 and ETD0051
for
IYC Medicare Advantage and Medicare Plus

Table of Contents

Certification to Health Insurance Issuer for Disclosure of PHI to Department

Rev. 3/20/2025

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

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

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

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

WHEREAS, DEPARTMENT and Insurer desire to exchange health information protected by HIPAA ("Protected Health Information" or "PHI"), pursuant to the authority of 45 CFR §§ 164.504 and 164.506 (c)(3); and

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

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

Further, DEPARTMENT certifies that:

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

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

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

Appendix 11
Department Terms and Conditions

Rev. Date: 03/17/2025

1.0 ENTIRE AGREEMENT: The following terms and conditions are hereby made a part of the underlying contract. These Department Terms and Conditions, the underlying contract, its exhibits, subsequent amendments and other documents incorporated by order of precedence in the contract encompass the entire contract ("Contract") and contain the entire understanding between the Wisconsin Department of Employee Trust Funds ("Department") and the contractor named in the Contract ("Contractor") on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. The Contract supersedes any other oral or written agreement entered into between the Department and the Contractor on the subject matter hereof. The terms "State" and "Department" may be used interchangeably herein.

The Contract may be amended at any time by written mutual agreement of the Department and Contractor, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend the Contract. No change in the Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between the Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under the Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in Wis. Stat. § 51.01(5); sexual orientation as defined in Wis. Stat. § 111.32 (13m), or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. Wis. Stat. § 16.765 (1). The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause; Wis. Stat. § 16.765 (2).

Pursuant to 2019 Wisconsin Executive Order 1, the Contractor agrees it will hire only on the basis of merit and will not discriminate against any persons performing a contract, subcontract or grant because of military or veteran status, gender identity or expression, marital or familial status, genetic information, or political affiliation.

Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the Contractor. Contractors with an annual work force of less than fifty (50) employees are exempt from this requirement. Contractor shall provide the plan to the Department within fifteen (15) business days of the Department's request for such plan after the award of the Contract; Wis. Admin. Code § ADM 50.04.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98 Notice of Unauthorized Acquisition of Personal Information.

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of the Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of the Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with the Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of services specified in the Contract (the "Services") and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and acknowledgement of, the Department. If the Department has concerns regarding the subcontractors a meeting will be scheduled to discuss a resolution.

After execution of the Contract, the Department and the Contractor will provide each other with the name of their designated contact persons.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under the Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of the Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State.

The Contractor will be responsible for payment of any losses by its subcontractors or agents.

When the Contractor becomes aware that a change in ownership or control of the Contractor or a name change has occurred or is certain to occur, the Contractor shall notify the Department within thirty (30) days after the effective date of any such ownership or name change.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) business days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) business days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 CONTRACTOR PERFORMANCE: Work under the Contract shall be performed in a timely, professional and diligent manner by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type specified in the Contract. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of the Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under the Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of the Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Services delivered under the Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 AUDIT PROVISION: The Contractor and its authorized subcontractors are subject to audits by the State, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

6.1 SOC 1/Type 2 Report: If the Department requires Contractor to provide a System and Organization Controls (SOC) audit report, Contractor will furnish the Department with a copy of Contractor's annual independent service auditor's report on management's description of Contractor's system and the suitability of the design and operating effectiveness of controls (SOC 1, Type 2). This independent audit of the Contractor's controls must be completed in accordance with the American Institute of Certified Public Accountants' (AICPA)

Statements on Standards for Attestation Engagements (SSAE) No. 18 (SOC 1, Type 2). The SSAE 18 (SOC 1, Type 2) annual audit will include all programs under the Contract and will be conducted at the Contractor's expense. If the Contractor's SSAE 18 (SOC 1, Type 2) audit covers less than twelve (12) months of a calendar year, the Contractor will provide a bridge letter to the Department, stating whether processes and controls have changed since the SSAE 18 (SOC 1, Type 2) audit. In addition, the Department requires Contractor to submit a letter of attestation indicating Contractor's receipt of management's assertion of control compliance from Contractor's subcontractors, when applicable.

6.2 **SOC 2/Type 2 Report:** If the Department requires Contractor to provide a SOC audit report, Contractor will furnish the Department with a copy of Contractor's annual independent service auditor's report on Contractor's controls relevant to security, availability, processing integrity, confidentiality, and privacy. The SOC audit report must be a type 2 report that includes management's description of Contractor's system and the suitability of the design controls set forth in AICPA Trust Services Criteria Section 100 (2017). This independent audit of the Contractor's controls must be completed in accordance with the AICPA SSAE No. 18 (SOC 2, Type 2). The SSAE 18 (SOC 2, Type 2) annual audit will include all programs under the Contract and will be conducted at the Contractor's expense. If the Contractor's SSAE 18 (SOC 2, Type 2) audit covers less than twelve (12) months of a calendar year, the Contractor will provide a bridge letter to the Department, stating whether processes and controls have changed since the SSAE 18 (SOC 2, Type 2) audit. In addition, the Department requires Contractor to submit a letter of attestation indicating Contractor's receipt of management's assertion of control compliance from Contractor's subcontractors.

6.3 **Contract Compliance Audit:** The Department may schedule and arrange for an independent certified public accountant or utilize the Department's internal audit resources to perform agreed upon procedures or consulting work related to the Contractor's compliance with the Contract on a periodic basis, as determined by the Department. The audit scope will be determined by the Department and may include recordkeeping, participant account activity, claims processing, administrative performance standards, and any other relevant areas to the programs under the Contract. The timeline of the audit will be mutually agreed upon by the Department and the Contractor. A minimum ten (10) business day notice is required.

6.4 **Open Access:** All Contractor books, records, ledgers, data, and journals relating to the programs under the Contract will be open for inspection and audit by the Department, its designees, or the State of Wisconsin Legislative Audit Bureau, at any time during normal working hours. A minimum ten (10) business day notice will be provided. Records or data requested shall be provided electronically in a format mutually agreed upon by the Department and Contractor. The Department shall have access to interview any employee and authorized agent of the Contractor involved with the Contract in conjunction with any audit, review, or investigation deemed necessary by the Department or the State.

6.5 **LAB Audit:** The Department is audited by the State of Wisconsin Legislative Audit Bureau (LAB) annually, as required by Wis. Stat. § 13.94(1)(dd). The Contractor agrees to provide necessary information related to any such audit for all programs under the Contract, as requested by the Department or auditor.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see: https://dpm.wi.gov/Hand%20Book%20Chapters/WHRH_Ch_246.pdf); the Contractor is required to perform background checks for all potential hires that will perform Services under the Contract, that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other state justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted and may be required by the Department. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information upon the Department's request. The Contractor must provide an attestation to the Department indicating that the background checks were completed, and such checks passed. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the Department agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be to assist Contractor in providing the Services, as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection to the Department's local computer network.

9.0 **SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL:** The Department shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this Section. In the course of

performing Services under the Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the Department.

The Contractor shall be responsible for damage to the Department's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the Department accordingly upon demand. This remedy shall be in addition to any other remedies available to the Department by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein or in the Contract shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under the Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of the Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of the Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 DISCOUNT FOR LATE DELIVERY: The Contractor agrees to accept a discount in the fees due to the Contractor under the Contract in the event any of the major deliverables is delivered by Contractor more than twenty-five (25) business days after the delivery date set forth in the then-current project work plan. The parties agree that the Contractor shall discount its fees, beginning on the twenty-sixth (26th) business day after the delivery date set forth in the then current project work plan, by an amount of one thousand dollars ($1,000) for each business day Contractor fails to deliver any or all major deliverables until such major deliverable is delivered as mutually agreed, up to a total of one hundred twenty thousand dollars ($120,000) per major deliverable. Any such discount is not a penalty and shall be in addition to all other legal or equitable remedies that may be available to the Department. Notwithstanding the foregoing, Contractor shall not owe any discount to the extent that any late delivery of a major deliverable was the result of a Department-caused delay. In the event that Contractor provides a discount under this Section, then the timeline set forth in the project work plan for each subsequent major deliverable shall be extended by the number of days for which the discount was applied.

13.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) calendar days of receipt providing goods and/or Services have been delivered, installed (if required), and accepted as specified. Invoices presented for payment must be submitted in accordance with instructions contained in the Department's purchase order or the Contract including reference to the purchase order number and submittal to the correct address for processing.

14.0 CONTRACT DISPUTE RESOLUTION: In the event of a dispute between the parties under the Contract, whether with respect to the interpretation of any provision of the Contract, or with respect to the performance of either party thereto, except for breach of Contractor's intellectual property rights, each party shall reserve the right to appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for an adjustment to such provision.

Contractor shall continue without delay to carry out all its responsibilities under the Contract, which are not affected by the dispute. Should Contractor fail to perform its responsibilities under the Contract that are not affected by the dispute without delay, the Department reserves the right to pursue recovery of any and all additional costs incurred by the Department as a result of such failure to proceed. Any costs incurred by the Contractor shall be borne by the Contractor and the Contractor shall not make any claim against the Department for such costs. The Department's non-payment of fees in breach of the Contract that are overdue by sixty (60) calendar days is a dispute that will always be considered to affect Contractor's responsibilities.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by the Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which

shall have a period of allotted time as specified below in which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First	Level 1 entity	Level 1 entity	20 business days
Second	Level 2 entity	Level 2 entity	30 business days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is the number of days from the date that the Invoking Party's notice was originally received by the other party. If the Second Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the appropriate Sections herein. The allotted time periods above are in addition to those periods for a party to cure provided elsewhere herein or in the Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

15.0 CONTROLLING LAW: All questions as to the execution, validity, interpretation, construction, and performance of the Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to the Contract or a party's obligations under the Contract shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

16.0 RIGHT TO SUSPEND OPERATIONS: If, at any time during the period of the Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor temporarily suspending all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

17.0 TERMINATION OF THE CONTRACT: The Department may terminate the Contract at any time at its sole discretion by delivering one-hundred eighty (180) calendar days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates the Contract, the Contractor shall refund all payments made under the Contract by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) calendar days prior to said termination.

Upon any termination of the Contract, the Contractor shall perform the Services specified in a transition plan if requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under the Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon the Department's request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination of the Contract for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

18.0 TERMINATION FOR CAUSE: If the Contractor fails to perform any material requirement of the Contract, breaches any material requirement of the Contract, or if the Contractor's full and satisfactory performance of the Contract is substantially endangered, the Department may terminate the Contract. Before terminating the Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) calendar day written notice and cure period.

The Department reserves the right to cancel the Contract in whole or in part without penalty in the event one (1) or more of the following occurs:

- **a.** If the Contractor intentionally furnished any statement, representation, warranty, or certification, in connection with the Contract which is materially false, incorrect, or incomplete;
- **b.** If applicable, if the Contractor fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **c.** If the Contractor incurs a delinquent Wisconsin tax liability;
- **d.** If the Contractor fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wis. Stat. § 111 Subchapter II, Wisconsin's Fair Employment Law, as required herein;
- **e.** If the Contractor is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement contracts;
- **f.** If the Contractor becomes a state or federal debarred Contractor, or becomes excluded from State contracts;

g. If the Contractor fails to maintain and keep in force all required insurance, permits and licenses as required per the Contract;
h. If the Contractor fails to maintain the confidentiality of the Department's information that is considered to be Confidential Information or Protected Health Information;
i. If the Contractor files a petition in bankruptcy, becomes insolvent, or otherwise takes action to dissolve as a legal entity;
j. If at any time the Contractor's performance threatens the health or safety of a State employee, citizen, or customer;
k. If the Contractor violates any requirements in Section 24.0 Confidential Information, Privacy and HIPAA Business Associate Agreement below regarding Confidential Information; or
l. If the Department or State fails to appropriate funds for the project described in the Contract; Wis. Stat. § 16.75 (3).

In the event of a termination for cause by the Department, the Department shall be liable for payments for any work accepted by the Department prior to the date of termination.

18.1 BREACH BY PATTERN OR PRACTICE: The Department has the right to terminate the Contract and/or pursue all available legal and equitable remedies if the Contractor, by pattern or practice, materially breaches any provision of the Contract. Actions that shall constitute a material breach include, but are not limited to, neglect, failure, or refusal to perform in accordance with any of the terms of the Contract. The Department may provide the Contractor with an opportunity to cure the material breach. Such cure period would be thirty (30) calendar days after the Contractor's receipt of the Department's written notice, as noted above. If Contractor's efforts to cure are unsuccessful, as determined by the Department in its sole discretion, the Department may terminate the Contract as soon as administratively feasible and/or pursue all available legal and equitable remedies.

19.0 REMEDIES OF THE DEPARTMENT: The Department shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in the Contract, the Department may issue a written notice of default providing for at least a thirty (30) business day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the Department. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the Department may: (1) exercise any remedy provided in law or in equity and/or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of the Contract after receiving reasonable notice from the Department to do so, the Contractor shall reimburse the Department for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with the Contract, or services from other sources as necessary to fulfill the Contract, the Contractor shall be responsible for the additional cost of such services, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the Department.

20.0 TRANSITIONAL SERVICES: Upon cancellation, termination, or expiration of the Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the Department to facilitate the orderly transition of the work under the Contract to the Department and/or to an alternative contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth in the Contract.

21.0 WARRANTY: Unless otherwise specifically stated by the Contractor, equipment purchased as a result of the Contract shall be warranted against defects by the Contractor for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the Contractor.

22.0 ADDITIONAL INSURANCE RESPONSIBILITY: The Contractor shall exercise due diligence in providing the Services under the Contract. In order to protect the Department's governing boards and any Department employee against liability, cost, or expenses (including reasonable attorney fees), which may be incurred or sustained as a result of Contractor's errors or other failure to comply with the terms of the Contract, the Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** per claim and **$5,000,000** aggregate in force during the Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Department of Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

The Contractor shall maintain commercial liability, bodily injury, and property damage insurance against any claim(s) which might occur in carrying out the Contract with a minimum coverage of **$1,000,000** per occurrence liability for bodily injury and property damage including products liability and completed operations. Contractor shall maintain motor vehicle insurance for all owned, non-owned, and hired vehicles that are used in carrying out the Contract with a minimum coverage of **$1,000,000** per occurrence combined single limit for automobile liability and property damage. The Department reserves the right to require higher or lower limits where warranted.

23.0 OWNERSHIP OF MATERIALS: Except as otherwise provided in Section 24.0, Subsection (v) Return or Destruction of Confidential Information, all information, data, reports, and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under the Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of the Contract. The Contractor shall not use such materials for any purpose other than carrying out the work described in the Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under the Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under the Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

The Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department, employees or members and generated by the claims administration and other Services provided by Contractor under the Contract.

All files (paper or electronic) containing any Wisconsin plan member, claimant or employee information and all records created and maintained in the course of the work specified by the Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of the Contract as may be necessary or appropriate for its performance of the Contract. Moreover, Contractor may maintain copies of such files after the term of the Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

24.0 CONFIDENTIAL INFORMATION, PRIVACY AND HIPAA BUSINESS ASSOCIATE AGREEMENT: This Section is intended to cover handling of Confidential Information under State and federal law, including, where applicable, the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the Genetic Information Nondiscrimination Act (GINA), and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used herein, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and refers to the Contractor.

(2) Confidential Information. "Confidential Information" means all tangible and intangible information and materials being disclosed in connection with the Contract, in any form or medium without regard to whether the information is owned by the State of Wisconsin, the Contractor, or by a third party, which satisfies at least one of the following criteria: (i) Individual Personal Information under Wis. Stat. § 40.07 and Wis. Admin. Code ETF § 10.70 ; (ii) Personally Identifiable Information under Wis. Stat. § 19.62(5); (iii) Protected Health Information under HIPAA, 45 CFR 160.103; (iv); proprietary information; (v) non-public information related to the State of Wisconsin's employees, customers, technology (including databases, data processing and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; (vi) information expressly designated as confidential in writing by the State of Wisconsin; (vii) all information that is restricted or prohibited from disclosure by state or federal law, including Medical Records as governed by Wis. Stat. §§ 40.07(2) and Wis. Admin. Code § ETF 10.01(3m); or (viii) any material submitted by the Contractor in response to a Department solicitation that the Contractor designates confidential and proprietary information and which qualifies as a trade secret, as provided in Wis. Stat. § 19.36(5) or material which can be kept confidential under the Wisconsin public records law.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code § ETF 10.01(3m).

(6) Protected Health Information. "Protected Health Information" has the meaning ascribed to it under 45 CFR 160.103.

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: The Department, a different business associate of the Department or a contractor performing services for the Department may provide Confidential Information to the Contractor under the Contract as the Department determines is necessary for the proper administration of the Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under the Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by the Contract or as required by law. Contractor shall not use or disclose member or employee names, addresses, or other information for any purpose other than specifically provided for in the Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by the Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07;

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware the confidentiality of the information has been or is suspected of being breached;

(6) Not use for its own benefit Confidential Information or any information derived from such information; and

(7) If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify the Department in writing upon receiving notice of such requirement and prior to any such disclosure, to give the Department an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(e) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the contiguous United States, or access of Confidential Information from outside the contiguous United States, is prohibited except on prior written authorization by the Department.

(f) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirement of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of the Department.

(g) MANDATORY REPORTING: Contractor shall report to the Department in the manner set forth in Section 24.0 , Subsection (m) Contractor Reporting of Breach or Suspected Breach or Disclosure to the Department any use or disclosure or suspected use or disclosure of Confidential Information not provided for by the Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(h) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy the Department's obligations under 45 CFR 164.524.

(i) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by the Department pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the Department's obligations under 45 CFR 164.526.

(j) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy the Department's obligations under 45 CFR 164.528.

(1) Contractor shall keep all HIPAA logs (logs of any systems that have information relating to HIPAA) for six (6) years**.**

(k) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of the Department's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation.

(l) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

(m) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE OF CONFIDENTIAL INFORMATION TO THE DEPARTMENT:

(1) As soon as practical, but no later than forty-eight (48) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of Confidential Information, Contractor shall notify in writing the Department Privacy Officer at ETFSMBPrivacyOfficer@etf.wi.gov, and the Department Program Manager. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the Department Program Manager and Privacy Officer to determine the Department's response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any persons affected (if available);
- **c.** A description of the Confidential Information included in the breach, impermissible use, or impermissible disclosure, including indicating whether such Confidential Information was encrypted;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the proactive steps taken by Contractor and being taken to correct the breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact the Department regarding the issue.

(2) As soon as practical, but not less than two (2) business days before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the Department Program Manager and Privacy Officer.

(3) Within thirty (30) business days after Contractor makes the initial report under this Section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure of Confidential Information and provide a report in writing to the Department Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any persons affected (whose Confidential Information was supplied to Contractor by the Department) and their contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. § 134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(n) COORDINATION OF BREACH RESPONSE ACTIVITIES:

(1) Contractor will fully cooperate with the Department's investigation of any breach of Confidential Information involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit;
- **b.** Within forty-eight (48) hours designating a contact person to whom the Department will direct inquiries, and who will communicate Contractor responses to Department inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for the Department;
- **c.** Applying appropriate resources to remedy the breach condition, investigate, document, restore the Department service(s) as directed by the Department, and undertake appropriate response activities such as working with the Department, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing daily reports to the Department outlining planned daily activities by 9:00 a.m. (CT) and including a status overview by 4:00 p.m. (CT) until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports to the Department daily or at mutually agreed upon timeframes, to the Department on breach response activities, findings, analyses, and conclusions;

f. Coordinating all media, law enforcement, or other breach notifications with the Department in advance of such notification(s), unless expressly prohibited by law; and

g. Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in Department-initiated meetings and/or conference calls regarding the breach.

(o) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the Department, as directed by the Department.

(p) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(q) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory, or judicial proceeding to disclose any Confidential Information, Contractor shall give the Department notice as soon as practical, but no later than within twenty-four (24) hours (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(r) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under the Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a reasonable corrective action plan, as directed by the Department.

(s) COMPLIANCE REVIEWS: The Department may conduct compliance reviews of the Contractor's security procedures before and during the Contract term to protect Confidential Information.

(t) AMENDMENT: The parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(u) SURVIVAL: The obligations of Contractor under this Section shall survive the termination of the Contract.

(v) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of the Contract for any reason, Contractor, with respect to Confidential Information received from the Department, another contractor of the Department, or created, maintained, or received by Contractor on behalf of the Department, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Return to the Department or, if agreed to by the Department, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out under Section 24.0, Subsection (d) Use and Disclosure of Confidential Information, which applied prior to termination;

(5) Return to the Department or, if agreed to by the Department, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by the Department, transmit the Confidential Information to another contractor of the Department.

(w) ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS: Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to the Department at no cost to the Department to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental

investigations, or administrative proceedings against the Department, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of these Terms and Conditions or the Contract.

25.0 ARTIFICIAL INTELLIGENCE: Contractor's use of Artificial Intelligence (AI) models shall at all times comply with and observe the terms of the Contract. "AI model" means a system that is designed to process or learn from data entered to conduct cognitive functions that simulate human intelligence. This includes, but is not limited to, search and filtering functionality that collects, tracks, and monitors data whether via sensors, user-entered data, or other sources without a human responsible for verifying the validity and integrity of data inputs and outputs to maintain the system's integrity, including legal due process if the model is allowed to make decisions on issues that impact human or legal rights.

(a) Contractor use of AI models shall comply with each of the following:

(1) Materially comply with and observe all applicable State and federal laws, administrative rules, and regulations, including but not limited to privacy, intellectual property, and equity requirements.

(2) Maintain the integrity of work performed and Services provided under the Contract, including, but not limited to, ensuring that bias is not introduced into Services provided pursuant to the Contract by Contractor.

(3) Maintain the quality of Department information under Contractor's authority.

(4) Maintain the confidentiality, privacy, and security of Confidential Information as defined in Section 24.0 (a) (2).

(b) The Contractor shall remove all Department information, including Confidential Information, from AI models used by Contractor upon the Department's request or, at the latest, upon Contract termination, including removal from AI model training data and learning.

(c) The Contractor shall not gain profit from use of Department information, including Confidential Information, that is outside the scope of the Contract.

(d) Upon request from the Department the Contractor will disclose within 30 calendar days from the day of the request which Services provided to the Department are using AI models.

26.0 INDEMNIFICATION:

(a) SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless the Department and its governing boards ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by the Department, its governing boards, and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

(b) SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for the Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office), court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor, Contractor employees or subcontractors; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of the Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and federal laws including, but not limited to, labor and wage and hour laws.

(c) INDEMNIFICATION NOTICE: The Department shall give the Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve the Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). The Department will cooperate, assist, and consult with the Contractor in the defense or investigation of any claim made or suit filed against the Department resulting from Contractor's performance under the Contract.

(d) NO INDEMNIFICATION OBLIGATIONS: Contractor shall, as soon as practicable, notify the Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under the Contract if such claim may involve the Department. The Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under the Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to the Contract. Department has not waived any right or entitlement to claim sovereign immunity under the Contract.

(e) CONTRACTOR'S DUTY TO INDEMNIFY: The Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim. The Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, the Contractor shall consult with the Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by the Department, or grants rights or concessions to a third party without first obtaining the Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified Parties, including sovereign immunity.

In carrying out any provision of the Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and State laws and regulations which are in effect during the period of the Contract and which in any manner affect the work or its conduct.

27.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the Department and the Contractor specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under the Contract or under applicable law.

28.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of the Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by the Contract.

The Department and the Contractor agree that it is a breach of the Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

29.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under the Contract shall be of the essence of the Contract, including the provision of the Services within the time agreed or on a date specified in the Contract.

30.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under the Contract. The Department shall not change the person designated without prior written notification to the Contractor, if possible.

The State of Wisconsin reserves the right to approve all key personnel assigned to the project described in the Contract. The Contractor agrees to use its best efforts to minimize personnel changes during the Contract term.

At the time of Contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under the Contract. Within thirty (30) calendar days of the Contract start date, the Contractor will provide an attestation to the Department indicating that background checks were completed for all such personnel and such checks passed; thereafter, annual attestations are required.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under the Contract. The Contractor shall not change this designation without prior written notice to the Department. For purposes of this written notice requirement, email notification will be sufficient.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this Section. The Contractor shall provide a notice of proposed diversion or replacement to the Department Program Manager and Contract Manager at least sixty (60) calendar days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) calendar days before the proposed diversion or replacement, the Department shall notify the Contractor whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) calendar days after departure shall entitle the Department to terminate the Contract. The Contractor's notice and justification of a change in key personnel must include identification of proposed substitute key personnel and must provide sufficient detail to permit the Department to evaluate the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed from the project by the Contractor and replaced by the Contractor within thirty (30) calendar days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

For any unauthorized change by the Contractor of any contracted personnel designated as key personnel, the Contractor will pay the Department a replacement fee of ten thousand dollars ($10,000) per occurrence.

31.0 INFORMATION SECURITY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Information Security Agreement ("Agreement") is designed to protect the Department's Confidential Information (defined above in Section 24.0) and Department Information Resources (defined below). This Agreement describes the information security obligations of Contractor, its employees, contractors, and third-party users that connect to Department Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) Department Information Resources. "Department Information Resources" means those devices, networks and related infrastructure that the Department has obtained for use to conduct Department business. Devices include but are not limited to, Department-owned devices; devices managed or used through service agreements; storage, processing, and communications devices and related infrastructure on which Department data is accessed, processed, stored, or communicated; and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other Department-created or managed business and research data, metadata, and credentials created by or issued on behalf of the Department.

(2) Subservice Organization: "Subservice Organization" means a subcontractor whose controls, in combination with the Contractor's controls, are necessary to perform Services under the Contract and related system requirements.

(c) ACCESS TO DEPARTMENT INFORMATION RESOURCES: In any circumstance when Contractor is provided access to Department Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to Department Information Resources. Contractors who access the Department's Information Resources from any Department location must at a minimum conform with Department security standards that are in effect at the Department location(s) where the access is provided. Any Contractor technology and/or systems that gain access to Department Information Resources must comply with, at a minimum, the elements in the Information Security Plan Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) SAFEGUARD STANDARD: Contractor agrees to protect the security of Confidential Information according to all applicable laws and regulations by generally accepted information risk management security control frameworks, standards or guidelines such as the ISO/IEC 27000-series, NIST 800-53, CIS Critical Security Controls for Effective Cyber Defense or HIPAA Security Rule – 45 CFR Part 160 and Subparts A and C of Part 164 and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. Contractor will ensure that Security measures are regularly reviewed including ongoing monitoring, monthly vulnerability testing and annual penetration and security incident response tests, revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement.

(f) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that the Department is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as the Department's internal security program for information and systems protection.

(2) Contractor shall develop, implement, and maintain a comprehensive Information Security Plan that contains administrative, technical, and physical safeguards designed to ensure the privacy, security, integrity, availability, and confidentiality of the Confidential Information.

(3) Annually, if the Contractor is required to provide an independent service auditor's report, such as a SOC 2, Type 2 audit report, Contractor will furnish the Department's designated staff person as directed with a copy of Contractor's required report. If the Contractor's SOC 2, Type 2 audit report covers less than twelve (12) months of a calendar year, the Contractor will provide a bridge letter to the Department as an attestation indicating whether significant changes have occurred to the processes and controls since the issuance of Contractor's last SOC 2, Type 2 audit report.

(4) Annually, or upon a significant change in risk posture, Contractor will review its Information Security Plan and update and revise it as needed. If at any time there are any material reductions to Contractor's Information Security Plan, Contractor will notify the Department within two weeks of the completion of the review and prior to implementation. In such instances, the Department will require an explanation of the reductions. At the Department's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to the Department's security requirements as defined herein.

(5) Annually, or upon change in Subservice Organizations, Contractor will demonstrate oversight of Subservice Organizations involved in the delivery of Services under the Contract. To demonstrate oversight, the Contractor shall submit a list of all current Subservice Organizations involved in the delivery of Services under the Contract and one of the following documents to the Department:

a. Policy and procedure regarding monitoring the compliance of Subservice Organizations handling of Department data;
b. Documentation showing oversight of Contractor's Subservice Organizations' security posture through annual reviews of Contractor's vendors' independent service auditor's reports; annual corrective action plans; or annual reviews of information technology controls; or
c. Letter of attestation assuming the Contractors' liability for its Subservice Organizations.

(6) Contractor will provide the Department written notice of any change in parties responsible for information security activities and functions that impact Services under the Contract, such as due to business acquisition or merger impacting Contractor, within thirty (30) calendar days of knowledge of such ownership change.

(g) ADDITIONAL INSURANCE: In addition to the insurance required under the Contract, Contractor, at its sole cost and expense, will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless the Department specifies otherwise: $1,000,000 each occurrence and $5,000,000 aggregate. If the Contractor maintains broader coverage and/or higher limits than the minimums shown above, the Department requires and is entitled to the broader coverage and/or higher limits maintained by the Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the Department.

(h) INFORMATION SECURITY PLAN REQUIREMENTS:

If Contractor cannot provide evidence of its Information Security Plan as required in Section 31.0, Subsection (f)(2) above, Contractor shall provide the following assurances to the Department:

(1) Security Policies:

a. Contractor's security policy is documented, has obtained management approval, is reviewed no less frequently than annually and is maintained to ensure its continuing suitability, adequacy, and effectiveness; and
b. Contractor's operational, technical, and administrative policies, standards and guidelines are documented, have obtained management approval, are reviewed no less frequently than annually and are maintained to ensure their continuing suitability, adequacy, and effectiveness.

(2) Security Organization:

a. The Contractor's security organization is governed and overseen by Contractor's senior leadership;

b. Contractor's security organization includes representation from across Contractor's organization with defined roles and responsibilities;
c. Contractor has clearly defined information security responsibilities;
d. Contractor has confidentiality or non-disclosure agreements in place with the appropriate external entities;
e. Contractor's management and implementation of information security (i.e., control objectives, controls, policies, processes, and procedures for information security) are reviewed independently at planned intervals, or when significant changes to the implementation of information security occur; and
f. Contractor's agreements with third parties involving accessing, processing, communicating, or managing the Contractor's information or information processing facilities, cover all relevant security requirements.

(3) Asset Management:
a. Contractor has identified, inventoried, assigned ownership, and established rules for acceptable use for information and associated assets; and
b. Contractor has a process in place to classify information in terms of its value, legal requirements, sensitivity, and criticality to Contractor.

(4) Human Resources:
a. Security roles and responsibilities of Contractor's employees, contractors and third-party users have been defined and documented in accordance with Contractor's information security policy;
b. Contractor performs background verification checks on all candidates for employment, contractors, and third-party users in accordance with relevant laws, regulations, and ethics, and proportional to the business requirements, the classification of the information to be accessed, and the perceived risks;
c. All Contractor's employees and, where relevant, contractors and third-party users, shall receive appropriate security awareness training and regular updates regarding Contractor's security policies and procedures, as relevant for their job function;
d. Contractor has a formal disciplinary process in place for employees who have committed a security breach;
e. Contractor's employees' responsibilities for performing employment terminations and changes of employment status are clearly defined and assigned;
f. All Contractor's employees, contractors and third-party users shall return all Contractor's and the Department's assets in their possession upon termination of their employment, contract, or agreement; and
g. The access rights of all Contractor employees, contractors and third-party users to information and information processing facilities are removed upon termination of their employment, contract, or agreement, or adjusted upon a status change.

(5) Physical and Environmental Security:
a. Secure Areas
i. Contractor has a physical and environmental policy in place, with standards and guidelines that have been documented, approved by Contractor management, reviewed at least annually, and maintained to ensure continuing suitability, adequacy and effectiveness;
ii. Contractor's secure areas are protected by appropriate entry controls to ensure that only authorized personnel are allowed access; and
iii. Contractor's physical protection and guidelines for working in secure areas have been adequately designed and access to the secure areas is logged and monitored..
b. Equipment security
i. Contractor's equipment, and the equipment Contractor may utilize in its operations that is owned by a third party, is maintained to ensure its continued availability and integrity; and
ii. Contractor's security measures have been applied to off-site equipment to address the risks of working outside the Contractor's premises.
c. Operations management
i. Contractor's operating procedures have been documented, maintained, and made available to all users who require them;
ii. Contractor controls changes to information processing facilities and systems; and
iii. Contractor has segregated duties and areas of responsibility to reduce opportunities for unauthorized or unintentional modification or misuse of Contractor's assets.
d. Third party service delivery management
i. Security controls, service definitions and delivery levels included in Contractor's third-party service delivery agreements are implemented, operated, and maintained by the third party; and
ii. The services, reports and records provided by third parties are regularly monitored, reviewed, and audited by Contractor.
e. Back-up
i. Contractor backs up data daily and, at least annually and based on the Contractor's backup policy, tests that back-ups can be restored.

f. Network security management

i. Networks are managed and controlled, either by Contractor or a third party under contract with Contractor; and

ii. Security features, service levels, and management requirements of all Contractor's network services have been identified and included in any network services agreement, whether these services are provided in-house by Contractor or outsourced.

g. Media handling

i. Contractor has procedures in place to prevent unauthorized disclosure, modification, misuse, removal or destruction of assets, and interruption to business activities; and

ii. Contractor has procedures in place for the management of removable media, including the secure and safe disposal of media when no longer required.

h. Exchange of information

i. Contractor has established agreements for the secure exchange of information and software between Contractor and appropriate external parties;

ii. Contractor shall ensure information involved in electronic messaging is protected;

iii. Contractor has developed and implemented policies and procedures to protect the exchange of information; and

iv. Contractor shall ensure the integrity of information being made available on a publicly available system is protected to prevent unauthorized modification.

i. Monitoring

i. Contractor shall produce and keep a rolling twelve (12) consecutive months of audit logs recording user activities, exceptions, and information security events to assist in future investigations and access control monitoring;

ii. Contractor's logging facilities and log information are protected against tampering and unauthorized access; and

iii. Contractor's system administrator and system operator activities are logged.

(6) Access Management:

a. Access control

i. Contractor has an established and documented access control policy that is reviewed at least annually;

ii. Contractor has a formal user registration and de-registration procedure in place for granting and revoking access to all information systems and services;

iii. Contractor restricts, controls, and monitors the allocation and use of access to its systems for unauthorized users and data usage;

iv. Contractor controls the allocation of passwords through an automated or semi-automated password management tool; and

v. Contractor's management reviews users' access rights at least annually using a formal process.

b. User responsibilities

i. Users are required to follow information security best practices in the selection and use of passwords;

ii. Users shall ensure unattended equipment is protected; and

iii. Users shall adopt a clear desk policy for papers and removable storage media and a clear screen policy for information processing facilities.

c. Network access control

i. Contractor's users shall adhere to the principle of least privilege or minimum access;

ii. Contractor has implemented appropriate authentication methods to control access by remote users;

iii. Contractor has segregated groups of information services, users, and information systems on networks;

iv. For shared networks, especially those extending across Contractor's boundaries, Contractor has restricted the capability of users to connect to the network, in line with Contractor's access control policy; and

v. Contractor has implemented routing controls for networks to ensure that computer connections and information flows do not breach Contractor's access control policy.

(7) Security Requirements of Information Systems:

a. Correct processing in applications

i. Contractor shall validate data input to applications to ensure the data is correct and appropriate, and incorporate validation checks to detect any corruption of information through processing errors or deliberate acts;

ii. Contractor has identified the requirements for ensuring authenticity and protecting message integrity in applications, and identified and implemented appropriate controls; and

iii. Contractor has validated the data output from an application to ensure that the processing of stored information is correct and appropriate to the circumstances.

b. Cryptographic controls
   i. Contractor has a cryptographic controls policy in place that is documented, has obtained management approval, is reviewed at least annually and is maintained to ensure its continuing suitability, adequacy, and effectiveness.

c. Security of system files
   i. Contractor has procedures in place to control the installation of software on operational systems;
   ii. Contractor selects test data carefully, and the test data is protected and controlled; and
   iii. Contractor restricts access to program source code.

d. Security in development and support processes
   i. Contractor has implemented procedures to maintain the security of application system software and information;
   ii. Contractor utilizes formal change control procedures to implement changes; and
   iii. Contractor supervises and monitors outsourced software development.

e. Technical Vulnerability Management
   i. Contractor documents the technical vulnerabilities, the exposure evaluated, and the appropriate measures taken to address the associated risk.

(8) Information Security Incident Management:

a. Contractor communicates information security events and weaknesses associated with information systems in a manner allowing timely corrective action to be taken;

b. All Contractor's employees, contractors, and third-party users of information systems and services are provided awareness training on reporting an observed or suspected incident; and

c. Management of information security incidents and improvements
   i. The responsibilities and procedures of Contractor's management have been established to ensure timely, effective, and orderly response to information security incidents;
   ii. Contractor has mechanisms in place to enable the security incidents to be quantified and monitored; and
   iii. Where a follow-up action against a person or organization after an information security incident involves legal action (either civil or criminal), Contractor shall collect, retain and present evidence in conformance with the rules for evidence established in the relevant jurisdiction(s).

(9) Business Continuity Management:
   i. Contractor has implemented one or more business continuity plans, including an information security plan, to maintain or restore operations and ensure availability of information at the required level and in the required timeframe following interruption to, or failure of, critical business processes;
   ii. Contractor tests and updates its business continuity plans and disaster recovery plans at least annually to ensure that they are up to date and effective; and
   iii. Contractor shall include the Department's designated contact in Contractor's business continuity plans for notification concerning any disruption that may impact the Services.

(10) Compliance:

a. Identification of applicable legislation
   i. Contractor understands all relevant statutory, regulatory, and contractual requirements under the Contract, and Contractor's approach to meet these requirements has been explicitly defined, documented, and kept up to date;
   ii. Contractor has implemented appropriate procedures to ensure compliance with legislative, regulatory, and contractual requirements under the Contract on the use of material which may be afforded intellectual property rights;
   iii. Contractor shall ensure that important records are protected from loss, destruction and falsification, in accordance with the statutory, regulatory, contractual, and business requirements under the Contract; and
   iv. Contractor shall ensure the protection and privacy of data as required in relevant legislation, regulations, and, as applicable, the Contract.

32.0 DISCLOSURE: If a State public official (Wis. Stat. § 19.42), a member of a State public official's immediate family, or any organization in which a State public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to the Contract, and if the Contract involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, the Contract is voidable by the Department unless appropriate disclosure is made according to Wis. Stat. § 19.45(6), before the Contract is signed. Disclosure must be made to the Department or the State of Wisconsin Ethics Commission, P.O. Box 7125, Madison, Wisconsin 53703 (telephone: 608-266-8123; fax: 608-264-9319; email: Ethics@wi.gov).

33.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

(a) Contractor certifies that no relationship exists between Contractor and the Department that interferes with fair competition or is a conflict of interest, and no relationship exists between the Contractor and another person or

organization that constitutes a conflict of interest with respect to a State contract. The Department may waive this provision, in writing, if those activities of the Contractor will not be adverse to the interests of the State.

(b) Contractor agrees that during performance of the Contract, the Contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the Department or has interests that are adverse to the Department to the extent allowed under applicable federal and state laws and regulations. The Department may waive this provision, in writing, if those activities of the Contractor will not be adverse to the interests of the State.

34.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the Department, the State, any of its departments, agencies or other subunits, or any State official or employee for commercial promotion is prohibited. News releases pertaining to the Contract, shall not be made without prior approval of the Department. Release of broadcast e-mails pertaining to the Contract shall not be made without prior written authorization of the Department.

35.0 EMPLOYMENT: The Contractor will not engage the services of any person or persons now employed by the State, including any department, commission, or board thereof, to provide services relating to the Contract without the written consent of the employing agency of such person or persons and of the Department.

36.0 INDEPENDENT CAPACITY OF CONTRACTOR: The Department and the Contractor agree that the Contractor, its officers, agents, and employees, in the performance of the Contract shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the State. The Contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the Contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the State.

37.0 TAXES: The State and its agencies are exempt from payment of all federal tax and State and local taxes on its purchases except Wisconsin excise taxes as described below; Wis. Stat. § 77.54 (9a), IRC § 115.

The State is exempt from payment of Wisconsin sales or use tax on its purchases. The State may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay State use tax on the cost of materials.

38.0 VENDOR TAX DELINQUENCY: The State may offset Contractor’s payments if Contractor has a delinquent State tax liability. If such action is taken by the State, the Department will not be liable for any impact sustained by the Contractor due to any delay, or total offset, of any payment owed to the Contractor under the Contract by the Department; Wis. Stat. § 73.12.

39.0 FOREIGN CORPORATION: If Contractor is a foreign corporation (any corporation other than a Wisconsin corporation), Contractor is required to conform to all the requirements of Wis. Stat. Chapter 180 relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporations, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

40.0 RECORDKEEPING AND RECORD RETENTION: The Contractor shall establish and maintain adequate records of all expenditures incurred under the Contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, State and local ordinances.

The Department shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to the Contract held by the Contractor.

It is the intention of the State to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of a contract. Pursuant to Wis. Stat. § 19.36(3), all records of the Contractor that are produced or collected under the Contract are subject to disclosure pursuant to a public records request. Upon receipt of notice from the State of a public records request for records produced or collected under the Contract, the Contractor shall provide the requested records to the Department. It is the Contractor's responsibility to defend the determination that a record is not subject to disclosure pursuant to a public records request in the event of an appeal or litigation. The Contractor, following final payment, shall retain all records produced or collected under the Contract for six (6) years.

41.0 ANTITRUST ASSIGNMENT: The Contractor and the State recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State (purchaser). Therefore, the Contractor hereby assigns to the State any and all claims for such overcharges as to goods, materials or services purchased in connection with the Contract.

42.0 ASSIGNMENT: No right or duty in whole or in part of the Contractor under the Contract may be assigned or delegated without the prior written consent of the Department.

43.0 WORK CENTER: The Contractor shall agree to implement processes that allow the Department to satisfy its obligation to purchase goods and services produced by work centers certified under the State Use Law, Wis. Stat. § 16.752.This shall result in requiring the successful Contractor to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses. A work center must be certified under Wis. Stat. § 16.752 and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

44.0 PATENT INFRINGEMENT: If goods, products, or articles are provided under the Contract, the Contractor guarantees such items were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of such items described in the Contract will not infringe any United States patent. The Contractor covenants that it will, at its own expense, defend every suit which shall be brought against the State (provided that the Contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such items, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

45.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the Department must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

46.0 FORCE MAJEURE: Neither the Contractor nor the Department shall be in default by reason of any failure in performance of the Contract in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the non-performing party.

47.0 SURVIVAL: The obligations and terms listed in this Section shall survive termination of the Contract in perpetuity unless otherwise noted. Contractor's duty to cooperate with audits under Sections 6.3 and 6.4 shall survive for one year after termination of the Contract or until the resolution of any Contract dispute, whichever is longer. Contractor's duties under Section 31.0 shall survive for as long as the Contractor has access to Department Information Resources and Department data. Payment obligations that accrue prior to the date of termination, or as part of a transition plan, shall survive termination of the Contract. Section 1.0, Section 10.0, Section 11.0, Section 14.0, Section 15.0, Section 19.0, Section 23.0, Section 24.0, Section 26.0, Section 28.0, Section 34.0, Section 38.0, Section 40.0, Section 42.0, and this Section 47.0 shall also survive termination of the Contract.

Exhibit 1

State of Wisconsin
Group Health Insurance Program
Agreement for UnitedHealthcare

Plan Year 2026

Issued by the State of Wisconsin Department of Employee Trust Funds on behalf of the Group Insurance Board

Release Date: April 16, 2025

TABLE OF CONTENTS

This State of Wisconsin Group Health Insurance Program Agreement (AGREEMENT) is by and between the DEPARTMENT and the CONTRACTOR named in the CONTRACT. Non-substantive changes may be made to this AGREEMENT, the CONTRACT, their appendices, exhibits, and attachments by the DEPARTMENT without the need for a formal CONTRACT amendment. The DEPARTMENT will notify CONTRACTOR of all such non-substantive changes via email. Should there be a requirement for substantive change(s) (changes to the CONTRACT that affect the rights of either party), a CONTRACT amendment will be required.

I. Definitions

Unless otherwise defined herein, any term needing definition shall have the definition found in the CERTIFICATE OF COVERAGE or in applicable Wisconsin law or federal law. As used in this AGREEMENT, the following terms are to be interpreted in accordance with these definitions:

ACCESS PLAN means the nationwide Preferred Provider Organization (PPO) Benefit Plan offering available to all Participants. Participants may use In-Network or Out-of-Network Providers for covered services.

AGREEMENT means this State of Wisconsin Group Health Insurance Program Agreement, which is part of the binding CONTRACT between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

ANNUITANT, when not otherwise specified, means an eligible retired EMPLOYEE of the State of Wisconsin or a participating LOCAL EMPLOYER who has been specified by the DEPARTMENT for enrollment in the HEALTH BENEFIT PROGRAM and is entitled to BENEFITS.

BENEFIT(S) means those items and services identified in the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.

BOARD means the Group Insurance Board.

BUSINESS DAY means each DAY except Saturday, Sunday, and official State of Wisconsin holidays, as listed under Wis. Stat. § 230.35(4)(a); (see also: DAY).

CERTIFICATE OF COVERAGE means the document appended to this AGREEMENT (as updated as required by the DEPARTMENT), that specifies the UNIFORM BENEFITS and services applicable to PARTICIPANTS of the GROUP HEALTH INSURANCE PROGRAM.

CONTINUANT means any SUBSCRIBER enrolled under federal or STATE continuation provisions.

CONTRACT means the contract document signed by the CONTRACTOR and the DEPARTMENT, and includes all appendices, exhibits, attachments made a part thereof, and this AGREEMENT.

CONTRACTOR means the licensed insurer who is the legal signatory to the CONTRACT.

DAY(S) means calendar day(s), unless otherwise indicated.

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

DEPENDENT is defined in the CERTIFICATE OF COVERAGE.

EMPLOYEE
When not specified, EMPLOYEE(S) means STATE EMPLOYEE and LOCAL EMPLOYEE.

STATE EMPLOYEE means an eligible EMPLOYEE of the STATE as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., or 8.

LOCAL EMPLOYEE means an eligible EMPLOYEE as defined under Wis. Stat. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stat. § 40.02 (28), other than the STATE, which has acted under Wis. Stat. § 40.51 (7), to make healthcare coverage available to its EMPLOYEES.

EMPLOYER
When not specified, EMPLOYER or EMPLOYERS means STATE EMPLOYER and LOCAL EMPLOYER.

STATE EMPLOYER means an eligible STATE agency as defined in Wis. Stat. § 40.02 (54).

LOCAL EMPLOYER means a Wisconsin Public Employer who has acted under Wis. Stat. § 40.51 (7), to participate in the HEALTH BENEFIT PROGRAM for its EMPLOYEES.

HEALTH BENEFIT PROGRAM or GROUP HEALTH INSURANCE PROGRAM (GHIP) means the program that provides group health BENEFITS to eligible STATE EMPLOYEES and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. The HEALTH BENEFIT PROGRAM is established, maintained, and administered by the BOARD.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) is defined in the CERTIFICATE OF COVERAGE and includes items and services specified in the SCHEDULE OF BENEFITS.

HOSPITAL is defined in the CERTIFICATE OF COVERAGE.

INSURANCE ADMINISTRATION SYSTEM or **IAS** is the DEPARTMENT'S benefit administration system used to manage GHIP member eligibility and enrollment for BENEFITS.

IN-NETWORK refers to a PROVIDER who has agreed in writing to provide, prescribe, or direct healthcare services, supplies, or other items covered under UNIFORM BENEFITS to PARTICIPANTS. The PROVIDER'S written participation agreement with a CONTRACTOR must be in force at the time such services, supplies, or other items covered under UNIFORM BENEFITS are provided to a PARTICIPANT.

INPATIENT means a PARTICIPANT admitted as a bed patient to a healthcare facility or in twenty-four (24)-hour home care.

OPEN ENROLLMENT means the time period that occurs at least annually to allow:
a) SUBSCRIBERS the opportunity to change CONTRACTORS and/or coverage; and
b) eligible individuals the opportunity to enroll for coverage in the HEALTH BENEFIT PROGRAM.

OUT-OF-NETWORK refers to a PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the CONTRACTOR'S professional directory of PROVIDERS.

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

PHARMACY BENEFIT MANAGER (PBM) is defined in the CERTIFICATE OF COVERAGE.

PREMIUM(S) means the rates shown in the HEALTH BENEFIT PROGRAM print and web materials published by the DEPARTMENT that includes the medical, pharmacy, and dental (when applicable) components, and administration fees required by the BOARD.

PRIMARY CARE PROVIDER (PCP) or PRIMARY CARE CLINIC (PCC) is defined in the CERTIFICATE OF COVERAGE.

PROVIDER is defined in the CERTIFICATE OF COVERAGE.

QUARTERLY means a period consisting of every consecutive three (3) months beginning in January of each calendar year.

SCHEDULE(S) OF BENEFITS means the document(s) appended to this AGREEMENT (as updated as may be required by the DEPARTMENT), that explains what medical services the HEALTH BENEFIT PROGRAM covers, and the cost PARTICIPANTS pay for such services.

SECURE/SECURED/SECURELY means the confidentiality, integrity, and availability of the DEPARTMENT'S data is of the highest priority and must be protected at all times.

STATE means the State of Wisconsin.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or their surviving DEPENDENT(S), who has been specified by the DEPARTMENT to the CONTRACTOR for enrollment in the GHIP and who is entitled to BENEFITS.

UNIFORM BENEFITS means the BENEFITS described in the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.

II. Statutory and Board Authority

A. Statutory and Legal Authority

The HEALTH BENEFIT PROGRAM is established by Chapter 40, Subchapter IV of Wisconsin Statutes (Wis. Stats. §40.51). The DEPARTMENT administers the HEALTH BENEFIT PROGRAM on behalf of the BOARD. The CONTRACTOR must meet the minimum requirements of Wis. Stats. Chapter 40 other applicable STATE and federal laws (both current as well as any new legislation passed during the term of the CONTRACT), the administrative rules of the DEPARTMENT, and the requirements in this AGREEMENT.

B. Board Authority

Wis. Stats. § 40.03 (6)(a) provides authority for the BOARD to enter into contracts with health insurance companies licensed to do business in the STATE. The BOARD establishes OPEN ENROLLMENT periods at least once per year and reserves the right to change the BENEFITS period to a fiscal year or to some other schedule that it deems appropriate.

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

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

The DEPARTMENT, on behalf of the BOARD, may designate a common vendor who will provide services related to the HEALTH BENEFITS PROGRAM as the DEPARTMENT deems appropriate.

III. Program Administration

A. Enrollment and Eligibility Maintenance

This section addresses the CONTRACTOR'S role in the enrollment process and maintaining eligibility files for PARTICIPANTS in the GROUP HEALTH INSURANCE PROGRAM (GHIP).

1. Eligibility

a. The DEPARTMENT maintains the primary record of eligibility for all PARTICIPANTS in the GHIP. Although the DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR must maintain an enrollment/eligibility system to support the GHIP.

b. The CONTRACTOR'S system(s) must be able to accommodate a HIPAA 834 file transfer from the DEPARTMENT, per the most recent guidance documentation issued by the DEPARTMENT or its IAS vendor.

c. The CONTRACTOR must accept an enrollment file update daily. Within two (2) BUSINESS DAYS of receipt of the enrollment file, the CONTRACTOR must accurately process the enrollment file additions, changes, and deletions. If a discrepancy is found such as an incorrect EMPLOYER name or number, or an invalid carrier code, the CONTRACTOR must produce and send a report listing any discrepancies via secure email or SFTP, as directed, to the IAS vendor.

d. The CONTRACTOR must resolve all enrollment discrepancies between the data in the DEPARTMENT'S IAS and the data in the CONTRACTOR'S database within five (5) BUSINESS DAYS of being notified by the IAS vendor and/or the DEPARTMENT of such a discrepancy or identification by the CONTRACTOR.

e. The CONTRACTOR must assist with the data discrepancy process (formerly known as the full file comparison) on a monthly basis. After receiving and processing the discrepancy file, the CONTRACTOR must produce and send a report listing any discrepancies via secure email to the IAS vendor. After review by the IAS vendor or the DEPARTMENT, if an update is needed, the DEPARTMENT will correct the data and send it to the CONTRACTOR. After receipt from the DEPARTMENT, the IAS vendor will send the changes on the next daily change file to the CONTRACTOR. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the IAS vendor. If after review, a correction is not needed, the IAS vendor will provide feedback on the error report to the CONTRACTOR.

f. CONTRACTOR delays in processing the 834 file must be communicated to the DEPARTMENT'S Program Manager or designee within one (1) BUSINESS DAY.

g. CONTRACTOR delays in processing the monthly data discrepancy file must be communicated to the DEPARTMENT Program Manager or designee within five (5) BUSINESS DAYS.

2. Enrollment

a. The CONTRACTOR must participate in the annual OPEN ENROLLMENT offering. The OPEN ENROLLMENT period is scheduled for each fall, prior to the covered program year. The covered program year begins the following January 1, unless otherwise specified by the BOARD.

b. During the OPEN ENROLLMENT period, the CONTRACTOR will accept any SUBSCRIBER who transfers from one benefit plan to another without requiring evidence of insurability, waiting periods, or exclusions as defined in Wis. Admin. Code INS §3.31 (3), and any eligible EMPLOYEE or STATE retiree under Wis. Stats. § 40.51 (16) who enrolls.

c. The CONTRACTOR will assist in the Coordination of Benefits (COB) for PARTICIPANTS enrolled in other coverage. The CONTRACTOR must collect from PARTICIPANTS COB information necessary to coordinate BENEFITS under Wis. Admin. Code INS §3.40 and report this information to the DEPARTMENT as needed.

d. The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the latter of either the receipt of the DEPARTMENT'S enrollment file or notification by Medicare for non-Medicare Advantage CONTRACTORS.

3. Errors

a. Clerical errors made by the EMPLOYER, the DEPARTMENT, or the CONTRACTOR shall not invalidate the BENEFITS of a PARTICIPANT that are otherwise validly in force, continue BENEFITS otherwise validly terminated, or create eligibility for any BENEFITS where none otherwise existed under the HEALTH BENEFIT PROGRAM.

b. Retroactive adjustments to PREMIUM or claims for coverage must be limited to no more than six (6) months of PREMIUMS paid, except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare.

c. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force must 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 the CERTIFICATE OF COVERAGE and SCHEDULE OF BENEFITS.

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

e. If the CONTRACTOR, its PROVIDER, or subcontractor sends wrong or misleading information to PARTICIPANTS, the DEPARTMENT may require the CONTRACTOR to send corrections to PARTICIPANTS by mail at the CONTRACTOR'S expense.

4. Identification (ID) Cards

a. The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage and the emergency room and office visit copayment amounts, if applicable.

b. The CONTRACTOR must issue new ID cards upon enrollment and following BENEFITS changes that impact the information printed on the ID cards. The CONTRACTOR is not required to send new ID cards to existing members if no information on the card has changed.

c. The CONTRACTOR must issue the ID cards and a welcome packet to newly enrolled PARTICIPANTS. The CONTRACTOR must issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, or at least ten (10) BUSINESS DAYS prior to the effective date of coverage.

d. The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR must send a written notice to the DEPARTMENT Program Manager following the OPEN ENROLLMENT period regarding any anticipated delays in mailing ID cards for the following enrollment year, as well as a confirmation email indicating the date(s) that ID cards were mailed.

e. ID cards generated by enrollment files received by the CONTRACTOR between the first DAY of the OPEN ENROLLMENT period and December 5 must be mailed by December 15 each year. ID cards generated by enrollment files specific to the OPEN ENROLLMENT period and received by the CONTRACTOR between December 6 and December 31 must be mailed within ten (10) BUSINESS DAYS.

f. The CONTRACTOR must provide replacement cards upon request at no cost to the PARTICIPANT. The CONTRACTOR must also have a process to make available to the PARTICIPANT a temporary, printable ID card.

5. Enrollment and Eligibility Information for PARTICIPANTS

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

   i. Information about PARTICIPANT responsibilities and plan requirements, including prior authorizations and referrals.
   ii. Directions on how to access the HEALTH BENEFIT PROGRAM PROVIDER directory on the CONTRACTOR'S website and directions on how to request a printed copy of the PROVIDER directory.
   iii. Directions on how to change the PARTICIPANT'S PRIMARY CARE PROVIDER or PRIMARY CARE CLINIC.
   iv. The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line number, list of telehealth services, and website address.

b. The CONTRACTOR will assist in distributing the federally required Summary of Benefits and Coverage (SBC) to non-Medicare PARTICIPANTS in a manner similar to the OPEN ENROLLMENT materials mailing process described in Section III.E.1. OPEN ENROLLMENT Materials.

c. In accordance with federal guidelines, the CONTRACTOR must issue or notify members how to receive 1095-B forms. The CONTRACTOR must submit a written notification to the DEPARTMENT Program Manager indicating the date(s) 1095-B forms were issued to PARTICIPANTS or when the web notice was posted, as required by federal law.

d. The CONTRACTOR must make available to PARTICIPANTS an online affiliated PROVIDER directory and provide a written listing of affiliated PROVIDERS upon request.

6. Coverage Termination and Continuation

a. A PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue GHIP coverage as required by STATE and federal law. The CONTRACTOR must bill the continuing PARTICIPANT directly for the required PREMIUM.

b. The CONTRACTOR must provide the SUBSCRIBER, upon the SUBSCRIBER'S request, written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

c. Upon discovery, the CONTRACTOR must report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS.

d. Upon the DEPARTMENT'S request, the CONTRACTOR must provide GHIP-related information to the DEPARTMENT, including aggregate claim amounts or other documentation.

B. PREMIUM

This section addresses the CONTRACTOR'S and DEPARTMENT'S responsibilities related to processing PREMIUMS, as well as services that may be included or excluded from PREMIUMS.

1. Services Included in PREMIUM

a. PREMIUMS paid to the CONTRACTOR by the DEPARTMENT are intended to pay for all services rendered by the CONTRACTOR to the DEPARTMENT. The CONTRACTOR may not charge an additional fee for any services described within this AGREEMENT.

b. The CONTRACTOR may not invoice the DEPARTMENT or PARTICIPANTS for any services that are outside the scope of this AGREEMENT, pursuant to CONTRACTOR'S role under this AGREEMENT without prior written consent of the DEPARTMENT.

2. PREMIUM Payments from the DEPARTMENT

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

b. The CONTRACTOR must support ACH payments of PREMIUM by the DEPARTMENT.

c. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

3. Direct Pay PREMIUMS

a. The CONTRACTOR must collect PREMIUMS directly from certain SUBSCRIBERS identified by the DEPARTMENT. No later than the second Wednesday of the month following CONTRACTOR'S receipt of the PREMIUMS, the CONTRACTOR must credit the DEPARTMENT for the applicable portion of PREMIUMS billed and received by the CONTRACTOR. When coverage is continued, the CONTRACTOR must bill the CONTINUANT directly for required PREMIUMS.

b. The CONTRACTOR must allow SUBSCRIBERS to submit direct pay PREMIUM payments via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the

CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the healthcare coverage must be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving written notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first.

4. PREMIUM Payments for Surviving DEPENDENTS

a. PREMIUMS for surviving DEPENDENTS (except those specified in section 4.b. below) must be paid first by deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then PREMIUMS will be paid directly to the CONTRACTOR by the surviving DEPENDENT.

b. PREMIUMS for surviving DEPENDENTS of a law enforcement officer who dies in the line of duty must be paid by the fallen officer's EMPLOYER until the DEPENDENT is no longer eligible for coverage as required under Wis. Stats. §66.0137 (5).

5. SUBSCRIBER Nonpayment of PREMIUMS

a. As required by federal law, if timely payment of PREMIUMS is made by the CONTINUANT in an amount that is not significantly less than the amount due, that amount is deemed to satisfy the CONTRACTOR'S requirement for the amount due. However, the CONTRACTOR may notify the CONTINUANT of the amount of the deficiency and grant a reasonable time period for payment of that amount, no less than thirty (30) calendar DAYS after the notice is mailed.

b. The CONTRACTOR must notify the DEPARTMENT within one (1) month of the effective date of termination of coverage due to non-payment of PREMIUM. PREMIUM refunds to the CONTRACTOR are limited to one (1) month following the termination date.

6. LOCAL EMPLOYER Group Program Participation

a. The CONTRACTOR must provide coverage for Local PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

b. The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

c. Local governments seeking to participate in the HEALTH BENEFIT PROGRAM may be subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the CONTRACTOR at 80% and DEPARTMENT'S PBM at 20%.

C. Rate Setting

This section addresses the annual process for establishing PREMIUM rates, including prohibited fees and allocation of a quality credit.

1. Annual Rate Bidding Process

a. Rates may be revised by the BOARD annually prior to OPEN ENROLLMENT, effective on each succeeding January 1 following the effective date of the CONTRACT.

b. The CONTRACTOR must submit rate bid(s) for the benefit year beginning January 1 following the effective date of the CONTRACT as directed by the DEPARTMENT. The CONTRACTOR'S sealed bids are submitted in the format specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience, and other relevant factors.

c. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any rate, limit new enrollment, or take other action as appropriate if the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.

d. The CONTRACTOR must submit statistical report(s) showing utilization and claims data on the CONTRACTOR'S plan as a whole, if community rated, or specifically the STATE and LOCAL EMPLOYEES and DEPENDENTS covered thereunder, if experience rated. If the plan is community rated, then the CONTRACTOR must provide the percentage the STATE and LOCAL EMPLOYEE groups represent of the total covered community.

e. The BOARD will require each CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant, along with supporting documentation deemed necessary by the BOARD'S consulting actuary.

f. The BOARD reserves the right to reject any CONTRACTOR'S bid when the BOARD believes it is not in the best interests of the HEALTH BENEFIT PROGRAM. The BOARD reserves the right to reopen the bid process after final bids are submitted when the BOARD determines that it is in the best interests of the HEALTH BENEFIT PROGRAM.

g. CONTRACTOR'S rates must be uniform statewide for each separate plan. CONTRACTORS may submit different rates which result from separate plans with mutually exclusive provider networks. Each network will be separately held to the Provider Access standards described in Section III.F. Provider Access.

h. The STATE and Local groups must be separately rated in accordance with generally accepted actuarial principles. The Local group is to be rated as a single entity for each plan. CONTRACTOR must provide rates for each of the plan design options for the Local group.

i. The CONTRACTOR must submit to the DEPARTMENT (or its designee) statistical report(s) showing financial and utilization data that includes claims and enrollment information annually, as required by the DEPARTMENT.

j. The DEPARTMENT reserves the right to audit, at the expense of the CONTRACTOR, the financial and utilization data, and other data the CONTRACTOR uses to support its bid. A bid based on data which an audit later determines is unsupported is subject to re-opening and renegotiating downward.

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

l. CONTRACTOR'S rates may not exceed the calculated rate in the utilization data submission without written justification.

m. The CONTRACTOR must provide coverage and rates for the following PREMIUM categories allowed by the BOARD:

    i. Individual (EMPLOYEE Only);
    ii. Family (EMPLOYEE Plus Eligible DEPENDENTS); and
    iii. Family rates (regular coverage) must be 2.5 times the individual rate.

n. The CONTRACTOR must provide coverage and rates for the following HEALTH BENEFIT PROGRAM options:

    i. Program Option 01 (STATE $250 deductible health plan and HDHP);
    ii. Program Option 02/12 (Local Traditional Plan);
    iii. Program Option 04/14 (Local Deductible Plan);
    iv. Program Option 06/16 (Local Health Plan);
    v. Program Option 07/17 (Local HDHP); and
    vi. Program Option 08 (Local Annuitant Health Program - LAHP).

o. The CONTRACTOR must offer the following Medicare coordinated coverage for the program options allowed by the BOARD:

    i. Medicare Individual: Individual rates must be justified by experience and may not exceed the calculated rate in the utilization data submission without written justification. Rates may not exceed 50% of the individual rate for regular, non-Medicare coverage, unless the BOARD'S consulting actuary determines that percentage to be lower.
    ii. Medicare Family All (all PARTICIPANTS under Medicare): Medicare Family All eligible rates must be twice the individual Medicare coordinated rate.
    iii. Medicare Family Some (at least 1 under Medicare, at least 1 other not under Medicare): Medicare Family Some rates must be the sum of the individual rate for regular coverage and the individual rate for Medicare-eligible coverage. Any administrative fees may only be assessed once for this family PREMIUM rate.

p. The CONTRACTOR must provide rates for Graduate Assistants, regardless of geographic area of operation, as follows:

    i. Individual: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate.
    ii. Family: Family rate must be within a range of 65% to 75% of the family regular coverage rate.

q. Local Program Option rates are based on the relative value of these plans to the Traditional Plan (Program Option 02/12). The ratio is to be determined annually by the BOARD'S consulting actuary.

r. Local Traditional Program Option rates must be no greater than 1.5 times the rate for the STATE program unless the Local group is sufficiently large that the rate is justified by experience, as determined by the BOARD'S consulting actuary.

s. The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of demographic differences other than age or sex, or is required by federal or STATE HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within-range percentage to conform to these requirements.

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

u. The CONTRACTOR will have the option of accepting adjusted and/or negotiated rates or withdrawing from the HEALTH BENEFIT PROGRAM. CONTRACTOR must notify the DEPARTMENT of withdrawal from the HEALTH BENEFIT PROGRAM before final bid offers are due.

2. Prohibited Fees

The CONTRACTOR is prohibited from including in their premium bid or rates:

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

b. The cost to administer any optional health and wellness benefit(s) beyond UNIFORM BENEFITS, except as approved by the DEPARTMENT.

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

3. Quality

a. The CONTRACTOR must collect Healthcare Effectiveness Data and Information Set (HEDIS) measures and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as specified by the National Committee for Quality Assurance (NCQA) guidelines. Upon request by the DEPARTMENT, the CONTRACTOR must provide information about subcontractors used to audit the HEDIS results and administer the CAHPS survey.

b. The CONTRACTOR must submit to the DEPARTMENT audited HEDIS data results annually for the previous calendar year for its contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. The results must include integration of the prescription drug data from the PBM. If CONTRACTOR uses a vended solution to produce HEDIS results, CONTRACTOR must utilize a vendor certified by NCQA.

c. The CONTRACTOR must submit to the DEPARTMENT the results of its annual CAHPS survey to the DEPARTMENT. Results must be based on responses for its contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. The survey must be conducted by a certified CAHPS survey vendor. Results must utilize the current version of the CAHPS survey as specified by the NCQA guidelines at the time the survey is administered. Results must be for each standard NCQA composite. Results must be submitted annually, and in a file format, as specified by the DEPARTMENT.

d. The DEPARTMENT will utilize the supplied HEDIS and CAHPS data for the calculation of the quality credit, which is a financial incentive to encourage quality improvement, built into the rate setting process. Quality measures for the quality credit will be established annually by the DEPARTMENT in cooperation with CONTRACTORS.

D. Data and Information Security

This section addresses requirements regarding the process of protecting data used in the course of administering the services described in this AGREEMENT from unauthorized access and data corruption.

1. Information Systems

a. 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 must be scalable and flexible so they can be adapted as needed, within negotiated timeframes, as requirements may change.

b. The CONTRACTOR shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM during the term of the CONTRACT without specific, prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. Examples of a major system change include a new platform for enrollment, claims payment, or data submission system. This does not apply to any program fixes, modifications, or enhancements. CONTRACTOR must notify the DEPARTMENT in writing when a new subservice organization is used, or when a current subservice organization is no longer used, to meet the CONTRACTOR'S service commitments and system requirements based on the trust services criteria for the CONTRACTOR'S organization (as set forth in AICPA's TSP section 100, 2017 Trust Services Criteria for Security, Availability, Processing Integrity, Confidentiality, and Privacy (AICPA, Trust Services Criteria). If the CONTRACTOR has plans to migrate to a different data or web platform, the CONTRACTOR must notify the DEPARTMENT no less than one hundred eighty (180) calendar DAYS in advance of the migration. The CONTRACTOR must notify the DEPARTMENT within thirty (30) calendar DAYS of a change in ownership.

c. 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.

d. All related hardware, software, firmware, protocols, methods, policies, procedures, standards, and guidelines that govern, store, or transport 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 the Center for Internet Security (CIS) Critical Security Controls to ensure the protection of all DEPARTMENT data.

e. 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 unauthorized connections.

f. 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 within sixty (60) calendar DAYS following the end of each calendar year.

2. Information Systems Security Audit

a. The CONTRACTOR and its authorized subcontractors are subject to the audit provisions outlined in Section 6.0 of the Department Terms and Conditions. Clarification of those provisions, specific to the HEALTH BENEFIT PROGRAM, are outlined in this section.

b. SOC 2 Type 2 requirements are outlined in Section 6.2 and Section 31.0(f)(3) of the Department Terms and Conditions.

c. The SSAE 18 (SOC 2, Type 2) audit must include all programs under the CONTRACT and be conducted at the CONTRACTOR'S expense.

d. The CONTRACTOR must determine which of the five SOC 2 Type 2 Trust Services Criteria (TSC) are applicable to the CONTRACTOR'S overall book of business. The five TSCs are:

   i. Security
   ii. Availability
   iii. Processing Integrity
   iv. Confidentiality
   v. Privacy

e. If the CONTRACTOR'S SSAE 18 (SOC 2, Type 2) audit report covers less than twelve (12) months of a calendar year, the CONTRACTOR must provide a bridge letter to the DEPARTMENT as an attestation that no significant changes have occurred to the processes and controls since the issuance of the CONTRACTOR'S last SOC 2, Type 2 audit report.

f. The CONTRACTOR must submit a letter of attestation indicating the CONTRACTOR'S receipt of management's assertion of control compliance from the CONTRACTOR'S subcontractors, as outlined in Section 6.2 of the Department Terms and Conditions.

3. Data Integration and Technical Requirements

a. 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. Any costs incurred by the DEPARTMENT because of CONTRACTOR'S failure to comply with this requirement will be paid by the CONTRACTOR.

b. 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 the SECURE, electronic exchange of files between the CONTRACTOR and the DEPARTMENT, as approved by the DEPARTMENT.

4. Data Integration and Use

a. The CONTRACTOR must provide all data and other information related to this AGREEMENT as needed in the file format specified by the DEPARTMENT or the DEPARTMENT'S designee. The CONTRACTOR shall place no restraints on the use of the data; provided that the DEPARTMENT will not disclose to third parties any data received from the CONTRACTOR that constitutes a trade secret as defined under Wisconsin law. The CONTRACTOR will be notified by the DEPARTMENT regarding how to retrieve the following data specifications:
    - Medical Claims
    - Provider Enrollment
    - Drug Claims

b. The CONTRACTOR agrees to use the identification (ID) numbers established by the DEPARTMENT for both the group and the SUBSCRIBER. ID numbers must not correlate to Social Security numbers. Social Security numbers must 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. The CONTRACTOR must keep a 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 ID number that is assigned by the DEPARTMENT. Any costs incurred by the DEPARTMENT because of CONTRACTOR'S failure to comply with this requirement will be paid by the CONTRACTOR.

c. In addition to data transfers to the DEPARTMENT'S data warehouse, the CONTRACTOR'S data transfers must include, but will not be limited to:

    i. Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The file must be in a file format compliant with the most recent Pharmacy Data Specifications provided by the PBM. The CONTRACTOR must fully incorporate available pharmacy claims data into data reporting, including, but not limited to the following:
        - HEDIS data;
        - Information requested on the DEPARTMENT'S annual Population Health Management report;
        - Catastrophic claims data; and
        - Other data as required by the DEPARTMENT. Where appropriate, such as for the catastrophic claims data report, the CONTRACTOR must separate out pharmacy claims from the DEPARTMENT'S PBM from any pharmacy claims that are paid by the CONTRACTOR.

    CONTRACTORS will be notified by the DEPARTMENT regarding how to retrieve and submit the following required data specifications:
        - Pharmacy Data

ii. Wellness and Chronic Condition Management Data – CONTRACTORS who can accept and accommodate a monthly file from the DEPARTMENT'S wellness and chronic condition management vendor that includes data for the CONTRACTOR'S PARTICIPANTS must use the most recent Wellness Data Specifications for biometrics, health assessments, and/or health coaching and chronic condition management, and integrate that data into the CONTRACTOR'S medical management program. CONTRACTORS will be notified by the DEPARTMENT regarding how to retrieve the following data specifications:
    - Health Assessment
    - Biometric Data
    - Coaching Outcomes

iii. WHIO Data – The CONTRACTOR must submit all claims (except Medicaid) data to WHIO for the CONTRACTOR'S commercial and Medicare covered lives residing in Wisconsin at a minimum. CONTRACTOR must submit claims to WHIO in a manner compliant with WHIO requirements. CONTRACTORS will be notified by the DEPARTMENT regarding how to retrieve data specifications and submit data.

d. For data transfers between vendors of STATE and Local programs not specified in this AGREEMENT, the CONTRACTOR must establish vendor to vendor data transfers within ninety (90) calendar DAYS of written notification from the DEPARTMENT to do so. Such data 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.

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

5. Data Warehouse File Requirements

a. The CONTRACTOR must comply with the DEPARTMENT'S data warehouse file specifications for submission of required data, ensuring correct format, layout, field values, and accuracy of data. All data provided must align with the specified standards and use data dictionaries where applicable. All file specifications are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM. The DEPARTMENT or the DEPARTMENT'S data warehouse vendor will notify the CONTRACTOR of file specification changes as soon as practicable. CONTRACTOR must retrieve the required data warehouse file specifications from the DEPARTMENT'S data warehouse vendor; the data warehouse vendor's website where the file layouts are located will be provided to the CONTRACTOR.

b. Data submitted by the CONTRACTOR to the DEPARTMENT'S data warehouse must include all of the following:

i. Data on payments for BENEFITS provided to PARTICIPANTS under this AGREEMENT. Payment data must include claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties.

ii. Data on other financial transactions associated with claim payments, including charged amount, allowed amount, per-claim rebates, discounts, payments made by third-party

insurance, including Medicare, and charges to PARTICIPANTS as co-payments, coinsurance, and deductibles.

iii. Data on the PROVIDERS of BENEFITS provided under this AGREEMENT.
iv. Data for all claims processed for PARTICIPANTS, as specified by the DEPARTMENT.
v. Data for all IN-NETWORK PROVIDERS in Wisconsin and the surrounding states (Minnesota, Iowa, Illinois, and Upper Michigan), as well as any states in which the CONTRACTOR has claims, including subcontracted PROVIDERS, as specified by the DEPARTMENT. For neighboring states, health plans are expected, at a minimum, to include the IN-NETWORK PROVIDERS for whom they have processed claims.
vi. Other data, as specified by the DEPARTMENT.

c. The CONTRACTOR must submit the required data monthly, or another frequency as agreed upon by the CONTRACTOR and the DEPARTMENT, on the date agreed upon by the CONTRACTOR and the DEPARTMENT, to the DEPARTMENT'S data warehouse. All data must be in the most recent file specification provided by the DEPARTMENT'S data warehouse vendor and meet all of the following requirements:
    i. The CONTRACTOR must submit all claims processed for PARTICIPANTS in the previous month.
    ii. The CONTRACTOR must submit the specified enrollment data for the previous month for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS.
    iii. The claim adjustment data the CONTRACTOR submits must follow the logic the DEPARTMENT'S data warehouse vendor defines in the data specifications.
    iv. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file.
    v. On all 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), if applicable.

d. The CONTRACTOR must establish and maintain a SECURE data transfer with the DEPARTMENT'S data warehouse. The CONTRACTOR must follow the data transmission instructions provided by the DEPARTMENT'S data warehouse vendor, which must include industry-standard electronic transmission methods via SECURE internet technology.

e. The CONTRACTOR must communicate any delays in submitting the required program data to the DEPARTMENT'S data warehouse vendor via email to the DEPARTMENT Program Manager or designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) BUSINESS DAY before the scheduled transfer as described above.

f. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR must resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse vendor or the DEPARTMENT and resubmit the data to the data warehouse.

g. The DEPARTMENT will charge the CONTRACTOR a penalty as described in Section IV.C. Penalty Assessments and Section IV.K. Data Warehouse Performance Standards for each data file submitted after the deadlines established above. For files that are delayed by no more than five (5) calendar DAYS and for which the CONTRACTOR provided the DEPARTMENT with notice of

delay at least one (1) BUSINESS DAY prior to the scheduled transfer date, the penalty will be waived.

h. The CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the CONTRACTOR'S data dictionary.

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

6. Data Warehouse File Submission Quality

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

b. As needed, the DEPARTMENT, in consultation with its data warehouse vendor and the CONTRACTOR, will develop a data improvement plan which will identify specific areas for the CONTRACTOR to improve the quality and completeness of its data submission, along with goals and timelines for improvement.

c. The CONTRACTOR shall pay the financial penalties described in Section IV.C. Penalty Assessments and Section IV.K. Data Warehouse Performance Standards for failure to submit data in accordance with this AGREEMENT, and which are assessed by the DEPARTMENT'S data warehouse vendor on behalf of the DEPARTMENT. Charges or penalties that are the direct result of the CONTRACTOR'S failure to meet the DEPARTMENT'S data submission requirements, timelines, or other requirements in this AGREEMENT that impact the DEPARTMENT'S data warehouse vendor will either be invoiced to the CONTRACTOR and due within thirty (30) calendar DAYS or deducted from a future payment(s) owed to the CONTRACTOR.

d. During the onboarding of a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data, as described in subsection III.D.6.a. above, to the DEPARTMENT'S data warehouse. 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. During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT'S data warehouse vendor notifies the CONTRACTOR of an error on its initial data submission, as described in subsection III.D.6.a. above, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty as described in Section IV.C. Penalty Assessments and Section IV.K. Data Warehouse Performance Standards for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor.

e. The penalties discussed in Section III.D. Data and Information Security and specified in Section IV. Performance Standards and Penalties do not apply to the penalty maximum described in Section IV.C. Penalty Assessments. See Section IV. Performance Standards and Penalties for data warehouse deliverable and penalty details.

E. Communications

This section addresses requirements related to CONTRACTOR'S communications with PARTICIPANTS.

All CONTRACTOR communications materials that are specific to the HEALTH BENEFIT PROGRAM and provided to PARTICIPANTS and EMPLOYERS must include a notice indicating the CONTRACTOR is a contracted business partner of the DEPARTMENT. Notice may be accomplished by including the DEPARTMENT'S logo on letters, e-mails, and other communications materials, or by including a statement indicating that the CONTRACTOR has been contracted by the DEPARTMENT.

1. OPEN ENROLLMENT Informational / Marketing Materials

a. The CONTRACTOR is required to prepare informational materials in a form and with 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.

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

c. The CONTRACTOR must 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 annual OPEN ENROLLMENT period:

    i. CONTRACTOR contact information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number (if applicable), and website address.
    ii. Content for the CONTRACTOR'S plan description page, including available features.
    iii. Information for PARTICIPANTS to access the CONTRACTOR'S PROVIDER directory on its web site, including a link to the PROVIDER directory.

d. The CONTRACTOR must submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval prior to distribution by the CONTRACTOR. For guidelines on vendor-produced materials pertaining to the GHIP, please consult the ETF Health Plan Account Manager Administration Manual.

e. The CONTRACTOR must submit one (1) digital copy of all OPEN ENROLLMENT materials in final format to the DEPARTMENT at least two (2) weeks prior to the start of the OPEN ENROLLMENT period.

2. Other Informational / Marketing Materials

a. Prior to the CONTRACTOR distributing materials and communications specified by the DEPARTMENT to PARTICIPANTS, such materials and communications must be pre-approved by the DEPARTMENT. This includes written and electronic communication to potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM, such as marketing, informational materials, letters, explanations of BENEFITS, summary plan descriptions, claim denials and appeals, and Summary of Benefits and Coverage.

b. The CONTRACTOR must certify on a QUARTERLY basis that all materials and communications as described above were submitted to the DEPARTMENT for approval prior to the CONTRACTOR distributing such to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM.

c. 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 its dedicated website, microsite or 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. For guidelines on vendor-produced materials pertaining to the GHIP, please consult the ETF Health Plan Account Manager Administration Manual.

d. The CONTRACTOR must include in its publications information for PARTICIPANTS regarding the CONTRACTOR'S language translation services and options for filing complaints related to discrimination, as specified by the DEPARTMENT.

e. 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.

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

3. CONTRACTOR Web Content and Web-Portal

a. The CONTRACTOR must host and maintain a customized website providing dedicated HEALTH BENEFIT PROGRAM web content (that may be provided via a microsite that meets all criteria below), and a web-portal dedicated to PARTICIPANTS. Web content on the CONTRACTOR'S microsite must provide basic HEALTH BENEFIT PROGRAM information. The CONTRACTOR'S web-portal will be used to present and track PARTICIPANT level information, such as claim status and BENEFIT accumulation.

b. The CONTRACTOR must include, within its customized website and/or web-portal or microsite dedicated to PARTICIPANTS, links to the DEPARTMENT'S wellness and chronic condition

management program, and the DEPARTMENT'S PBM vendor's pharmacy benefit web portal and/or public facing website.

c. The CONTRACTOR must submit the web content and web-portal design to the DEPARTMENT'S Program Manager for review as directed by the DEPARTMENT. The DEPARTMENT must approve the web content prior to CONTRACTOR publishing the content.

d. The CONTRACTOR'S website, microsite and web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market, which include Microsoft Edge, Mozilla Firefox, Google Chrome, and Apple Safari. Ongoing adoption and support of future browser versions and other browsers that gain significant market share is required.

e. The CONTRACTOR'S web-portal must be simple, intuitive, and easy to use and navigate. The CONTRACTOR'S web-portal must be able to render effectively on any mobile device, which includes smartphones and tablets.

f. The CONTRACTOR'S website, microsite and web-portal must have mobile capabilities. At a minimum the mobile capabilities must allow the PARTICIPANT to access HEALTH BENEFIT PROGRAM information.

g. The CONTRACTOR'S website, microsite and web-portal must use SSL/TLS for end-to-end encryption for all connections between the user devices and the website/web-portal/microsite with the use of browsers or smartphone applications (apps).

h. The CONTRACTOR'S web-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.

i. The web-portal must disable SSL/TLS negotiations which are using non-SECURE protocols and weak ciphers.

j. The CONTRACTOR must provide the DEPARTMENT reports on the current security safeguards enabled for the website, microsite and web-portal, upon the DEPARTMENT'S request.

k. After CONTRACTOR'S initial website, microsite and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website or microsite 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 or microsite and web-portal.

l. The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website or microsite content for the upcoming OPEN ENROLLMENT period. The DEPARTMENT will annually communicate to the CONTRACTOR the due date for this submission. After the DEPARTMENT'S approval of the web content, the CONTRACTOR must launch the updated web content at least two (2) weeks prior to the annual OPEN ENROLLMENT period.

m. The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links on the CONTRACTOR'S website or microsite pages that include HEALTH BENEFIT PROGRAM information or on the web-portal to external (governmental and non-governmental) websites/portals or website or microsite pages.

n. The CONTRACTOR will notify the DEPARTMENT Program Manager of any substantial changes being made to the CONTRACTOR'S website prior to the implementation of such changes. A substantial change in this case is a change that may affect a PARTICIPANT'S ability to find HEALTH BENEFIT PROGRAM information on the website.

o. Basic information must be available on the CONTRACTOR'S website without requiring login credentials, including:

    i. General information about the HEALTH BENEFIT PROGRAM and other programs offered by the BOARD;
    ii. Directions on how to access the HEALTH BENEFIT PROGRAM PROVIDER directory and Summary of Benefits and Coverage (SBC);
    iii. Information about PARTICIPANT HEALTH BENEFIT PROGRAM requirements, including prior authorizations and referrals;
    iv. Ability for PARTICIPANTS to submit questions via the CONTRACTOR'S website; and,
    v. Contact information including the CONTRACTOR'S dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and mailing address.

p. To ensure accessibility among persons with a disability, the CONTRACTOR'S website must comply with Section 508 of the Rehabilitation Act of 1973 [29 U.S.C. § 794 (d)] and implementing regulations at 36 CFR 1194 Subparts A-D. The CONTRACTOR'S website must also conform to the most recent Web Content Accessibility Guidelines (WCAG) https://www.w3.org/WAI/standards-guidelines/wcag/).

q. The CONTRACTOR'S website or microsite must be hosted in a SECURE data center with system monitoring, managed firewall services and managed backup services within the United States and be available twenty-four (24) hours a DAY, seven (7) calendar DAYS a week, except for regularly scheduled maintenance.

r. The CONTRACTOR'S data center network must include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of midnight 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 CONTRACTOR'S website/web-portal/microsite dedicated to the HEALTH BENEFIT PROGRAM. Unscheduled disruption to the availability of the website or web-portal or microsite must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

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

t. The CONTRACTOR must be able to link PARTICIPANT 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 receipt of the enrollment file. The CONTRACTOR may utilize another process for validation if the process is pre-approved by the DEPARTMENT.

u. The CONTRACTOR must have web-portal 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:

    i. Username and password creation and recovery;
    ii. Enrollment confirmation;
    iii. Secure upload functionality for submitting program required documentation;
    iv. 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 United States Postal Service mail, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT; and,

v. The CONTRACTOR must ensure that critical PARTICIPANT, PROVIDER, and other web accessible and/or telephone-based functionality and information, including the CONTRACTOR'S website or microsite containing HEALTH BENEFIT PROGRAM information and the web-portal, 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 must be scheduled in advance with notification on the CONTRACTOR'S website, microsite, and web-portal.

F. Provider Access

This section addresses requirements regarding PROVIDER network availability and continuity of care when networks change.

1. Provider Access Standards

a. The CONTRACTOR must submit an annual Wisconsin PROVIDER network list for the upcoming benefit period to the DEPARTMENT and the BOARD'S consulting actuary. This is in addition to the monthly PROVIDER data submission detailed in Section III.D. Data and Information Security.

b. The CONTRACTOR must sort Wisconsin PROVIDERS by zip code based on where they are physically located within each county and major city in the region. Major cities are those that have over thirty-three percent (33%) of the county population. These PROVIDERS must agree to accept new patients.

c. The CONTRACTOR must comply with the provider network access standards set forth in Wis. Admin. Code § INS 9.32 and Wis. Stat. § 609.22, if not preempted by federal law. The CONTRACTOR must also meet the provider access standards as described in the Provider Network Submission Tool that is collected by the DEPARTMENT annually via the DEPARTMENT'S actuary. The DEPARTMENT will use this data to determine the counties in which the CONTRACTOR is qualified. CONTRACTORS are determined to be qualified on a county-by-county

basis by meeting the provider access standards in this section and the operating experience required for CONTRACTORS.

d. The BOARD reserves the right to offer the State Maintenance Plan (SMP) in any counties in which a qualified Tier 1 plan is not available. See Section 2 of Certificate of Coverage: Eligibility, Enrollment, and Termination for information about tiers. A Preferred Provider Organization (PPO) is not qualified in areas served by the SMP.

e. The DEPARTMENT may determine a CONTRACTOR is not qualified in a county if the CONTRACTOR meets the provider access standards and the DEPARTMENT determines the CONTRACTOR is not effectively administering the HEALTH BENEFIT PROGRAM in accordance with this AGREEMENT (e.g., failure to provide effective medical management, etc.).

f. The DEPARTMENT will list the CONTRACTORS determined to be qualified in each county in the annual OPEN ENROLLMENT materials. At its discretion, the DEPARTMENT may also list the CONTRACTORS determined to be non-qualified in each county.

g. The BOARD reserves the right to allow for exceptions in certain counties when the CONTRACTOR can demonstrate the criteria in Section III.F. Provider Access cannot be met.

2. OUT-OF-NETWORK Services

a. Care from an OUT-OF-NETWORK PROVIDER may require prior-authorization from the CONTRACTOR unless it is an emergency or urgent care situation.

b. The CONTRACTOR must have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent care situation that results in care from OUT-OF-NETWORK PROVIDERS.

3. Continuity of Care

a. The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24, if not preempted by federal law, for PROVIDERS listed in the annual OPEN ENROLLMENT materials and listed in the CONTRACTOR'S provider network submission. In the event a PROVIDER or PROVIDER group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the PARTICIPANT shall be held harmless and indemnified by the CONTRACTOR. This does not apply in the case of loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care.

b. At least thirty (30) calendar DAYS (or as soon as is practicable) prior to the termination of a PROVIDER agreement, or the closing of an IN-NETWORK clinic, PROVIDER location, or HOSPITAL during the benefit period, the CONTRACTOR must:

    i. Send written notification to all PARTICIPANTS who have had services from that PROVIDER in the past twelve (12) months that includes the following information:
        - How to find a new IN-NETWORK PROVIDER or facility;
        - The continuity of care provision as it relates to this situation; and,
        - Contact information for questions.

ii. Update the PROVIDER directory on the CONTRACTOR'S website or microsite.
iii. If an IN-NETWORK PROVIDER fails to notify CONTRACTOR that they are no longer an IN-NETWORK PROVIDER (e.g., PROVIDER leaves an IN-NETWORK practice group and goes to work for an OUT-OF-NETWORK practice group), CONTRACTOR must send the notification described above upon CONTRACTOR'S receipt of notice of termination by the PROVIDER. (See Wis. Admin. Code INS § 9.35 (1) (b) 1.)

c. The CONTRACTOR must keep a record of this notification mailing and provide the DEPARTMENT with documentation, including PARTICIPANT and mailing address used, upon the DEPARTMENT'S request.

d. The CONTRACTOR will assist the PARTICIPANT in selecting a new IN-NETWORK PROVIDER or facility and obtaining any necessary referrals or authorizations.

e. If the CONTRACTOR offers more than one (1) network to PARTICIPANTS and the networks change on January 1st, a SUBSCRIBER who failed to make an election during the OPEN ENROLLMENT period to change networks in order to maintain access to his or her current PROVIDERS may change to the appropriate network during the next OPEN ENROLLMENT period or other enrollment opportunity as specified in this AGREEMENT.

G. Care Management

This section addresses the DEPARTMENT'S care management-related initiatives, requirements related to designating a PRIMARY CARE PROVIDER or PRIMARY CARE CLINIC, population health management, and pilot programs offered by the CONTRACTOR.

1. DEPARTMENT Initiatives

a. The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives upon request by the DEPARTMENT. DEPARTMENT Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The DEPARTMENT may request input and collaboration from the CONTRACTOR in identifying opportunities for population health management initiatives across GHIP contractors for an overall population health management approach. The CONTRACTOR may coordinate with HOSPITALS, PROVIDER groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.

i. Care Coordination. The CONTRACTOR must ensure care coordination is offered for PARTICIPANTS with high-risk health condition(s) by conducting outreach within three (3) to five (5) BUSINESS DAYS of a PARTICIPANT'S initial discharge from an INPATIENT HOSPITAL stay of more than twenty-four (24) hours.
ii. Diabetes Management and Prevention. The CONTRACTOR must provide PARTICIPANTS with diabetes management and prevention programming and/or refer PARTICIPANTS to the DEPARTMENT'S wellness and chronic condition management program vendor's diabetes management and prevention services.

2. PRIMARY CARE PROVIDER/PRIMARY CARE CLINIC Designation

a. If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP/PCC that is not IN-NETWORK with the selected CONTRACTOR, the CONTRACTOR must notify the

SUBSCRIBER within five (5) BUSINESS DAYS of either the DEPARTMENT'S transmission of the enrollment data or the beginning of the new program year and aid the person in selecting an IN-NETWORK PCP/PCC.

b. If the SUBSCRIBER is not responsive to the CONTRACTOR'S efforts, the CONTRACTOR will assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC.

3. Population Health Management

a. The CONTRACTOR must apply effective methods to support PARTICIPANTS' health, reduce risks and prevent unnecessary costs. This includes, but is not limited to:

   i. Managing costs for medical services, HOSPITAL confinement or other BENEFITS to be provided with evidence-based peer and utilization review mechanisms for monitoring healthcare costs.
   ii. Offering complex case management programming to PARTICIPANTS.
   iii. As applicable, coordinating programming with the DEPARTMENT'S wellness and chronic condition management vendor(s) by:
      - Integrating PARTICIPANT data provided by the DEPARTMENT'S wellness and chronic condition management vendor(s) into CONTRACTOR'S population health management system(s) and/or processes; and
      - Using PARTICIPANT level data from the DEPARTMENT'S wellness and chronic condition management vendor(s) to identify PARTICIPANTS eligible for complex/chronic case management and enroll PARTICIPANTS in such programs.
   iv. Referring PARTICIPANTS to the appropriate resources provided by the DEPARTMENT'S wellness and chronic condition management vendor(s). The CONTRACTOR must provide the DEPARTMENT documentation annually via the Population Health Management Report that demonstrates the CONTRACTOR'S efforts in actively promoting the services available to PARTICIPANTS through the DEPARTMENT'S wellness and chronic condition management program. This includes but is not limited to general and targeted communications and referrals.

b. The CONTRACTOR will not give PARTICIPANTS financial or other incentives of monetary value that do not qualify as a medical expense under IRS Code Section 213(d) for participation in population health management programming.

c. The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data as stated in Section III.D.3. Data Integration and Technical Requirements, in Section 4 of the Certificate of Coverage: Benefits & Coverages, and from the DEPARTMENT'S wellness and chronic condition management vendor(s) to manage population health.

d. The CONTRACTOR must provide the DEPARTMENT, upon the DEPARTMENT'S request, aggregate data on engagement and impact of the CONTRACTOR'S population health programming efforts on behalf of PARTICIPANT health, program quality and financial impact.

4. Pilot Programs

a. Pilot programs are those that impact Uniform Benefits, including but not limited to cost-sharing or changes to covered medical services.

b. The CONTRACTOR may provide a pilot program, with the DEPARTMENT'S prior approval, for limited-term trial to PARTICIPANTS to study the program's impact and evaluate options for future year Uniform Benefit change proposals.

c. The CONTRACTOR may not assess a fee for the pilot program to the DEPARTMENT or PARTICIPANTS.

d. Pilot programs cannot include financial or other incentives of monetary value that do not qualify as a medical expense under IRS Code Section 213(d) for participation unless approved by the DEPARTMENT.

e. The CONTRACTOR may submit pilot proposals to the DEPARTMENT during the annual time frame specified by the DEPARTMENT (usually between November 15 – December 15) that include the following elements:

    i. An estimate of the cost to implement the program, as well as the cost savings estimated from implementing the program.
    ii. An estimate of the number of GHIP members who would be eligible for the program.
    iii. An estimate of the number of GHIP members who are expected to participate in a program if offered.
    iv. Copies of at least two (2) peer-reviewed studies that show the program's methodologies or intervention components are successful in impacting population health and are appropriate for GHIP members.
    v. Evaluation methods and reporting that will be used to monitor the implementation of the proposed program design, as well as the outcomes of program participants.

f. Pilot programs must result in minimal burden to other DEPARTMENT-contracted vendors who would be affected by the program. Existing processes or cooperative arrangements should be used, if possible, when cross-vendor programming is proposed (examples: health plan-pharmacy vendor, health plan-wellness vendor).

g. CONTRACTOR may include pilot program promotional information via links on CONTRACTOR'S GHIP-dedicated website, on OPEN ENROLLMENT materials, new member welcome packets or other member materials, if such information does not exceed 25% of the materials provided. Pilot program materials should be submitted to the DEPARTMENT for review prior to the release of the materials and should include the following:

    i. A clear reference in the description of the program that it is a pilot for PARTICIPANTS for the current benefit year and may be changed or discontinued in future years.
    ii. A description of any limitation to enrollment numbers, eligibility requirements, or other factors that would be relevant to the member being able to receive the benefits (e.g., availability to high-deductible health plan members, retirees versus active, etc.).

h. The CONTRACTOR must report annually to the DEPARTMENT on the progress and outcomes of the pilot.

H. Administrative Services and Supports

This section addresses administrative services provided by the CONTRACTOR not specified in other sections. The CONTRACTOR must not modify any of the services or program content provided as part of the CONTRACT without prior written approval by the DEPARTMENT Program Manager.

1. Account Management and Staffing

a. Upon execution of the CONTRACT, the CONTRACTOR must designate an Account Manager and backup Account Manager to support the DEPARTMENT for the life of the CONTRACT.

b. The DEPARTMENT reserves the right to reasonably deny the CONTRACTOR'S designated Account Manager and request a replacement. The CONTRACTOR'S 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.

c. The CONTRACTOR'S Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR must 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.

d. The CONTRACTOR must designate an 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 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 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.

e. The CONTRACTOR must provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. Key staff are staff in positions of executive or managerial responsibility and/or whose performance affects the services provided under this AGREEMENT. The CONTRACTOR must 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 must provide the DEPARTMENT with contact information for the CONTRACTOR'S key staff, which the DEPARTMENT will share with EMPLOYERS.

f. The CONTRACTOR must notify the DEPARTMENT'S Program Manager if the CONTRACTOR'S Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to reasonably deny the CONTRACTOR'S replacement personnel designees.

g. The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. 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 benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff.

h. The CONTRACTOR must provide staff attendance at the annual EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the OPEN ENROLLMENT period, and any ANNUITANT group meetings, as appropriate.

i. 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.

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

k. The CONTRACTOR'S Account Manager must notify the DEPARTMENT of any major system changes to the CONTRACTOR'S administrative and/or operative systems; the DEPARTMENT will then notify the BOARD.

2. Claims

a. Targets for claims processing performance standards and associated penalties are specified in Section IV. Performance Standards and Penalties.

b. Upon request, the CONTRACTOR will assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

c. Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR must provide a listing of the total dollar amount of the applicable claims paid by the HEALTH BENEFIT PROGRAM on behalf of the PARTICIPANT.

d. In the event that the CONTRACTOR approves or reimburses for a service in error that is considered non-covered under UNIFORM BENEFITS, the CONTRACTOR agrees it will not seek reimbursement from the DEPARTMENT or the PARTICIPANT for such service and shall hold the DEPARTMENT and the PARTICIPANT harmless from any liability for payment of such service.

e. The CONTRACTOR is responsible for resolving discrepancies in claims payments for all Medicare data match inquiries.

3. Customer Service

a. The CONTRACTOR must operate a customer service department for the HEALTH BENEFIT PROGRAM during normal CONTRACTOR business 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, except official State of Wisconsin holidays as listed under Wis. Stat. §230.35(4)(a). The CONTRACTOR must report its standard customer service department hours of operation and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARTMENT. The CONTRACTOR must report any unanticipated CONTRACTOR customer service closures promptly to the DEPARTMENT in the format specified by the DEPARTMENT.

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

c. PARTICIPANTS must be able to submit questions using e-mail and via a website or microsite. For the hearing-impaired population, the CONTRACTOR'S call center will utilize the national relay service (711) or the caller can use their own relay system. The CONTRACTOR must track, document, and record all calls and correspondence to CONTRACTOR'S customer service representatives and retrieve such calls and correspondence, when necessary, by PARTICIPANT name or the PARTICIPANT'S DEPARTMENT eight (8)-digit member ID.

d. The CONTRACTOR must 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.

e. The CONTRACTOR must monitor and report to the DEPARTMENT on the Customer Service performance standards for the HEALTH BENEFIT PROGRAM (see Section IV.I.2). . Targets for the customer service performance standards and associated penalties are specified in Section IV. Performance Standards and Penalties.

f. The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and email and/or website or microsite. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls must be indexed and properly recorded by CONTRACTOR to allow for reporting and analysis based on a distinct transaction. CONTRACTOR must provide such reporting and analysis to the DEPARTMENT upon the DEPARTMENT'S request.

g. The CONTRACTOR must certify annually that their customer service inquiry system meets the requirements in Section IV. Performance Standards and Penalties. The DEPARTMENT reserves the right to request from the CONTRACTOR a report by month for a rolling twelve (12) month period showing the volume and type of inquiry with a break-down by topic. The report must include a comparison to the same month of the previous calendar year and illustrate trends.

h. 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.

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

j. The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five percent (5%) each year of all PARTICIPANT inquiries made by each submission type (e.g., phone, email,

website or microsite) must be audited (e.g., by lead worker, supervisor, manager, auditor, etc.) 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.

k. 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.

l. Service Level Response Time: CONTRACTOR must respond timely to DEPARTMENT inquiries. Such inquiries may include, but are not limited to, inquiries regarding audits, invoicing, and appeals. Response time targets and associated penalties are specified in Section IV.E.4.d.

4. Incentives

The CONTRACTOR may not offer any financial incentives or discounts that do not qualify as a 213(d) medical expense under federal law (see the IRS publication 502) to PARTICIPANTS. All incentives offered must be approved in advance by the DEPARTMENT.

5. Recovery of Overpayments

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

6. Subrogation and Other Payers

The CONTRACTOR must 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.

7. 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 HEALTH BENEFIT PROGRAM, or members of the BOARD. Neither the CONTRACTOR nor any of its subcontractors shall request or receive kickbacks.

8. Notice of Significant Events

a. The CONTRACTOR must notify the DEPARTMENT Program Manager in writing of any "Significant Event" within ten (10) calendar DAYS after the CONTRACTOR becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect on the CONTRACTOR'S ability to meet its obligations under this AGREEMENT, including, but not limited to, any of the following:

    i. disposal of major assets;
    ii. loss of fifteen percent (15%) or more of the CONTRACTOR'S membership;
    iii. 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;
    iv. the imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

v. the withdrawal of, or notice of intent to withdraw, dissolution of existing relationship, state licensing or certification, United States Department of Health and Human Services (HHS) qualification or any other status under STATE or federal law;
vi. default on a loan or other financial obligations;
vii. strikes, slow-downs, or substantial impairment of the CONTRACTOR'S facilities or of other facilities used by the CONTRACTOR in the performance of this AGREEMENT.

b. In addition, any change in the ownership of or controlling interest in the CONTRACTOR, any merger with another entity or the CONTRACTOR'S acquisition of another organization that participates in the HEALTH BENEFIT PROGRAM is a "Significant Event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (fifty-one percent (51%) interest in the CONTRACTOR or any transfer of ten percent (10%) or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the DEPARTMENT Program Manager at least sixty (60) calendar DAYS advance notice (or as soon as is practicable) of any such event in order to fulfill the BOARD'S responsibility to assess the effects of the pending action upon the interests of the HEALTH BENEFIT PROGRAM and its PARTICIPANTS. The DEPARTMENT may accept a shorter period of notice when circumstances justify.

c. The DEPARTMENT and the BOARD agree to keep the information disclosed as required above confidential under Wis. Stat. § 19.36 (5) of the Wisconsin Public Records Law until the earliest of one of the dates noted in section III.H.8.d. below, unless:

i. The CONTRACTOR waives confidentiality, or
ii. A court orders the DEPARTMENT or BOARD to disclose the information, or
iii. The DEPARTMENT or BOARD determines that, under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records.

d. The DEPARTMENT also agrees to notify the CONTRACTOR of a request to disclose the information as a public record prior to making such disclosure, to permit the CONTRACTOR to defend the confidentiality of the information.

e. 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 DEPARTMENT as a public record beginning on the earliest of the following dates:

i. The date the pending change in ownership or controlling interest, any merger or any acquisition of another entity becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.
ii. The date such action becomes effective.
iii. Sixty (60) calendar DAYS after the DEPARTMENT receives the information.

9. Bonding, Reinsurance and Insolvency

a. The CONTRACTOR must maintain appropriate bonding and/or reinsurance and must submit documentation evidencing such upon request by the DEPARTMENT. The appropriate bonding and/or reinsurance ensures that, in the event the CONTRACTOR becomes insolvent or otherwise unable to meet the financial provisions of the CONTRACT, bonding or reinsurance exists to pay those obligations.

b. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT confined as an INPATIENT, BENEFITS must continue until:

   i. the confinement ceases;
   ii. the attending physician determines confinement is no longer medically necessary;
   iii. the end of 12 months from the date of insolvency; or
   iv. the contract maximum is reached, whichever occurs first.

c. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer coverage to another CONTRACTOR in the event that a CONTRACTOR becomes insolvent or is otherwise unable to meet the financial provisions of the CONTRACT.

d. In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a "Significant Event," a significant loss of primary PROVIDERS and/or HOSPITALS, or no longer meets the minimum provider access standards defined under Wis. Stat. § 609.22 and Wis. Admin. Code INS 9.32, and included in Section III.F.1. Provider Access Standards, or if the BOARD so directs due to a "Significant Event," the BOARD may do any of the following, including any combination of the following:

   i. Terminate the CONTRACT upon any notice it deems appropriate, including no notice.
   ii. Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR enroll in another health plan.
   iii. Authorize a special enrollment period so that a SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR may voluntarily enroll in another health plan.
   iv. Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.
   v. Require that prior to selecting a health plan, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.
   vi. Take no action.

10. Contract Termination

a. In the event the CONTRACT is terminated by the CONTRACTOR, the CONTRACTOR must continue to cover BENEFITS for any PARTICIPANT who is admitted to a HOSPITAL as an INPATIENT on the date of CONTRACT termination until the earliest of the following dates:

   i. The BENEFIT maximum is reached;
   ii. The attending physician determines that INPATIENT confinement is no longer medically necessary;
   iii. The end of twelve (12) months after the date of CONTRACT termination; or
   iv. The PARTICIPANT'S confinement ends.

b. If the BOARD terminates the CONTRACT, all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the CONTRACT termination date. Such arrangements may include, but are not limited to, transferring the patient to another facility, or permitting OUT-OF-NETWORK

PROVIDERS to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.

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

d. The CONTRACTOR must submit claims data as specified in Section III.D. Data and Information Security during a six (6) month run-out period following the CONTRACT termination date. The DEPARTMENT will withhold twenty-five percent (25%) of premium payment for the last month of the CONTRACT period, to be paid no later than ninety (90) calendar DAYS following complete and accurate run-out file submission (applies to both medical and PROVIDER files), unless there are issues receiving timely run-out claims data.

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

f. See Section 17.0, Termination of the Contract, of the Department Terms and Conditions for additional requirements related to CONTRACT termination.

11. Transition Plan

a. The CONTRACTOR must provide a first draft of a transition plan within ten (10) BUSINESS DAYS of the determination that the CONTRACT will be terminated and work with the DEPARTMENT'S Program Manager to establish a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT within thirty (30) calendar DAYS of the determination. The transition plan must be approved by the DEPARTMENT prior to the transition start date.

b. Notwithstanding language in the Department Terms and Conditions, the CONTRACTOR shall provide transition services even if the DEPARTMENT withholds premiums owed the CONTRACTOR in the last month of the CONTRACT period, as stated above in Section III.H.11. Transition Plan.

12. Expert Services

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

b. The CONTRACTOR must have legal and technical staff available to the DEPARTMENT for consultation as needed for program administration, and for assistance with any appeals processes.

c. The CONTRACTOR must monitor the development of and provide notification and information to the DEPARTMENT in a timely manner concerning state or federal regulations or legislation that may affect the HEALTH BENEFITS PROGRAM.

13. Mailing and Postage

The CONTRACTOR must pay for all mailing, postage, and handling costs for the distribution of materials as required by Section III.E. Communications, or by other express provisions of the CONTRACT.

I. Grievances and Appeals

This section addresses the process by which PARTICIPANTS can express and seek remedy for any dissatisfaction with the CONTRACTOR.

1. Grievance Process Overview

a. The CONTRACTOR must have an internal grievance process in accordance with applicable federal or STATE law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance process, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process (for new CONTRACTORS) and upon request by the DEPARTMENT. (See Section III.I.4. Investigation and Resolution Requirements and Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights.)

b. Any dispute about BENEFITS or claims arising under this AGREEMENT must 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 or to an Independent Review Organization, if applicable.

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

d. If any PARTICIPANT has a problem or complaint relating to a determination of BENEFITS, the PARTICIPANT should contact the CONTRACTOR. The CONTRACTOR must 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, they may omit this step and immediately file a formal grievance. A claim review is not a substitute for a grievance.

e. The steps in the PARTICIPANT grievance process include (with Section references):
    i. Claim review (optional for PARTICIPANT) (Section III.I.2. Claim Review);
    ii. PARTICIPANT notice (Section III.I.3. PARTICIPANT Notice);
    iii. Investigation and resolution (Section III.I.4. Investigation and Resolution Requirements);
    iv. Notification of DEPARTMENT Administrative Review Rights or External Review Rights (Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights); and,
    v. External review (Section III.I.6. External Review).

2. Claim Review

a. The CONTRACTOR must perform a claim review when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, the CONTRACTOR must notify the PARTICIPANT of the decision.

b. If the decision is to uphold the denial of BENEFITS, the CONTRACTOR must provide the PARTICIPANT written notification as to the specific reason(s) for the continued denial of BENEFITS and of their right to file a grievance.

3. 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 BENEFITS contractual provision(s) upon which the denial is based.

4. Investigation and Resolution Requirements

a. Investigation of any grievance will be initiated by the CONTRACTOR within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem.

b. Grievances related to an urgent health concern will be handled within three (3) BUSINESS DAYS of the CONTRACTOR'S receipt of the grievance.

5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights

a. In the final grievance decision letters, the CONTRACTOR must inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision or their right to request an external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR must cite the specific UNIFORM BENEFITS contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.

b. If the PARTICIPANT disagrees with the grievance committee's final decision, the PARTICIPANT 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. If the PARTICIPANT disagrees with the outcome, and the grievance committee's final decision is not eligible for external review, 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.

c. The determination of the DEPARTMENT is final and not subject to further review unless the PARTICIPANT submits a timely appeal of the determination by the DEPARTMENT to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3).

d. The DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR and/or PBM based on medical necessity, appropriateness, healthcare 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 external review process under applicable federal or STATE law. See Section III.I.6. External Review.

e. If the PARTICIPANT disagrees with a determination by the DEPARTMENT, the PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and . This process may

include an administrative hearing. The CONTRACTOR must, upon the DEPARTMENT'S request, participate in all administrative reviews, including administrative hearings, requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings must be conducted in accordance with the guidelines, rules, and regulations promulgated by the DEPARTMENT.

f. BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

6. External Review

a. The PARTICIPANT must have the option to request an external review by an Independent Review Organization (IRO), subject to applicable federal and STATE law. Denials of coverage by a CONTRACTOR and/or PBM are eligible for external review if based on medical necessity, appropriateness, healthcare setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate. In accordance with federal or STATE law, any decision by an IRO is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the external review decision is rendered.

b. Within five (5) calendar DAYS of the CONTRACTOR'S receipt of a PARTICIPANT'S request for external review, the CONTRACTOR must notify the DEPARTMENT of the request in the format specified by the DEPARTMENT.

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

d. Within thirty (30) calendar DAYS of the CONTRACTOR'S receipt of the final external review determination, the CONTRACTOR must send a copy of the detailed report provided from the external reviewer to the DEPARTMENT. The CONTRACTOR must redact all member-identifying information from this copy before sending it to the DEPARTMENT.

e. 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.

7. Provision of Complaint Information

a. All information and documentation related to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a CONTRACTOR must be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the CONTRACTOR must cooperate in obtaining the authorization and accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy.

b. 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 to the DEPARTMENT at no charge within fifteen (15) BUSINESS DAYS of the DEPARTMENT'S request, or by an earlier date as requested by the DEPARTMENT.

8. 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 must process the complaint as a grievance in compliance with the HEALTH BENEFIT PROGRAM'S provisions regarding a formal grievance.

9. Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT'S general counsel and the DEPARTMENT Program Manager within ten (10) BUSINESS DAYS after CONTRACTOR is served a Summons and Complaint involving a PARTICIPANT. This requirement does not extend to cases of subrogation.

10. Compliance with Departmental Determinations

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 or to appeal the determination to the BOARD within ninety (90) calendar DAYS.

J. Audits and Disclosure Requirements

This section addresses the process by which the DEPARTMENT and other government entities may conduct audits, the requirement to participate in audits, and requirements to retain records.

1. Audit and Other Services

a. The CONTRACTOR must maintain sufficient documentation to provide for the financial and management audit of its performance under this AGREEMENT. Such documentation must include, but not be limited to, program expenditures, claim processing efficiency and accuracy, and customer service. The CONTRACTOR must make financial records, claims documentation, and all other relevant records available for review or audit as requested by the DEPARTMENT and assist as needed in review of these records.

b. At its discretion, the BOARD may require an independent third-party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit.

c. The CONTRACTOR must address any areas for improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. The CONTRACTOR must notify the DEPARTMENT of all identified areas for improvement and the status of all improvements as necessary.

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

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

f. In addition to third-party audits, at the request of the DEPARTMENT, the CONTRACTOR must make available prior to the beginning of any benefit year a full description of the configuration of the CONTRACTOR'S claims processing system. The CONTRACTOR will also certify to the DEPARTMENT that the claims processing system will properly process claims according to the CONTRACT prior to the start of the benefit year.

g. The CONTRACTOR must submit a Model Audit Rule (MAR) Certification to the DEPARTMENT on an annual basis.

h. The CONTRACTOR must submit financial stability documentation to the DEPARTMENT on an annual basis, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles) as directed in Section IV.G.5. Financial Stability Documentation.

i. The CONTRACTOR is exempt from the Service Organization Control (SOC) audit report provision outlined in Section 6.1 of the Department Terms and Conditions for an annual Statement on Standards for Attestation Engagements (SSAE) No. 18 (SOC 1, Type 2) audit report.

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

2. Examination of Records

a. The DEPARTMENT, or its designee, shall have the right to examine any records of the CONTRACTOR relating to the HEALTH BENEFIT PROGRAM in compliance with Wis. Stat. § 40.07 and any applicable federal or other STATE laws and rules. CONTRACTOR shall furnish the requested records within ten (10) BUSINESS DAYS of CONTRACTOR'S receipt the DEPARTMENT'S request or as directed by the DEPARTMENT. All such records are the sole property of the DEPARTMENT.

b. Upon a showing satisfactory to the BOARD that the CONTRACTOR is required by law to maintain a copy of such records, 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 will require the CONTRACTOR to:

    i. 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) and ETF 10.70 (1), that are included in such information;
    ii. Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,
    iii. Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record, provided by the DEPARTMENT to the CONTRACTOR, that would violate Wis. Stat. § 40.07 (1) or (2).

3. Record Retention

a. The DEPARTMENT and the BOARD shall have the right to examine any of the CONTRACTOR'S pertinent records or other documentation 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, until the expiration of seven (7) years after the termination of the CONTRACT and any extensions.

b. Any records that relate to litigation or settlement of claims arising out of the performance of this AGREEMENT or costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions, must be retained for seven (7) years after the conclusion of the litigation, regardless of the termination date of the CONTRACT.

c. The CONTRACTOR must accurately maintain records for seven (7) years after the termination of the CONTRACT. This requirement supersedes the period set forth in Section 40.0, Recordkeeping and Record Retention, of the Department Terms and Conditions.

d. The CONTRACTOR shall insert the substance of this clause (Record Retention) into any contract that the CONTRACTOR enters into with a subcontractor to carry out any of the CONTRACTOR'S obligations under this AGREEMENT.

4. Requirement to Review PROVIDERS

a. The CONTRACTOR must, on a QUARTERLY basis, complete a fraud, waste, and abuse review according to a stated plan described under Section IV.H. QUARTERLY Reporting Requirements. Upon execution of the CONTRACT, the CONTRACTOR will attest that such a plan exists, and will provide a written copy of the plan to the DEPARTMENT upon request. The CONTRACTOR must provide results of any material findings to the DEPARTMENT.

b. Examples of potential PROVIDER fraud that could be included in QUARTERLY reviews:
   i. Billing for items or services not rendered.
   ii. Billing for work already reimbursed by another insurer.
   iii. Overcharging for services or supplies.
   iv. Completing an unjustified Certificate of Medical Necessity (CMN) form.
   v. Double billing resulting in duplicate payment.
   vi. Misrepresenting medical diagnoses or procedures to maximize payments.
   vii. Inappropriate use of place of service codes.
   viii. Knowingly misusing PROVIDER identification numbers resulting in improper billing.
   ix. Providing medically unnecessary services.
   x. Routinely waiving deductibles/coinsurances.
   xi. Submitting bills exceeding the limiting charge.
   xii. Unbundling (billing for each component of the service instead of billing or using an inclusive code).
   xiii. Up-coding the level of service provided.
   xiv. Billing for a known work-related injury.

K. Reporting Requirements

This section addresses requirements regarding data-driven means of benchmarking the performance of specific processes or functions, with the primary aim of increasing efficiency, reducing errors, and optimizing healthcare metrics.

1. Reporting Requirements

a. The CONTRACTOR is required to submit reports to the DEPARTMENT to allow the DEPARTMENT to adequately monitor the HEALTH BENEFIT PROGRAM.

b. Reports must be submitted SECURELY to the DEPARTMENT via email, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT.

c. The DEPARTMENT reserves the right to modify reporting requirements or frequency as deemed necessary to monitor the CONTRACT and programs. The CONTRACTOR must comply with such changes within forty-five (45) calendar DAYS, or another timeframe as approved by the DEPARTMENT. Instructions and specific due dates will be provided by the DEPARTMENT annually.

d. Each report submitted by the CONTRACTOR to the DEPARTMENT must:
    i. Be verified by the CONTRACTOR for accuracy and completeness prior to submission;
    ii. Be delivered on or before scheduled due dates;
    iii. Be submitted as directed by the DEPARTMENT;
    iv. Fully disclose all required information in a manner that is responsive and with no material omission; and
    v. Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report.

e. The CONTRACTOR will provide process documentation for reporting to the DEPARTMENT upon request.

f. Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book of business.

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

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

L. STATE and Federal Mandates

1. The CONTRACTOR must report to the DEPARTMENT on any STATE and federally required compliance audits or other activities that involve the HEALTH BENEFIT PROGRAM, as requested by the DEPARTMENT.

2. Reporting on compliance will, at minimum, provide evidence that the CONTRACTOR has met the requirements of the compliance activities. Additional information may be required by the DEPARTMENT based upon the type of compliance activity being reported.

a. Specifically pertaining to the transparency requirements set forth in the Consolidated Appropriations Act of 2021, the CONTRACTOR must attest annually that transparency-related requirements have been met beginning with each compliance year specified by the Act and rules as they are finalized by Federal authorities. The CONTRACTOR must also make compliance reports required by the Act specific to Mental Health Parity available to the DEPARTMENT upon request, and in the event that reporting is required by the federal government. The CONTRACTOR must also notify the DEPARTMENT if any aspect of the DEPARTMENT'S HEALTH BENEFIT PROGRAM design or administrative requirements create risks to compliance.

b. In cases where the DEPARTMENT must provide STATE or federal reporting related to the CONTRACT and such reporting requires data to be submitted by the CONTRACTOR, the CONTRACTOR must provide that data in the format and by the timeline requested by the DEPARTMENT so that the DEPARTMENT can meet the STATE or federal requirement. The CONTRACTOR shall reasonably cooperate with the DEPARTMENT to meet this reporting requirement and will promptly meet with the DEPARTMENT to determine a mutually agreeable process to produce the necessary data in the required format.

c. If any action, inaction, or error on the part of the CONTRACTOR with regards to a term, condition, or requirement under the CONTRACT results in federal or STATE tax penalties, interest, or fees, the CONTRACTOR shall be responsible for paying such costs either directly to the federal or STATE authority or to the DEPARTMENT or PARTICIPANTS as reimbursements if such costs were paid by the DEPARTMENT or PARTICIPANTS.

IV. Performance Standards and Penalties

This section contains the performance standards and associated penalties for the services contained in this AGREEMENT. See Section III.K. Reporting Requirements for conditions on reporting.

A. Performance Standards and Penalties

1. Performance standards are specific to the HEALTH BENEFIT PROGRAM, not general performance for the CONTRACTOR'S book of business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR must notify the DEPARTMENT upon realization that a standard will not be met prior to the deadline or in keeping with other performance reporting directives from the DEPARTMENT. The CONTRACTOR must provide a letter with the reports certifying the information provided in the reports is correct.

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

3. CONTRACTOR'S performance will be measured by the DEPARTMENT on a QUARTERLY basis. The DEPARTMENT will provide written notification to the CONTRACTOR when a penalty is assessed for a failure to meet a performance standard listed in Section IV. Performance Standards and Penalties.

4. The CONTRACTOR must maintain supporting data and documentation that is sufficient for the DEPARTMENT or the DEPARTMENT'S auditor to validate CONTRACTOR'S reported performance; such validation materials will be mutually agreed upon between the CONTRACTOR and the DEPARTMENT and requested from the DEPARTMENT on an as needed basis.

B. Deliverable Reporting Requirements

1. The CONTRACTOR must provide deliverables and submit reports to the DEPARTMENT as specified in the sections below. Repeated or habitual failure to meet the deadlines as established may impact the CONTRACTOR'S ability to participate in the HEALTH BENEFIT PROGRAM in future years.

2. Deliverables must be submitted to the DEPARTMENT in the method specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify deliverable requirements as deemed necessary to monitor the CONTRACT and programs.

3. Instructions on submitting individual deliverables and specific due dates will be provided by the DEPARTMENT annually. Due dates may be revised with advance notice to CONTRACTOR via email.

C. Penalty Assessments

1. The total penalties assessed in Section IV. Performance Standards and Penalties shall not exceed three percent (3%) of the CONTRACTOR'S total medical premium in any given quarter, except where noted.

2. The penalties assessed in Section IV.E.1. Data Management are not subject to the three percent (3%) limit noted in C.1. above.

3. The data warehouse penalties assessed in Section III.D. Data and Information Security and Section IV., J. – L. are not subject to an assessment maximum in any given quarter or year.

4. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. If the DEPARTMENT elects to not exercise a penalty clause in a particular instance, such decision shall not be construed as acceptance by the DEPARTMENT of the CONTRACTOR'S performance. The DEPARTMENT retains the right to pursue future assessment of that performance requirement and associated penalties. The DEPARTMENT shall be the sole determinant as to whether the CONTRACTOR meets a performance standard. See Section IV.L. Payment of Penalty Amounts Owed by CONTRACTOR.

D. Administrative Deliverables

Instructions on submitting general administrative deliverables and specific due dates will be provided by the DEPARTMENT annually.

1. Approval of Communications	
Description	The CONTRACTOR must receive pre-approval from the DEPARTMENT of all communication materials specified by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS participating in the HEALTH BENEFIT PROGRAM. This includes written and electronic communication, such as marketing collateral, informational notices, standard letters, summary plan descriptions, claim denials and appeals, and Summary of Benefits and Coverage. *(See Sections III.E.2. Other Informational / Marketing Materials and III.E.3. CONTRACTOR web Content and Web-Portal.)*
Due	As needed, certified QUARTERLY
2. Assignment of PRIMARY CARE PROVIDER (PCP) or PRIMARY CARE CLINIC (PCC)	
Description	If a PARTICIPANT does not choose a PCP/PCC, or the PCP/PCC is no longer available, the CONTRACTOR must assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC. *(See Section III.G.2 PRIMARY CARE PROVIDER/PRIMARY CARE CLINIC Designation and Certificate of Coverage.)*
Due	As needed
3. Coordination of Benefits (COB) Report	
Description	The CONTRACTOR must collect from SUBSCRIBERS COB information necessary to coordinate BENEFITS under Wis. Admin. Code §3.40 and report this information to the DEPARTMENT as needed. *(See Section III.A.2. Enrollment.)*
Due	As needed
4. Enrollment Discrepancy Report	
Description	The CONTRACTOR must maintain a discrepancy report spreadsheet that includes the error details and final resolution provided by the IAS vendor and submit it to the IAS vendor. *(See Section III.A.1. Eligibility.)*
Due	As directed by the DEPARTMENT
5. External Review Request Notification	

Description	Within five (5) calendar DAYS of the CONTRACTOR'S receipt of a PARTICIPANT'S request for external review, the CONTRACTOR must notify the DEPARTMENT of the request in the format specified by the DEPARTMENT. *(See Section III.I.6. External Review.)*
Due	See description

6. External Review Determination	
Description	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. Within thirty (30) calendar DAYS, the CONTRACTOR must provide a redacted copy of the determination to the DEPARTMENT. *(See Section III.I.6. External Review.)*
Frequency	See description
7. Identification (ID) Cards	
Description	The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage, and the emergency room and office visit copayment amounts, if applicable. *(See Section III.A.4. Identification (ID) Cards.)*
Due	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards.
8. ID Card Issuance Delay Notification	
Description	The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section III.A.4. Identification (ID) Cards.)*
Due	Upon identification of issue
9. Key Contacts Listing (ET-1728)	
Description	The CONTRACTOR must provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section III.H.1. Account Management and Staffing.)*
Due	January, April, July, October
10. Major Administrative and Operative System Changes	
Description	The CONTRACTOR must submit written notice to the DEPARTMENT at least one hundred eighty (180) calendar DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM. *(See Section III.D.1. Information Systems.)*
Due	As needed
11. Medicare Enrollment Denial	
Description	The CONTRACTOR must notify 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 Certificate of Coverage.)*
Due	See description
12. Notification of Account Manager or Key Staff Changes	
Description	The CONTRACTOR must notify the DEPARTMENT via ETFSMBInsuranceSubmit@etf.wi.gov and the Health Program Manager if the Account Manager, backup, or key staff changes. *(See Section III.H.1. Account Management and Staffing.)*
Due	As needed
13. Notification of Legal Action	
Description	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR must notify the DEPARTMENT'S chief legal counsel via

	ETFSMBOfficeofLegalServices@etf.wi.gov within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section III.I.9. Notification of Legal Action.)*
Due	As needed

14. Notification of Data Breach	
Description	The CONTRACTOR must 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, HIPAA, and GINA. *(See Department Terms and Conditions.)*
Due	As needed
15. Notification of Significant Events	
Description	The CONTRACTOR must notify the DEPARTMENT of all Significant Events as described in Section II.B. Board Authority and Certificate of Coverage Section 7.
Due	As needed
16. Over-Age Disabled Child Review Notification	
Description	The CONTRACTOR must notify the DEPARTMENT of individual over-age disabled DEPENDENT review results per DEPARTMENT submission instructions. CONTRACTOR may perform individual reviews at any time of the year. If it is found that the child no longer meets the criteria, termination of the child's coverage must be prospective. The DEPARTMENT must be copied on the notification of the CONTRACTOR'S review prospectively and as described in the submission instructions. *(See Certificate of Coverage Section 7.)*
Due	Prior to termination of DEPENDENT'S coverage
17. PARTICIPANT Enrollment Information	
Description	The CONTRACTOR must provide the minimum following information described in section III.A.5, at a minimum, to all PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website or microsite and directions on how to request a printed copy of the provider directory. • Directions on how to change their PCP/PCC. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website or microsite address. *(See Section III.A.5. Enrollment and Eligibility Information for PARTICIPANTS.)*
Due	Upon enrollment
18. PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	
Description	In the final grievance decision letter, the CONTRACTOR must inform the PARTICIPANT of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. *(See Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights.)*
Due	See description
19. PARTICIPANT Notification of Grievance Rights	
Description	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 BENEFITS contractual provision(s) upon which the denial is based. *(See Section III.I.1. Grievance Process Overview or Section IV. Performance Standards and Penalties.)*
Due	See description

20. PARTICIPANT Notification of Terminated Provider Agreement	
Description	The CONTRACTOR must send written notification to all PARTICIPANTS receiving services from a terminated PROVIDER as described in Section III.F.3. Continuity of Care.
Due	See description
21. SUBSCRIBER Notification Upon Termination of Employment	
Description	The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section III.A.6.b.)*
Due	See description
22. Transition Plan	
Description	The CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARTMENT. *(See Section III.H.12. Expert Services.)*
Due	First draft due within ten (10) BUSINESS DAYS of determining the CONTRACT will be terminated. Final plan due within thirty (30) BUSINESS DAYS of the determination.
23. Web Content and Web-Portal Design and Changes	
Description	The CONTRACTOR must submit the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT Program Manager of any substantial changes being made to the website or microsite prior to implementation. *(See Section III.E.3. CONTRACTOR Web Content and Web-Portal.)*
Due	As directed by the DEPARTMENT

E. Administrative Performance Standards and Guarantees

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

1. Data Management (The penalties assessed in this Section IV.E.1. are not subject to the 3% limit noted in Section IV.C.1.)	
Performance Standards	*Penalties*
a. Notification of Data Breach: The CONTRACTOR must 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.	$2,500 - first violation $5,000 - second violation $10,000 - third and any additional violations $100,000 annual maximum
b. 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
c. 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	$15,000 – First violation $20,000 – Second violation $25,000 – Third and any additional violations $100,000 annual maximum

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.	

2. Enrollment	
Performance Standards	*Penalties*
a. 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. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.A.1. Eligibility.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
b. Enrollment Discrepancies and Exceptions Resolution: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the IAS vendor's database and the CONTRACTOR'S database) as identified within five (5) BUSINESS DAYS of notification by the DEPARTMENT or identification by the CONTRACTOR. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Sections III.A.1. Eligibility.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
c. Enrollment Discrepancies and Exceptions Corrections: The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the IAS vendor. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Sections III.A.1. Eligibility.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
d. ID Card Issuance for Elections <u>During the Plan Year</u>: The CONTRACTOR must 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 Section IV.) regarding ID cards issued during the OPEN ENROLLMENT PERIOD. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.A.4. Identification (ID) Cards.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
e. ID Card Issuance for Elections <u>During the OPEN ENROLLMENT Period</u>: The CONTRACTOR must 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 OPEN ENROLLMENT period through December 5. For enrollment files specific to the OPEN ENROLLMENT period generated after December 5 (i.e., between December 6 or December 31), ID cards must be mailed within 10 BUSINESS DAYS of receipt of the enrollment file. CONTRACTOR will confirm each ID card mailing date(s) and if any delays or changes to the mailing dates occur or are expected. Specific deliverable dates may be defined by the DEPARTMENT. *(See Section III.A.4. Identification (ID) Cards.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met

f.	**Direct Pay Terminations:** The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section III.B.2. PREMIUM Payments from the DEPARTMENT.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
3.	**Other**	
	Performance Standards	*Penalties*
a.	**Audit:** The CONTRACTOR must address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section III.J.1 Audit and Other Services.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
b.	**Major System Changes and Conversions:** The CONTRACTOR must verify and commit that during the length of the CONTRACT, it must not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. The CONTRACTOR must certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.D.1. Information Systems)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
c.	**Non-Disclosure:** The CONTRACTOR must not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section II.B. Board Authority and Certificate of Coverage Section 7.)*	Five thousand dollars ($5,000) per incident
d.	**Service Level Response Time:** The CONTRACTOR must respond to the DEPARTMENT within two (2) BUSINESS DAYS from the confirmed delivery date of the DEPARTMENT'S inquiry. If the CONTRACTOR is unable to resolve the issue within two (2) BUSINESS DAYS, the CONTRACTOR shall, within two (2) BUSINESS DAYS of the confirmed delivery date of the DEPARTMENT'S inquiry, confirm to the DEPARTMENT that the inquiry was received and provide an estimate of when the CONTRACTOR will resolve the issue. CONTRACTOR shall respond to the DEPARTMENT and resolve issues in a timeframe mutually agreed upon by the CONTRACTOR and the DEPARTMENT. *(See Section III.H.3 Customer Service.)*	Two-hundred and fifty dollars ($250) per BUSINESS DAY for which the standard is not met.

F. Annual Deliverables

Instructions on submitting annual deliverables and specific due dates will be provided by the DEPARTMENT annually.

1. 1095-B Issuance Notification	
Description	The CONTRACTOR must submit a written notification to the DEPARTMENT Program Manager indicating the date(s) 1095-Bs were issued, or when the web notice was posted, as required by federal law. *(See Section III.A.5.c.)* **Note:** 1095-Bs are not required for Medicare plans.
Frequency	Annually
2. Annual ID Card Issuance Confirmation	
Description	The CONTRACTOR must send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section III.A.4. Identification (ID) Cards.)*

Frequency	Annually (January)

3. Customer Service Department Operating Hours and Anticipated Closures	
Description	The CONTRACTOR must report standard customer service department operating hours and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARTMENT. The CONTRACTOR must promptly report any unanticipated closures to the DEPARTMENT in the format specified by the DEPARTMENT. *(See Section III.H.3. Customer Service.)*
Frequency	Annually
4. Model Audit Review Certification	
Description	The CONTRACTOR must submit a Model Audit Rule (MAR) on an annual basis. *(See Section III.J.1. Audit and Other Services.)*
Frequency	Annually (August)
5. OPEN ENROLLMENT Informational Materials Review	
Description	The CONTRACTOR must submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)*
6. SUBSCRIBER Notification of Changes Review	
Description	The CONTRACTOR must submit the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the annual OPEN ENROLLMENT period identifying those PROVIDERS that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. The CONTRACTOR must issue the written notice after DEPARTMENT approval. *(See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)*
Frequency	Annually (September)
7. SUBSCRIBER Notification of Changes Issuance Confirmation	
Description	The CONTRACTOR must submit a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in Item 10) above was issued to PARTICIPANTS. *(See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)*
Frequency	Annually (October)
8. Summary of Benefits and Coverage	
Description	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual OPEN ENROLLMENT materials mailing process. *(See Section III.A.1. Eligibility.)*
Frequency	As needed
9. Utilization Review Meeting	
Description	The CONTRACTOR must meet with DEPARTMENT staff on an annual basis to report and discuss annual experience and utilization regarding: • Disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors: • Demonstrating support for technology and automation; • DEPARTMENT experience by disease and risk categories; • 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; and

	• DEPARTMENT Initiatives, which currently include: Care Coordination and Diabetes Management and Prevention. This information must be presented in a format as determined by the DEPARTMENT. The DEPARTMENT will provide additional reporting criteria in advance of the meeting. *(See Section III.G.1. Department Initiatives and Certificate of Coverage Section 4.)*
Frequency	Annually

G. Annual Reporting Requirements

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

1. Business Recovery Plan and Simulation Report	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must test its business recovery plan and submit the test results to the DEPARTMENT. *(See Section III.D.1. Information Systems.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
2. CAHPS Survey Results Report	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must submit the results of its annual CAHPS survey to the DEPARTMENT. *(See Section III.C.3. Quality.)*	Disqualification from Quality Credit
3. Customer Service Inquiry System Certification	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must certify to the DEPARTMENT that CONTRACTOR'S customer service inquiry system meets the requirements in Section III.H.3. Customer Service.	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
4. Financial and Utilization Data Submission	
Performance Standard	*Penalty*
Annually, in February, the CONTRACTOR must submit to the DEPARTMENT or the DEPARTMENT'S designee, as specified by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. *(See Sections II.B. Board Authority and III.C.1. Annual Rate Bidding Process.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
5. Financial Stability Documentation	
Performance Standard	*Penalty*
Annually, in June, the CONTRACTOR must submit financial stability documentation, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public account in accordance with generally accepted accounting principles) to the DEPARTMENT. *(See Section III.J.1. Audit and Other Services.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
6. Grievance Summary Report	
Performance Standard	*Penalty*
The CONTRACTOR must retain records of grievances and submit an **annual** summary to the DEPARTMENT of the number, type, and the resolution or outcome of grievances received. *(See Section II.B. Board Authority and Certificate of Coverage Section 7.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met

7. HEDIS Results Report	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must submit to the DEPARTMENT audited HEDIS data results for the previous calendar year for CONTRACTOR'S commercial membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. *(See* Section *III.C.3. Quality.)*	Disqualification from Quality Credit
8. Model Audit Rule (MAR) Certification	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must submit a MAR Certification to the DEPARTMENT. *(See Section III.J.1. Audit and Other Services.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
9. Over-Age Disabled Child Eligibility Verification Report and Certification	
Performance Standard	*Penalty*
Annually, the CONTRACTOR must report and certify to the DEPARTMENT total results from its process to verify the eligibility of adult disabled children age twenty-six (26) or older, which includes checking that the: • Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year; and, • Support and maintenance requirement is met; and, • Child is not married. *(See Certificate of Coverage Section 7.)*	Twenty–five hundred dollars ($2,500) per report or deliverable for which the standard is not met
Performance Standard	
10. Population Health Management and Pilot Program Report	
Annually, in April, the CONTRACTOR must provide the DEPARTMENT with information and outcomes on the CONTRACTOR'S population health/chronic condition management and DEPARTMENT-approved pilot programs, as applicable. This information must be presented in a format as determined by the DEPARTMENT. The DEPARTMENT will provide additional reporting criteria in advance of the due date. *(See Sections III.G.3.d and III.G.4.h.)*	

H. QUARTERLY Reporting Requirements and Penalties

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

1. Fraud and Abuse Review Results	
Performance Standard	*Penalty*
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. *(See Certificate of Coverage Section 7.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
2. CONTRACTOR QUARTERLY Performance Report	
Performance Standard	*Penalty*
On a QUARTERLY basis, unless otherwise noted, in the format specified by the DEPARTMENT, the CONTRACTOR must submit: a) a performance report summarizing the CONTRACTOR'S performance under the performance standards specified in this AGREEMENT, and b) a signed QUARTERLY CONTRACTOR letter certifying the information provided in the performance report is correct. *(See Section IV.A.1.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met

3. Performance Report – Supporting Documentation	
Performance Standard	*Penalty*
As needed, within five (5) BUSINESS DAYS of the DEPARTMENT'S request, the CONTRACTOR must provide the DEPARTMENT with supporting data and documentation that is sufficient for the DEPARTMENT or the DEPARTMENT'S auditor to validate CONTRACTOR'S reported performance. *(See Section IV.A.4.)*	Five hundred dollars ($500) per BUSINESS DAY for which the standard is not met

I. QUARTERLY Performance Standards and Penalties

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

CONTRACTOR monthly statistics for each QUARTERLY performance standard will be averaged by the DEPARTMENT for each QUARTER to determine the penalty. Penalty calculation example:

> If the performance standard is 98% and the CONTRACTOR reports monthly statistics of 79%, 82%, and 98% for the 3 months of the QUARTER, the penalty would be based on the average of the percentages for the 3 months for the performance standard, which, in this case, equals 86.33% for the QUARTER. The penalty is assessed for each percentage point or fraction thereof (rounded to two decimal places) under the performance standard of 98% (98 – 86.33 = 11.67). If the penalty is $1,000 for each percentage point or faction thereof under 98%, the penalty would be $1,000 x 11.67, or $11,670 for the performance standard penalty for that QUARTER.

1. Claims Processing	
Performance Standard	*Penalty*
a. Processing Accuracy: At least ninety-seven percent (97%) 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 III.H.2. Claims.)*	Five thousand dollars ($5,000) for each percentage point for which the standard is not met in each quarter
b. Claims Processing Time: At least ninety-five percent (95%) of all claims received must be processed within thirty (30) calendar DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section III.H.2. Claims.)*	Five thousand dollars ($5,000) for each percentage point for which the standard is not met in each quarter
2. Customer Service	
Performance Standard	*Penalty*
a. Call Answer Timeliness: At least eighty percent (80%) of calls received by the CONTRACTOR'S customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section III.H.3. Customer Service.)* * The penalty is assessed for each percentage point or fraction thereof (rounded to two decimal places).	**Small Plans (Fewer than 10,000 members)** o Penalty: $1,000 per percentage point* below 80%. • **Medium Plans (10,000-50,000 members)** o Penalty: $3,000 per percentage point* below 80%. • **Large Plans (More than 50,000 members)**

	o Penalty: $5,000 per percentage point* below 80%.
b. Call Abandonment Rate: No more than three percent (3%) 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 III.H.3. Customer Service.)* * The penalty is assessed for each percentage point or fraction thereof (rounded to two decimal places).	**Small Plans (Fewer than 10,000 members)** o Penalty: $1,000 per percentage point* above 3%. • **Medium Plans (10,000-50,000 members)** o Penalty: $3,000 per percentage point* above 3%. • **Large Plans (More than 50,000 members)** o Penalty: $5,000 per percentage point* above 3%.
c. Open Call Resolution Turn-Around-Time: At least ninety percent (90%) 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 III.H.3. Customer Service.)* * The penalty is assessed for each percentage point or fraction thereof (rounded to two decimal places).	**Small Plans (Fewer than 10,000 members)** o Penalty: $1,000 per percentage point* below 90%. • **Medium Plans (10,000-50,000 members)** o Penalty: $3,000 per percentage point* below 90%. • **Large Plans (More than 50,000 members)** o Penalty: $5,000 per percentage point* below 90%.
d. Electronic Written Inquiry Response: At least ninety-eight percent (98%) of customer service issues submitted by email and website or microsite are responded to within two (2) BUSINESS DAYS. *(See Section III.H.3. Customer Service.)* * The penalty is assessed for each percentage point or fraction thereof (rounded to two decimal places).	**Small Plans (Fewer than 10,000 members)** o Penalty: $1,000 per percentage point* below 98%. • **Medium Plans (10,000-50,000 members)** o Penalty: $3,000 per percentage point* below 98%. • **Large Plans (More than 50,000 members)** o Penalty: $5,000 per percentage point* below 98%.

J. Data Warehouse Deliverable Requirements

The CONTRACTOR must submit data to the DEPARTMENT'S data warehouse vendor in accordance with the file specifications specified by the DEPARTMENT.

1. Claims Data Transfer to Data Warehouse
Monthly, the CONTRACTOR must submit to the DEPARTMENT'S data warehouse, in accordance with the most recent file specifications specified by the DEPARTMENT, all claims processed for PARTICIPANTS. *(See Section III.D.4. Data Integration and Use.)*

2. Provider Data Transfer to Data Warehouse
Monthly, the CONTRACTOR must submit to the DEPARTMENT'S data warehouse, in accordance with the most recent file specifications specified by the DEPARTMENT, the specified data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS in Wisconsin and the surrounding states (Minnesota, Iowa, Illinois, and Upper Michigan), as well as any states in which the CONTRACTOR has claims, as specified by the DEPARTMENT. *(See Section III.D.4. Data Integration and Use.)*

K. Data Warehouse Performance Standards

The CONTRACTOR must submit data and corrected data, when necessary, by the dates indicated by the DEPARTMENT'S data warehouse vendor. Performance standards for the data warehouse will be measured by the DEPARTMENT as needed.

Performance Standard	*Penalty*
1. Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse vendor, in accordance with the most recent file specification specified by the DEPARTMENT, all claims processed for PARTICIPANTS according to the schedule established in Section III.D. Data and Information Security. *(See Section III.D.4. Data Integration and Use.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
2. PROVIDER Enrollment Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse vendor in accordance with the most recent file specification specified by the DEPARTMENT, the specified data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS according to the schedule established in the CERTIFICATE OF COVERAGE Section 7. *(See Section III.D.4. Data Integration and Use.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
3. Data Warehouse Submission Delays: The CONTRACTOR must communicate any delays in submitting program data to the DEPARTMENT'S data warehouse vendor via email to the DEPARTMENT Program Manager or designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) calendar DAY before the scheduled transfer. *(See Section III.D.4. Data Integration and Use.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
4. Data File Corrections: Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR must resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse vendor or the DEPARTMENT. *(See Section III.D.4. Data Integration and Use.)*	One thousand dollars ($1,000) per BUSINESS DAY for which the standard is not met
5. Two-Chance Rule: During the implementation of the DEPARTMENT'S data warehouse or a new CONTRACTOR, the CONTRACTOR will have two (2) 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. *(See Section III.D.4. Data Integration and Use.)*	One thousand seven hundred fifty dollars ($1,750) for each submission after the allowed submissions.
6. One-Chance Rule: During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT'S data warehouse vendor identifies an error with the CONTRACTOR'S initial data submission, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor. *(See Section III.D.4. Data Integration and Use.)*	One thousand seven hundred fifty dollars ($1,750) for each submission after the allowed submissions.

Performance Standard	*Penalty*
7. Pass-Through Data Warehouse Penalties: The DEPARTMENT will pass through any penalties assessed by the DEPARTMENT'S data warehouse vendor for failure to submit data in accordance with the CONTRACT. *(See Section III.D.4. Data Integration and Use.)*	The amount charged by the DEPARTMENT'S data warehouse vendor for the CONTRACTOR'S failure to meet data submission requirements not otherwise subject to a penalty as described above

L. Payment of Penalty Amounts Owed by CONTRACTOR

The DEPARTMENT will provide the CONTRACTOR with an invoice for penalties or monies owed. The CONTRACTOR must document any dispute of amounts listed in the invoice and provide such documentation to the DEPARTMENT Program Manager within ten (10) BUSINESS DAYS of receiving the DEPARTMENT'S invoice. The DEPARTMENT will review the CONTRACTOR'S submitted documentation and make a determination as to whether the penalty or monies owed are waived or reduced. Funds owed to the DEPARTMENT must be paid within thirty (30) calendar DAYS from the date of the CONTRACTOR'S receipt of the DEPARTMENT'S invoice. After thirty (30) calendar DAYS, the DEPARTMENT may collect owed funds by deducting the amounts from the payments made to the CONTRACTOR, and the CONTRACTOR may be subject to further penalties.

V. MEDICARE ADVANTAGE Provisions

A. MEDICARE ADVANTAGE Definitions

In addition to the Definitions provided in Section I. Definitions, above, the MEDICARE ADVANTAGE Provisions include the following definitions:

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

EVIDENCE OF COVERAGE (EOC) is the document supplied by the MEDICARE ADVANTAGE CONTRACTOR and issued to PARTICIPANTS disclosing and setting forth the health care benefits and terms and conditions of coverage of the PLAN to which PARTICIPANTS are entitled.

MEDICARE as defined in the EVIDENCE OF COVERAGE.

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

MEDICARE ADVANTAGE CONTRACTOR means the licensed insurer who is the legal signatory to the CONTRACT and is contracted by the DEPARTMENT to provide MEDICARE ADVANTAGE plans for MEDICARE-eligible SUBSCRIBERS. The MEDICARE ADVANTAGE CONTRACTOR is also referred to in this AGREEMENT as a CONTRACTOR. Certain terms and conditions in this AGREEMENT do not apply to the MEDICARE ADVANTAGE CONTRACTOR, as noted. Some terms and conditions specifically noted in the MEDICARE ADVANTAGE Provisions section only apply to the MEDICARE ADVANTAGE CONTRACTOR. Where no such clarification is made, the term or condition in this AGREEMENT shall apply to the MEDICARE ADVANTAGE CONTRACTOR.

B. MEDICARE ADVANTAGE Statutory and Board Authority

In addition to the requirements provided in Section II. Statutory and Board Authority, above, the MEDICARE ADVANTAGE Provisions contain the following additional requirements.

C. Statutory and Legal Authority

The MEDICARE ADVANTAGE CONTRACTOR must comply with all CMS MEDICARE ADVANTAGE and MEDICARE PART D requirements, including provider network access, care utilization review, GRIEVANCES and appeals, the quality improvement program, eligibility and enrollment, customer service, marketing, and claims processing, except as waived by CMS for employer group waiver plans. In cases where CMS requirements and the non-MEDICARE requirements of this AGREEMENT differ, the more rigorous standard shall supersede.

VI. MEDICARE ADVANTAGE Program Administration

In addition to (or if noted as a replacement for) the requirements provided in Section III. Program Administration, above, the MEDICARE ADVANTAGE Provisions contain the following additional (or replacement) requirements.

A. Enrollment and Eligibility Maintenance

This section addresses the MEDICARE ADVANTAGE CONTRACTOR'S role in the process of enrolling and maintaining eligibility files for PARTICIPANTS in the MEDICARE ADVANTAGE plan.

1. Eligibility

The MEDICARE ADVANTAGE CONTRACTOR must ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT'S coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE PARTS A or B after the EFFECTIVE DATE, the MEDICARE ADVANTAGE CONTRACTOR must notify the DEPARTMENT on the BUSINESS DAY after the MEDICARE ADVANTAGE CONTRACTOR identifies the PARTICIPANT as having disenrolled from PARTS A or B and the EFFECTIVE DATE of termination.

2. Enrollment

Section III.A.2. Enrollment, paragraph d., above, is <u>replaced</u> with the following:

The MEDICARE ADVANTAGE CONTRACTOR must notify the DEPARTMENT in writing if MEDICARE does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by MEDICARE. The notification must be provided within two (2) BUSINESS DAYS of the latter of either the receipt of the DEPARTMENT'S enrollment file or notification by MEDICARE.

3. Enrollment & Eligibility Information for Participants

The DEPARTMENT reserves the right to require the MEDICARE ADVANTAGE CONTRACTOR to assist with drafting and mailing the federally required materials such as the Annual Notice of Coverage to MEDICARE ADVANTAGE PARTICIPANTS, in a manner similar to the OPEN ENROLLMENT materials mailing process described in Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials., above.

4. Coverage Termination and Continuation

If the ANNUITANT or CONTINUANT contacts the MEDICARE ADVANTAGE CONTRACTOR directly to cancel coverage, the MEDICARE ADVANTAGE CONTRACTOR is to reject all non-written cancellation requests and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT. If the ANNUITANT or CONTINUANT contacts the MEDICARE ADVANTAGE CONTRACTOR directly to cancel coverage, the MEDICARE ADVANTAGE CONTRACTOR must approve all written cancellation requests, pursuant to CMS Rules and Regulations. Additionally, the MEDICARE ADVANTAGE CONTRACTOR will immediately notify the DEPARTMENT of the written termination request received.

B. PREMIUMS

1. Direct Pay PREMIUMS

The DEPARTMENT represents that EMPLOYER manuals will conform with the Medicare Managed Care Manual Chapter 9 Section 20.4.2 requirements regarding EMPLOYER conditions in determining plan beneficiary premium subsidy.

Pursuant to the Wisconsin Public Local Employers' Group Health Insurance Program Standards, Guidelines and Administration Manual (ET-1144) Section 1301 C) 2), the EMPLOYER may determine if and/or how much of an ANNUITANT'S plan beneficiary PREMIUM it will subsidize, subject to the following conditions in determining the plan beneficiary PREMIUM subsidy:

a. The EMPLOYER may subsidize different amounts for different classes of ANNUITANTS in the plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly); and

b. The EMPLOYER cannot vary the plan beneficiary PREMIUM subsidy for individuals within a given class of ANNUITANTS.

C. Rate Setting

This section addresses the annual process for establishing PREMIUM rates, including prohibited fees and allocation of a quality credit.

1. Annual Rate Bidding Process

This section <u>replaces</u> Sections III.C.1.d., g. and n., Rate Setting, above. Sections III.C.1.m. and p. do not apply to the MEDICARE ADVANTAGE CONTRACTOR.

a. The MEDICARE ADVANTAGE CONTRACTOR must submit statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically for the STATE and LOCAL EMPLOYER PARTICIPANTS covered thereunder if experience rated. If the premium is community-rated then the MEDICARE ADVANTAGE CONTRACTOR should provide the percentage the STATE and Local groups represent of the total covered community.

b. The rates must be uniform statewide, or nationwide if appropriate, except that MEDICARE ADVANTAGE CONTRACTOR may submit different rates which result from separate plan designs. The STATE and Local groups must be separately rated in accordance with generally accepted actuarial principles.

c. The MEDICARE ADVANTAGE CONTRACTOR must provide coverage and rates for the following HEALTH BENEFIT PROGRAM options:

   i. Health Plan Medicare and Local Traditional Plan (Program Options 01/02/12/06/16/07/17/08); and
   ii. Local Deductible Plan (Program Option 04/14).

2. Prohibited Fees

This section replaces Section III.C.2., Prohibited Fees, paragraphs a. and b., above.

The MEDICARE ADVANTAGE CONTRACTOR is ***permitted*** to include the following costs in its premium bid or rates:

a. The cost to handle any claims paid outside of UNIFORM BENEFITS only if they are required by CMS or other federal regulation.

b. The cost to administer any optional health and wellness benefit(s) beyond UNIFORM BENEFITS if approved by the DEPARTMENT.

3. Quality

a. As a replacement for Section III.C.3. Quality, paragraphs a. through d., above, the MEDICARE ADVANTAGE CONTRACTOR must submit the results of its annual CAHPS survey to the DEPARTMENT. Results must be based on responses for its contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS from insured adult members in Wisconsin (commercial or MEDICARE ADVANTAGE).

b. The MEDICARE ADVANTAGE CONTRACTOR must annually provide the DEPARTMENT its overall CMS Star ratings for the plan serving PARTICIPANTS, and for each measure and each domain included in the overall rating, in a format and timeframe as requested by the DEPARTMENT.

D. Data and Information Security

1. Information Systems Security Audit

The following sentence is added to the end of Section III.D.2.d. above:

Any SOC 2 Type 2 requirements shall not apply to the extent agreed upon by the DEPARTMENT in a separate writing.

2. Data Integration and Use

a. The following <u>replaces</u> Section III.D.4.d., above:

d. For data transfers between vendors of STATE and Local programs not specified in this AGREEMENT, the MEDICARE ADVANTAGE CONTRACTOR must work with such vendor(s) to establish vendor to vendor data transfers as soon as possible and provide written notification to the DEPARTMENT of the agreement to provide such transfers. Notwithstanding the foregoing, the MEDICARE ADVANTAGE CONTRACTOR has the right to reasonably refuse such data transfers to a vendor.

b. The following paragraph f. is added to Section III.D.4. above:

f. The MEDICARE ADVANTAGE CONTRACTOR must provide a copy of any CMS Model Output Report (MOR) file and a copy of the Monthly Membership Report (MMR) file, including all fields as received from CMS, to the DEPARTMENT, for the population served under this AGREEMENT. The MEDICARE ADVANTAGE CONTRACTOR must provide the MOR file to the DEPARTMENT within thirty (30) calendar DAYS of the DEPARTMENT'S request, which shall be no more often than once annually. The MEDICARE ADVANTAGE CONTRACTOR will provide the DEPARTMENT the MMR file monthly by the end of the corresponding month.

E. Communications

This section addresses OPEN ENROLLMENT and other requirements related to MEDICARE ADVANTAGE CONTRACTOR communications with PARTICIPANTS.

1. Informational / Marketing Materials

a. The BOARD expects the MEDICARE ADVANTAGE CONTRACTOR to play an active role in member education and outreach prior to the OPEN ENROLLMENT period to ensure that PARTICIPANTS understand the MEDICARE ADVANTAGE benefits and providers available under the HEALTH BENEFIT PROGRAM and how to access additional information about the program.

b. MEDICARE ADVANTAGE PARTICIPANT Marketing Materials. The DEPARTMENT will provide the MEDICARE ADVANTAGE CONTRACTOR with copies of any and all materials relating to the coverage available through the MEDICARE ADVANTAGE plan that the DEPARTMENT intends to disseminate to eligible ANNUITANTS and their eligible DEPENDENTS. The DEPARTMENT and the MEDICARE ADVANTAGE CONTRACTOR will work together to approve materials prior to distribution. The DEPARTMENT understands that the MEDICARE ADVANTAGE plan is subject to federal and STATE regulatory oversight, and that eligible PARTICIPANT materials and marketing materials (including, but not limited to, cover letters accompanying direct mail kits, announcement mailings, etc.) may be required to be filed with, reviewed and approved by, CMS or state regulators prior to use. The DEPARTMENT agrees not to distribute such material prior to mutual agreement of materials. The DEPARTMENT also agrees to comply with all relevant federal and STATE regulatory requirements regarding the distribution and fulfillment of eligible PARTICIPANT materials and/or marketing materials and applicable timeframes.

F. Provider Access

This section addresses requirements regarding provider network availability and continuity of care when networks change.

1. Provider Access Standards

a. If the MEDICARE ADVANTAGE CONTRACTOR is required to report a change in its provider network to CMS, it must also report such a change to the DEPARTMENT within five (5) BUSINESS DAYS of reporting such a change to CMS.

b. The MEDICARE ADVANTAGE CONTRACTOR must certify annually that its PROVIDER contracts meet the requirements in Section III.F. Provider Access, above. If the DEPARTMENT determines it is necessary, and has exhausted all other reasonable alternatives, it will invoke the DEPARTMENT Terms and Conditions, in an effort to obtain agreement that DEPARTMENT can review provider contracts for the purpose of confirming that the PROVIDER contracts meet the requirements in Section III.F. and validating reported data regarding PROVIDER payments. The DEPARTMENT understands that the MEDICARE ADVANTAGE CONTRACTOR has stated that it is unable to release PROVIDER contracts to the DEPARTMENT without express permission by the PROVIDER to share the contract. The MEDICARE ADVANTAGE CONTRACTOR may be allowed to redact proprietary and confidential information from such PROVIDER contracts before the DEPARTMENT review unless such information is imperative to the review.

c. The DEPARTMENT acknowledges that federal law preempts Wis. Stat. § 609.24(1)(e), which requires that PROVIDER contracts contain provisions addressing reimbursement rendered under Section III.F. Provider Access, above, and if PROVIDER contracts do not contain such provisions, the MEDICARE ADVANTAGE CONTRACTOR is required to reimburse the PROVIDER according to the most recent contracted rate.

G. Administrative Services and Supports

This section addresses administrative services provided by the MEDICARE ADVANTAGE CONTRACTOR not specified in other sections. The MEDICARE ADVANTAGE CONTRACTOR must not modify any of the services or program content provided as part of the CONTRACT without prior written approval by the DEPARTMENT Program Manager.

1. Account Management and Staffing

a. The MEDICARE ADVANTAGE CONTRACTOR will provide, at no additional expense to DEPARTMENT, at the DEPARTMENT'S request, a part-time Service Account Manager who will perform duties on-site at the DEPARTMENT.

b. The MEDICARE ADVANTAGE CONTRACTOR must also provide a central point of contact for PARTICIPANT enrollment and PREMIUM issues related to the HEALTH BENEFIT PROGRAM.

2. Claims

a. The MEDICARE ADVANTAGE CONTRACTOR must process claims for BENEFITS and services as described in UNIFORM BENEFITS. Targets for claims processing performance standards and associated penalties are specified in Section IV. Performance Standards and Penalties, above.

b. In the event the MEDICARE ADVANTAGE CONTRACTOR receives a written demand from an affected member or an affected OUT-OF-NETWORK PROVIDER with regard to any interest due for late payment of clean claims under Wis. Stat. § 628.46, the MEDICARE ADVANTAGE CONTRACTOR agrees to promptly supplement the Federally required prompt pay interest rate and pay at the 7.5% rate provided for in Wis. Stat. § 628.46.

3. Benefits

a. The MEDICARE ADVANTAGE CONTRACTOR will not offer the HDHP described in UNIFORM BENEFITS.

b. The MEDICARE ADVANTAGE CONTRACTOR will offer Renew Active, a fitness program that includes access to a free gym membership at in-network gyms.

c. The MEDICARE ADVANTAGE CONTRACTOR will offer the Healthy at Home post-discharge program for up to 30 DAYS following all INPATIENT HOSPITAL and skilled nursing facility stays, at no cost to the PARTICIPANT following a referral after each discharge. The Healthy at Home post-discharge program includes:
   i. Home-delivered meals: Up to 28 home-delivered meals when referred by the MEDICARE ADVANTAGE CONTRACTOR. Restrictions, limitations and exclusions may apply, including shipping and other requirements.
   ii. Non-emergency transportation: Up to 12 one-way trips to and from medically related appointments and pharmacies, up to 50 miles per trip, when referred by the MEDICARE ADVANTAGE CONTRACTOR.
   iii. In-home non-medical personal care may provide up to 6 hours of in-home non-medical care by a professional caregiver who can perform tasks such as companionship, preparing meals, bathing, medication reminders, providing transportation and more.

d. The MEDICARE ADVANTAGE CONTRACTOR will offer routine podiatry treatments, up to 6 visits per year, for care that is generally considered preventive, i.e., cutting or removal of corns, warts, calluses, and nails.

4. Out-of-Network Services

If the MEDICARE ADVANTAGE CONTRACTOR offers a national passive PPO network, it must offer the same copayment, coinsurance, and deductible schedules for OUT-OF-NETWORK providers as

available for IN-NETWORK PROVIDERS. The MEDICARE ADVANTAGE CONTRACTOR will be responsible for any BALANCE BILLING if the PARTICIPANT uses an OUT-OF-NETWORK PROVIDER.

H. Grievances and Appeals

1. Grievance Process Overview

The MEDICARE ADVANTAGE CONTRACTOR must follow CMS rules set forth in 42 CFR part 422, subpart M, and Chapter 13 of the Medicare Managed Care Manual. When CMS rules differ from the provisions in Section III.I., the rules that are most favorable to the member apply. The DEPARTMENT'S administrative and external (independent) review rights described in Section III.I do not apply.

The following provisions do not apply to the MEDICARE ADVANTAGE CONTRACTOR:

a. **Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights**
b. **Section III.I.6. External Review Rights paragraphs b., and c.**
c. **Section III.I.10. Compliance with Departmental Determinations.**

Section III.I.6.d. External Review Rights, above, is deleted and replaced with the following language applicable to the MEDICARE ADVANTAGE CONTRACTOR: Every month on the seventh (7th) BUSINESS DAY of the month (for the prior month), the CONTRACTOR must send a copy of a monthly detailed report from the external reviewer to the DEPARTMENT. The CONTRACTOR must redact all member-identifying information from this report before sending it to the DEPARTMENT.

I. Audits and Disclosure Requirements

This section addresses the process by which the DEPARTMENT and other government entities may conduct audits, the requirement to participate in audits, and requirements to retain records.

1. Record Retention

a. M**EDICARE ADVANTAGE ENROLLMENT Record Retention:** The DEPARTMENT'S record of a PARTICIPANT'S enrollment election must exist in a format that can be easily, accurately, and quickly reproduced for later reference by each individual PARTICIPANT, the MEDICARE ADVANTAGE CONTRACTOR and/or CMS, as necessary, and be maintained by DEPARTMENT for the term of the CONTRACT and for ten (10) years thereafter.

b. **MEDICARE ADVANTAGE Disenrollment Record Retention:** The DEPARTMENT'S record of PARTICIPANT'S election to disenroll must exist in a format that can be easily, accurately, and quickly reproduced for later reference by each individual PARTICIPANT, the MEDICARE ADVANTAGE CONTRACTOR and/or CMS, as necessary, and be maintained by the DEPARTMENT for at least ten (10) years following the EFFECTIVE DATE of the PARTICIPANT'S disenrollment from the PLAN.

J. Identification (ID) Cards

Section III.A.4.a. Identification (ID) Cards, above, does not apply to the MEDICARE ADVANTAGE CONTRACTOR. Instead, the following applies:

a. The MEDICARE ADVANTAGE CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the ID card print date, and the emergency room and office visit copayment amounts, if applicable.

K. Incentives

Section III.H.4. Incentives, above, is deleted and replaced with the following language applicable to the MEDICARE ADVANTAGE CONTRACTOR:

a. The MEDICARE ADVANTAGE CONTRACTOR must receive written approval annually from the DEPARTMENT prior to offering any financial incentive or discount programs to PARTICIPANTS.

b. The MEDICARE ADVANTAGE CONTRACTOR must provide an incentive file to the DEPARTMENT, as directed by the DEPARTMENT, that contains all incentive payments or other items of monetary value that do not qualify as a 213 (d) medical expense under federal law that were issued to ANNUITANTS, CONTINUANTS, and their DEPENDENTS. The MEDICARE ADVANTAGE CONTRACTOR must send the incentive file to the DEPARTMENT annually no later than the tenth (10th) calendar DAY of January. Further, the MEDICARE ADVANTAGE CONTRACTOR must annually send the DEPARTMENT a check in the amount of the calculated FICA based on the incentives earned in the program year no later than the last BUSINESS DAY of January. The MEDICARE ADVANTAGE CONTRACTOR must link all payment records to the primary SUBSCRIBER and avoid duplications for instances of a reissued incentive.

c. All wellness incentives paid to participants of the State of Wisconsin Group Health Insurance Program are considered taxable income to the group health plan subscriber and are reported to the Wisconsin Retirement System who will issue a W-2. Health information is protected by federal law and Renew Rewards will never share your health information with the WI Dept. of Employee Trust Funds or the Group Insurance Board.

L. Administrative Deliverables

a. **Section IV.D.7. Identification (ID) Cards, above, does not apply to the MEDICARE ADVANTAGE CONTRACTOR; instead, the following applies**:

7. MEDICARE ADVANTAGE Identification (ID) Cards	
Description	The MEDICARE ADVANTAGE CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the ID card print date, and the emergency room and office visit copayment amounts, if applicable.
Frequency	Upon enrollment and when BENEFIT changes impact the information printed on the ID cards.

b. **The following is <u>added</u> to Section IV.D. Administrative Deliverables, above, and applies to the MEDICARE ADVANTAGE CONTRACTOR:**

24. Incentive Payments	
Description	The MEDICARE ADVANTAGE CONTRACTOR must provide an incentive file to the DEPARTMENT, as directed by the DEPARTMENT, that includes all incentive payments or other items of monetary value that do not qualify as a 213 (d) medical expense under federal law that were issued to ANNUITANTS, CONTINUANTS, and their DEPENDENTS. *(See MEDICARE ADVANTAGE Section VI.K. Incentives.)*

Frequency	Annually by the 10th calendar DAY of January.

M. Annual Reporting Requirements

In addition to the requirements in Section IV.G. Annual Reporting Requirements, above, the MEDICARE ADVANTAGE CONTRACTOR must provide the following report:

24. CMS Star Ratings	
Description	The MEDICARE ADVANTAGE CONTRACTOR submits CMS overall Star ratings and Star ratings for each measure and each domain included in the overall rating (*See MEDICARE ADVANTAGE Provisions Section VI.C.3. Quality, paragraph b.)*
Frequency	Annually
Penalty	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met

N. STATE and Federal Mandates

Section III.L.2.c. above is replaced with the following language for the MEDICARE ADVANTAGE CONTRACTOR:

c. Subject to the indemnification standards under Exhibit 5 of the Contract, if any action, inaction, or error on the part of the CONTRACTOR with regards to a term, condition, or requirement under the CONTRACT results in federal or STATE tax penalties, interest, or fees being assessed against the DEPARTMENT, the CONTRACTOR shall be responsible for paying such costs directly to the federal or STATE authority, or to the DEPARTMENT if the DEPARTMENT paid such penalty, interest, or fee.

VII. MEDICARE ADVANTAGE Performance Standards and Penalties

In addition to (or, if noted, as a replacement for) the Performance Standards and Penalties listed in Section IV. above, the MEDICARE ADVANTAGE Provisions contain the following additional (or replacement) requirements.

A. Administrative Deliverables

Section IV.D.20. PARTICIPANT Notification of Terminated Provider Agreement, above, is replaced with the following for the MEDICARE ADVANTAGE CONTRACTOR:

20. Participant Notification of Terminated Provider Agreement	
Description	At least thirty (30) calendar DAYS prior to the termination of a PROVIDER agreement, or the closing of an IN-NETWORK clinic, PROVIDER location, or HOSPITAL during the BENEFIT PERIOD, the MEDICARE ADVANTAGE CONTRACTOR must send written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that PROVIDER in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK PROVIDER or facility. • The continuity of care provision as it relates to this situation. • Contact information for questions. The MEDICARE ADVANTAGE CONTRACTOR must send the above written notification subject to the MEDICARE ADVANTAGE CONTRACTOR receiving notification from the PROVIDER of their termination.

B. Administrative Performance Standards and Guarantees

The following Performance Standards and Penalties are in addition to the Performance Standards and Penalties listed in Section IV.E. Administrative Performance Standards and Guarantees, above:

5. Data Management	
Performance Standards	*Penalties*
a. CMS Model Output Report (MOR): The MEDICARE ADVANTAGE CONTRACTOR must provide a copy of any CMS MOR file including all fields as received from CMS, for the population served under this AGREEMENT to the DEPARTMENT. The MOR file must be provided upon request, no more often than annually and will be submitted within thirty (30) calendar DAYS of the DEPARTMENT'S request. *(See MEDICARE ADVANTAGE PROVISIONS VII.D.1.a.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met.
b. MEDICARE ADVANTAGE Monthly Membership Report (MMR): The MEDICARE ADVANTAGE CONTRACTOR must provide a copy of the MMR file including all fields as received from CMS, for the population served under this AGREEMENT to the DEPARTMENT. The MMR file must be provided monthly to the DEPARTMENT by the end of the corresponding month. *(See MEDICARE ADVANTAGE Provisions VII.D.1.a.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met

6. Enrollment	
Performance Standards	*Penalties*
a. MEDICARE Disenrollment: The MEDICARE ADVANTAGE CONTRACTOR must ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT'S coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE Parts A or B after the EFFECTIVE DATE, the MEDICARE ADVANTAGE CONTRACTOR must notify the DEPARTMENT on the BUSINESS DAY after the MEDICARE ADVANTAGE CONTRACTOR identifies the PARTICIPANT as having disenrolled from Parts A or B and the EFFECTIVE DATE. *(See MEDICARE ADVANTAGE Provisions VII.A.1.a.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met.
7. MEDICARE ADVANTAGE Other	
Performance Standards	*Penalties*
a. Taxable Income Report for Participant Incentive Payments: The MEDICARE ADVANTAGE CONTRACTOR must provide an incentive file annually to the DEPARTMENT, by the tenth (10th) calendar DAY of January, as directed by the DEPARTMENT, that includes all incentive payments or other items of monetary value that do not qualify as an IRS Section 213 (d) medical expense that were issued to MEMBERS for tax reporting purposes. The MEDICARE ADVANTAGE CONTRACTOR will follow the mutually agreed upon process and validation of incentive data. *(See MEDICARE ADVANTAGE Provisions Section VI.L. Administrative Deliverables.)* Also see Section III.L. State and Federal Mandates.	One thousand ($1,000) dollars per calendar DAY for which the standard is not met. $50,000 annual maximum

VIII. MEDICARE PLUS Provisions

A. MEDICARE PLUS Definitions

In addition to the Definitions provided in Section I. above, the following definitions apply to the MEDICARE PLUS Provisions:

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

MEDICARE: Means **Benefits** available under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE PLUS: Is a fee-for-service MEDICARE supplement plan administered by the CONTRACTOR for retirees eligible for MEDICARE Parts A and/or B and pays for BENEFITS described in the MEDICARE PLUS CERTIFICATE OF COVERAGE (ET-4113).

REASONABLE CHARGES: Means an amount for a health care service that is reasonable, as determined by the CONTRACTOR. The CONTRACTOR takes into consideration, among other factors (including national sources) determined by the CONTRACTOR: (1) amounts charged by health care PROVIDERS for similar health care services when provided in the same geographical area; (2) the CONTRACTOR'S methodology guidelines; (3) pricing guidelines of any third party responsible for pricing a claim; and (4) the negotiated rate determined by the CONTRACTOR in accordance with the applicable contract between the CONTRACTOR and a health care PROVIDER. As used herein, the term "area" means a county or other geographical area that the CONTRACTOR determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. Also, the amount the CONTRACTOR determines as reasonable may be less than the amount billed. In these situations, the PARTICIPANT is held harmless for the difference between the billed and paid CHARGES unless the PARTICIPANT accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. This definition applies to the MEDICARE PLUS CERTIFICATE OF COVERAGE (ET-4113) Section 8. Additional Services.

IX. MEDICARE PLUS Program Administration

In addition to the Program Administration requirements provided in Section III. above, the following requirements apply to the MEDICARE PLUS Provisions.

A. PREMIUMS

This section addresses the CONTRACTOR'S and the DEPARTMENT'S additional responsibilities related to processing PREMIUMS, as well as services that may be included or excluded from PREMIUMS for PARTICIPANTS in the MEDICARE PLUS plan.

1. MEDICARE PARTICIPANT PREMIUMS

a. 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 MEDICARE Parts A and B BENEFITS 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.

b. If a MEDICARE coordinated family PREMIUM category has been established for a family, and one or more family members enrolled in MEDICARE Parts A and B dies, the family PREMIUM category in effect shall not change solely as a result of the death.

c. In the event that a PARTICIPANT is enrolled in non-MEDICARE-reduced coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the MEDICARE reduced PREMIUM for any months for which BENEFITS are reduced in accordance with UNIFORM BENEFITS or the MEDICARE PLUS certificate administered by the 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.

Also see the **Uniform Benefits Certificate of Coverage Section 3.C, Medicare Participant Premiums**.

2. Prohibited Fees

This section replaces Section III.C.2., Prohibited Fees, above.

The CONTRACTOR is prohibited from including in their premium bid:

a. The cost to handle any claims paid outside of MEDICARE PLUS.

b. The cost to administer any optional health and wellness BENEFIT(S) beyond MEDICARE PLUS, except as approved by the DEPARTMENT.

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

B. Administrative Services & Supports

1. Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in the MEDICARE PLUS CERTIFICATE OF COVERAGE (ET-4113). Targets for claims processing performance standards and associated penalties are specified in Section IV, Performance Standards & Penalties, above.

The MEDICARE PLUS plan provides coverage for BENEFITS and services received out-of-country. The CONTRACTOR'S documentation requirements for out-of-country claim submissions, such as itemized bills in English and information on foreign currency exchange rates at the time, must be described in their member materials. The CONTRACTOR will determine usual, customary, and REASONABLE CHARGES for MEDICALLY NECESSARY services or other items that are provided out-of-country. The Contractor will pay the lesser of usual, customary, and REASONABLE CHARGES or billed amounts.

The CONTRACTOR shall comply with Wis. Stat. § 628.46 with regard to any interest due for late payment of claims submitted by an OUT-OF-NETWORK provider.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide a listing of the total dollar amount of the applicable claims paid by the HEALTH BENEFIT PROGRAM on behalf of the PARTICIPANT and/or their eligible DEPENDENTS.

The CONTRACTOR is responsible for resolving discrepancies in claims payments for all MEDICARE data match inquiries.

C. Grievances & Appeals

This section addresses the process by which PARTICIPANTS can express and seek remedy for any dissatisfaction with the CONTRACTOR.

1. Notification of DEPARTMENT Administrative Review Rights

This section replaces Section III.I.5., Notification of DEPARTMENT Administrative Review Rights or External Review Rights, above.

a. 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 external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR will cite the specific MEDICARE PLUS contractual provision(s).

b. If the PARTICIPANT disagrees with the grievance committee's final decision, the PARTICIPANT may submit a written request for review to the DEPARTMENT within sixty (60) DAYS of the date of the final grievance decision letter. The DEPARTMENT will review and communicate the outcome of the review to the PARTICIPANT. If 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) DAYS of the date of the DEPARTMENT'S final review letter.

c. The determination of the DEPARTMENT is final and not subject to further review unless the PARTICIPANT submits a timely appeal of the determination by the DEPARTMENT to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3).

d. The DEPARTMENT will not issue a determination regarding denials of coverage by the CONTRACTOR and/or PBM 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 external review process under applicable federal or STATE law.

e. If the PARTICIPANT disagrees with a determination by the DEPARTMENT, the PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). 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 the guidelines, rules, and regulations promulgated by the DEPARTMENT.

f. BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

D. Benefits

This section addresses requirements regarding other BENEFITS.

1. Overview

BENEFITS are reviewed annually by the DEPARTMENT and the BOARD and any changes to BENEFITS must be implemented by the CONTRACTOR as directed by the BOARD. This shall include the Contractor developing the necessary reporting and/or data transfers needed by the DEPARTMENT and other vendors to administer the change(s) to BENEFITS.

2. Emergency / Urgent / Catastrophic Care

The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK OR OUT-OF-NETWORK providers at the In-Network level of BENEFITS. This OUT-OF-NETWORK care, for example, out-of-country claims, may be subject to usual and customary and REASONABLE CHARGES, as defined in the CERTIFICATE OF COVERAGE, while holding the PARTICIPANT harmless as described in the MEDICARE PLUS CERTIFICATE OF COVERAGE (ET-4113), unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger networks may offer coverage through affiliated networks as long as there is no additional cost to the HEALTH BENEFIT PROGRAM or PARTICIPANT for doing so.

The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these

situations, including directing care IN-NETWORK, and/or a transfer to a more suitable facility when appropriate.

The CONTRACTOR must submit to the DEPARTMENT upon request, a report of all claims (including non-urgent and non-emergent) paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the PROVIDER in the format specified by the DEPARTMENT.

The CONTRACTOR will provide coverage for certain mental health services OUT-OF-NETWORK as required by law for college students who are PARTICIPANTS in the HEALTH BENEFIT PROGRAM.

3. MEDICARE

The CONTRACTOR will provide BENEFITS and services as described in the MEDICARE PLUS CERTIFICATE OF COVERAGE (ET-4113) for enrolled PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if MEDICARE does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by MEDICARE. 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.

Certificate of Coverage

2026 State of Wisconsin Group Health Insurance Program

Effective January 1, 2026

ET-2180 (Revised April 15, 2025)

Certificate of Coverage

This **Certificate of Coverage (Certificate)** is your summary plan description and contains the Uniform Benefits offered under the **Group Health Insurance Program (GHIP)**. *Keep this document with your other insurance papers.*

The purpose of this **Certificate** is to help you (the **Subscriber**) and your **Dependents** understand the **Benefits** covered under the **GHIP**.

All **Health Plans** that participate in the **GHIP** must offer the same coverage described in this **Certificate**. Your **Health Plan** may adopt policies, procedures, or rules to help determine **Benefits** covered under this **Certificate.**

If any part of this **Certificate** is or becomes prohibited by law, it will no longer apply; the rest of this **Certificate** will continue in full force.

The **Benefits** described herein comply with state of Wisconsin and federal minimum benefits requirements, and any additional coverage requirements made by the **Group Insurance Board** (**Board**).

*This **Certificate** should be used in conjunction with the **Schedule of Benefits** for your specific health plan. Visit the Department of Employee Trust Funds' website at www.etf.wi.gov or select the appropriate link below to view the **Schedules of Benefits**. Please note this **Certificate** is subject to updates at any time. Please visit www.etf.wi.gov for the most current version. **Note:** Links to the SoBs listed below will become active in August 2025.*

- Access High Deductible Health Plan (HDHP – PO1, PO7, PO17)
- Access Plan for State of Wisconsin, Local Health Insurance and LAHP Members (PO1, PO6, PO8, PO16)
- Health Plan Medicare and Local Traditional Plan (PO1, PO2, PO6, PO7, PO8, PO12, PO16, PO17)
- High Deductible Health Plan (HDHP – PO1, PO7, PO17)
- IYC Health Plan (PO1, PO6, PO8, PO16)
- Local Deductible Access Plan (PO4, PO14)
- Local Deductible Plan (PO4, PO14)
- Local Traditional Access Plan (PO2, PO12)

Table of Contents

1. Glossary of Terms

When spelled with capital letters and bolded, the following terms refer to the specific statements or ideas below:

Access Plan: means the nationwide **Preferred Provider Organization (PPO) Benefit Plan** offering available to all **Participants. Participants** may use **In-Network** or **Out-of-Network Providers** for covered services.

Advance Care Planning: means making decisions about the health care you want to receive and your goals for care if you were facing a medical crisis.

Allowed Amount: means the maximum dollar amount that your **Health Plan** will pay a **Provider** for services, based upon the contract agreement between the **Health Plan** and the **Provider**.

Allowable Expense: means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more **Plans** covering the person for whom the claim is made. The difference between the cost of a private **Hospital** room and the cost of a semi-private **Hospital** room is not considered an **Allowable Expense** unless the patient's stay in a private **Hospital** room is medically necessary either in terms of generally accepted medical practice or as specifically defined by the **Health Plan**. When a **Health Plan** provides **Benefits** in the form of services, the reasonable cash value of each service rendered shall be considered both an **Allowable Expense** and a **Benefit** paid. However, when there is a maximum **Benefit** limitation for a specific service or treatment, the **Secondary Plan** will also be responsible for paying up to the maximum **Benefit** allowed for its **Plan**. This will not duplicate **Benefits** paid by the **Primary Plan**.

Ambulatory Surgery Center (ASC): means a free-standing facility where surgeries are performed that allows patients to go home the same day. **ASCs** might be part of a **Hospital** system, but they are not usually physically attached to a **Hospital**. **ASCs** might also be known as Surgery Centers or Outpatient Surgery Centers.

Annuitant: means a retiree of the Wisconsin Retirement System. See Section 2.A. Subscriber Eligibility for more information.

> **Local Annuitant:** means 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, or a disability benefit under Wis. Stat. § 40.65, or a person receiving an annuity through a program administered by **ETF** under Wis. Stat. § 40.19 (4) (a). It can also refer to a retired public **Employee** under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long-Term Disability Insurance (LTDI)), or any **Dependent** of such an **Employee**, who is receiving a continuation of the **Employee's** annuity, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect the **Local Annuitant Health Program (LAHP)**. See Section 2.A. Subscriber Eligibility for more information.
>
> **State Annuitant:** means any retired **Employee** of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability **Benefit** under Wis. Adm. Code § ETF 50.40, a currently insured recipient of a disability **Benefit** under Wis. Stat. § 40.65, or a terminated **Employee** with 20 years of creditable service.

Bed and Board: means the costs of rooms, meals, and general care needed by patients who are in the **Hospital**.

Benefit Period: means the total duration of **Confinements** that are separated from each other by less than 60 calendar days.

Benefit Plan: means the package of coverage and cost-sharing levels that you are enrolled in under the State of Wisconsin **GHIP**.

Benefit: means the service that is paid for as a part of your coverage under the State of Wisconsin **GHIP**.

Board: means the **Group Insurance Board**.

Business Day: means each calendar day except Saturday, Sunday, and official State of Wisconsin holidays, as listed under Wis. Stat. § 230.35(4)(a).

Certificate of Coverage (Certificate): means this document, which may be updated as required by the Department, and includes details on the services that are covered by your **Benefit Plan** under the State of Wisconsin **GHIP**.

Charge: means an amount for a health care service from a **Provider** that is reasonable, as determined by the **Health Plan**. **Charges** include all taxes for which the **Participant** can legally be billed, including but not limited to sales tax.

Claim Determination Period: means a calendar year. However, it does not include any part of a year during which a person has no coverage under the **GHIP** or any part of a year before the date the **Coordination of Benefits** provision or a similar provision takes effect.

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

Coinsurance: means a specified percentage of the **Allowed Amount** that the **Participant** or family must pay each time those covered services are provided, subject to any limits specified in the **Schedule of Benefits**.

COBRA Contractor: means the company that administers the Consolidated Omnibus Budget Reconciliation Act for employees who are covered under the Group Health Insurance Program.

Confinement: means the period of time between admission as an **Inpatient** or **Outpatient** to a **Hospital**, covered residential center, **Skilled Nursing Facility,** or licensed **Ambulatory Surgery 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**.

Congenital: means a condition which exists at birth.

Continuant: means any **Subscriber** enrolled under federal or **State** continuation provisions.

Coordination of Benefits (COB): means the process **Health Plans** use to determine which **Plan** will pay first for covered medical services or prescription drugs and what the second **Plan** will pay after the first **Plan** has paid.

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 **Schedule of Benefits**.

Custodial Care: means the provision of **Bed and Board**, nursing care, personal care, or other care designed to assist an individual who, in the opinion of an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this), has reached the maximum level of recovery. **Custodial Care** is provided to patients who need a protected, monitored, and/or controlled environment, or who need help to support the essentials of daily living. It shall not be considered **Custodial Care** if the **Participant** is under active medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary for the **Participant** to function outside of a protected, monitored, and/or controlled environment, or if it can reasonably be expected, in the opinion of the **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this), that the medical or surgical treatment will enable that person to live outside an institution. **Custodial Care** also includes rest cures, respite care, and **Home Care** provided by family members.

Deductible: means the amount the **Participant** owes for health care services the **Participant's Benefit Plan** covers before the **Benefit Plan** begins to pay. For example, if the **Participant's Deductible** is $1,500, the **Benefit Plan** will not pay anything until the **Participant** has incurred $1,500 in out-of-pocket expenses for covered health care services subject to the **Deductible**. The **Deductible** may not apply to all services.

Dependent: means any eligible member or beneficiary of the **GHIP** who is not the **Subscriber**. See Section 2.B. Dependent Eligibility for more information.

Durable Medical Equipment: means physical tools, implements, or items which are prescribed by a **Provider** and used primarily to treat an **Illness** or **Injury**. They are generally not useful to a person in the absence of an **Illness** or **Injury**.

E-Visit: means an evaluation and treatment by a **Provider** using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An **E-Visit** is also called a digital visit.

Effective Date: means the date, as certified by **ETF** (or as shown on the records of the **Health Plan** for **Participants** who pay **Premium** directly to the **Health Plan**), on which the **Participant** becomes enrolled and entitled to the **Benefits** specified in this **Certificate.**

Employee: means a person who is working for pay. See also **Local Employee** and **State Employee**. See Section 2.A. Subscriber Eligibility for more information.

> **Local Employee:** means a person who is working for pay for a city, county, or other municipal unit of government in Wisconsin that has opted to participate in the State of Wisconsin **GHIP**, and is eligible as defined under Wis. Stat. § 40.02 (46) or 40.19 (4) (a), of an **Employer** as defined under Wis. Stat. § 40.02 (28), other than the State, which has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its **Employees**.
>
> **State Employee:** means a person who works for a State of Wisconsin agency, the University of Wisconsin, or UW Hospitals and Clinics, and is an eligible **Employee** as defined under Wis. Stat. § 40.02 (25).

Employee Trust Funds (ETF): means the State of Wisconsin Department of Employee Trust Funds, also referred to as the **Department**.

Employer
When not specified, **Employer** or **Employers** means **State Employer** and **Local Employer**.

> **State Employer** means an eligible State agency as defined in Wis. Stat. § 40.02 (54).
>
> **Local Employer** means a Wisconsin Public Employer who has acted under Wis. Stat. § 40.51 (7), to participate in the **GHIP** for its **Employees**.
>
> **State Employer** means an eligible State agency as defined in Wis. Stat. § 40.02 (54).

Embedded: means that when a **Participant** within a family plan meets the individual portion of **Participant** financial responsibility (e.g., **Deductible**) within the family's total financial responsibility, that **Participant** is no longer responsible for any further out-of-pocket costs. The remaining family **Deductible** in this example 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:

a. Serious jeopardy to the **Participant's** health. With respect to a pregnant person, it includes serious jeopardy to the unborn child.
b. Serious impairment to the **Participant's** bodily functions.
c. Serious dysfunction of one or more of the **Participant's** body organs or parts.

Additional detail on **Emergency** care appears in Section 4.F. Covered Services.

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 **Health Plan** and/or **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 acceptable medical practice to treat that **Illness** or **Injury** for a **Participant's Illness** or **Injury**. Additional detail on the criteria used by **Health Plans** to determine what is **Experimental** is included in Section 5.A. Excluded Services, Experimental and Investigational Treatments.

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 Drugs** and **Non-Preferred Drugs** before coverage applies. Drugs that are not included in the **Formulary** are not covered by the **Benefits** of the **GHIP**.

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

Group Health Insurance Program (GHIP): means the **Benefits** program offered by the **Group Insurance Board** that provides medical, pharmacy, and wellness **Benefits** to enrolled public workers.

Group Insurance Board (Board): means the governing body that oversees the **GHIP**.

Habilitation Services: means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of **Inpatient** and/or **Outpatient** settings.

Health Plan: means the health insurer that is under contract with the **Board** to provide **Benefits** and services to **Participants** of the **GHIP.**

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

Hold/Held Harmless: means the **Participant** is not responsible for any additional **Charges** out-of-pocket beyond the **Copayment, Coinsurance,** or **Deductible** that is required per the **Participant's Schedule of Benefits.**

Home Care Benefits: means health care services provided in your home that are intended to help you recover from an **Injury** or **Illness**. The intention of **Home Care Benefits** is to help you get better, regain your independence, become as self-sufficient as possible, maintain your current condition or level of function, or slow decline.

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

Hospital: means an institution that:

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 place for treatment of chemical dependency, a nursing home, or a federal **Hospital**.

Hospital Confinement or **Confined in a Hospital:** means being registered as a bed patient in a **Hospital** on the advice of an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may do this) or receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**.

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

Immediate Family: means the **Dependents**, parents, brothers, and sisters of the **Participant** and their spouses.

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

In-Network Provider: means a **Provider** who has agreed in writing, by executing a participation agreement, to provide, prescribe, or direct health care services, supplies, or other items covered under the policy to members of the **Health Plan**. The **Provider**'s written participation agreement must be in force at the time such services, supplies, or other items covered under the policy are provided to a **Participant**.

Inpatient: means **Participant** admitted as a bed patient to a healthcare facility or in twenty-four (24)-hour **Home Care**.

Maintenance Care: means ongoing care delivered after an acute episode of an **Illness** or **Injury** has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated.

Maximum Out-of-Pocket (MOOP): means the most the **Participant** pays during a policy period (usually a calendar year) before the **Benefit Plan** begins to pay 100% of the **Allowed Amount**. This limit never includes the **Premium**, balance-billed **Charges,** or **Charges** for health care that the **Benefit Plan** does not cover. Payments for out-of-network services or other expenses do not accumulate toward this limit.

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

Medical Supplies: means non-durable or disposable health care materials that are ordered or prescribed by a **Provider** for medical purposes.

Medicare: refers to 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 Part D** refers to prescription drug coverage.

Medicare Advantage: means a **Benefit Plan** created by Title 18, Part C of the U.S. Social Security Act of 1965 that is only available to retired **Participants** who are enrolled in **Medicare**.

Medicare Plus: Is a fee-for-service **Medicare** supplement plan administered by a contractor for retirees eligible for **Medicare** Parts A and/or B. **Benefits are** described in the **Medicare Plus Benefits Certificate of Coverage**.

Miscellaneous Hospital Expense: means **Usual and Customary Hospital** ancillary **Charges**, other than **Bed and Board**, made because of the care necessary for an **Illness** or other condition requiring **Inpatient** or **Outpatient** hospitalization for which **Benefits** are available.

Natural Tooth: means a tooth that would not have required restoration in the absence of a **Participant's** trauma or **Injury**.

Non-Participating Pharmacy: means a pharmacy who 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: 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 Medications** included on the **Formulary**, which are covered by the **Benefits** with a higher **Copayment**.

Open Enrollment: means the yearly period when all members may make changes to their **Benefits**. The dates for this time period are set each year by **ETF** and the **Board.**

Out-of-Area Service: means any services provided to **Participants** outside the **Service Area**.

Out-of-Network Provider: means a **Provider** who does not have a signed participating **Provider** agreement and is not listed on the most current edition of the **Health Plan**'s professional directory of **Providers**. Care from an **Out-of-Network Provider** may require **Prior Authorization** from the **Health Plan** unless it is **Emergency** or **Urgent Care** (except under the **Access Plan** or other **PPO Plans**).

Out-of-Pocket Limit (OOPL): means 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 **Benefit 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.

Outpatient: means the **Participant** receiving medical services and treatments from a healthcare facility but not admitted as an **Inpatient**. **Outpatient** care may include emergency department services, observation services, **Outpatient** surgery, lab tests or X-rays.

Palliative Care: means specialized medical care for people living with an advanced life-limiting **Illness**, focused on providing relief from the symptoms and stress of the **Illness**.

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 **GHIP**. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the **GHIP** are provided to a **Participant**.

Pharmacy Benefit Manager (PBM): means a third-party administrator that is contracted with the **Board** to administer the prescription drug **Benefits** under the **GHIP**. The **PBM** is primarily responsible for processing and paying prescription drug claims, developing and maintaining the **Formulary**, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Plan: means any of the following which provides **Benefits** or services for, or because of, medical, pharmacological, or dental care treatment:

a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment and group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
b. A governmental plan that provides healthcare coverage that is required or provided by law. However, such a plan does not include:
    - **Medicare Advantage** as this provision is preempted by federal law. This does not include a **State** plan under **Medicaid** (Title XIX, Grants to States for Medical

Assistance Programs of the United States Social Security Act, as amended from time to time).

- Any plan whose benefits, by law, are in excess of those of any private insurance program or other non-governmental program is not included in the definition of a **Plan**. Each contract or other arrangement for coverage is a separate **Plan**. Also, if an arrangement has two parts and **Coordination of Benefits (COB)** rules apply only to one of the two, each of the parts is a separate **Plan**.

Post-Stabilization Care: means care that is related to an **Emergency** service that is provided after a **Participant** is stabilized to maintain the stabilized condition, or, under certain circumstances, to improve or resolve the **Participant's** condition.

Postoperative Care: means the medical observation and care of a **Participant** necessary for recovery from a covered surgical procedure.

Preferred Drug: 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 on the **Formulary**, which are covered by the **Benefits** of the **GHIP**.

Preferred Provider Organization (PPO) and **PPO Network**: means **Health Plans** such as the **Access Plan** and **SMP** that include both **In-Network** and **Out-of-Network Providers**. These **Health Plans** usually cover **In-Network Provider** services with lower costs to **Participants** than **Out-of-Network Providers**. The different levels of **Benefits** for the **Access Plan** are described in their **Schedule of Benefits**.

Preferred Specialty Pharmacy: means a **Participating Pharmacy** which meets criteria established by the **PBM** to administer **Specialty Medication** services and has executed a written contract with the **PBM** to provide services to **Participants**. The **PBM** may execute written contracts with more than one **Participating Pharmacy** as a **Preferred Specialty Pharmacy.**

Premium: means amount to be paid for health insurance every month.

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

Primary Care Clinic (PCC): means an **In-Network** clinic that can be named as the center where a **Participant's Primary Care Providers** are co-located.

Primary Care Provider (PCP): means an **In-Network Provider** who is named as a **Participant's** primary health care contact. They provide entry into the health care system. They also evaluate a **Participant's** total health needs and provide medical care in one or more medical fields. When medically needed, they then preserve continuity of care. They are also in charge of coordinating other **Provider** health services and refer the **Participant** to other **Providers**.

Primary Plan/Secondary Plan: the order of **Benefit** determination rules state whether the **GHIP** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person. When the **GHIP** is a **Secondary Plan**, the **GHIP Benefits** are determined after those of the **Primary Plan** and may be reduced because of the **Primary Plan**'s **Benefits**. When the **GHIP** is a **Primary Plan**, the

GHIP's **Benefits** are determined before those of the **Secondary Plan** and without considering the **Secondary Plan**'s **Benefits**. When there are more than two **Plans** covering the person, the **GHIP** may be a **Primary Plan** as to one or more other **Plans** and may be a **Secondary Plan** as to a different **Plan** or **Plans**. See Section 6. **Coordination of Benefits** for more information.

Prior Authorization: means obtaining approval from the **Health Plan** before obtaining the services. This is a request for coverage of a service or procedure. While the authorization is to a specific **Provider**/clinic, it is for the services that a **Provider** or clinic will perform. Unless otherwise indicated by the **Health Plan**, **Prior Authorization** is required for care from any **Out-of-Network Providers** unless it is an **Emergency** or **Urgent Care**. The **Prior Authorization** must be in writing. **Prior Authorizations** are at the discretion of the **Health Plan**. Some prescriptions may also require **Prior Authorization**, which must be obtained from the **PBM** and are at its discretion.

Provider: means a doctor, **Hospital**, clinic, or any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more **Benefits**.

Referral: means when a **Participant's PCP** sends them to another **Provider** for services. A **Referral** is a written order from your **PCP** for you to see a specialist or receive certain medical services. Many **Plans** require you to get a **Referral** before you can receive medical care from anyone except your **PCP**. If you don't receive a **Referral** first, the **Plan** may not pay for the services.

Rehabilitation Services: means health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. **Rehabilitation Services** may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation in a variety of **Inpatient** and/or **Outpatient** settings.

Remote Patient Monitoring: means the collection and interpretation of a person's physiologic data that is sent digitally to a health care **Provider** to support treatment and management of medical conditions.

Schedule of Benefits: means the document that is issued to accompany this **Certificate w**hich details specific **Benefits** for covered services provided to **Participants** by the **Benefit Plan** elected. To determine which **Benefit Plan** you have, see the **Schedule of Benefits** attached to this **Certificate**, or visit **ETF**'s website at http://etf.wi.gov/benefits-by-employer and search for your **Employer**.

Secondary Plan: see **Primary Plan/Secondary Plan** definition.

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.

Service Area: means the area within specific zip codes in the counties in which the **In-Network Providers** are approved by the **Health Plan** to provide professional services to **Participants** covered by the **GHIP**.

Shared Decision Making (SDM): means a program offered by a **Health Plan** or health care **Provider** that **Participants** must complete when considering whether to undergo certain medical

or surgical interventions. **SDM** programs are designed to inform **Participants** about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that **Participants** can decide the best possible course of treatment. The **Health Plan** or health care **Provider** will provide the **Participant** with written Patient Decisions Aids (PDAs) as part of the **SDM** program.

Skilled Care: means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving **Skilled Care** are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In most cases, **Skilled Care** is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior do not require **Skilled Care** and are considered **Custodial Care**.

Skilled Nursing Facility: means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a **Skilled Nursing Facility**.

Specialty Medications: means medications that 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.

State: means the State of Wisconsin.

State Maintenance Plan (SMP): means a **Plan** offered as a qualified tier 1 **Plan,** as determined by the **Board. SMP** is a **Preferred Provider Organization (PPO) Benefit Plan. Participants** are encouraged to use **In-Network Providers** for covered services as the Out-of-Pocket costs for **Out-of-Network Providers** are high, as described on **SMP's** plan description page. The **SMP** offers **Uniform Benefits** and the **HDHP Uniform Benefits.**

Subscriber: means an eligible **Employee** or **Annuitant** who is enrolled in the State of Wisconsin **Group Health Insurance Program**.

Telehealth: means a service delivered via real-time audio and video. **Telehealth** may also be called telemedicine, online or virtual evaluation and management, or a video visit.

Telephone Visit: means an evaluation and treatment by a **Provider** using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

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 **PCP**. It also does not include care that can be safely postponed until the **Participant** returns to the **Service Area** to receive such care from an **In-Network Provider**. The **Health Plan** must ensure the **Participant** is **Held Harmless** from any effort(s) by third parties to collect from the **Participant** the amount above the **Usual and Customary Charges** for medical/**Hospital** services.

Usual and Customary Charge: means an amount for a treatment, service, or supply provided by an **Out-of-Network Provider** that is reasonable, as determined by the **Health Plan**, when taking into consideration, among other factors determined by the **Health Plan**, amounts charged by health care **Providers** for similar treatment, services, and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care **Provider** as full payment for similar treatment, services, and supplies.

Uniform Benefits: means the **Benefits** described within this document and in the **Schedule of Benefits**.

Virtual Check-In: means a brief discussion either by telephone or real-time audio and video between a **Provider** and an established patient to manage a medical condition. These are services separate from and less intensive than **Telehealth, Telephone Visits, or E-Visits**.

2. Eligibility, Enrollment, and Termination

A. Subscriber Eligibility

The following people may enroll as **Subscribers** in the State of Wisconsin **Group Health Insurance Program**:

1. Active Wisconsin State agency and University of Wisconsin **Employees** who participate in the Wisconsin Retirement System (WRS), as described in Wis. Stat. § 40.02 (25) (a).
2. Elected state officials, including members of the legislature (Wis. Stat. § 40.02 (25) (a) 2).
3. **Employees** of the legislature (Wis. Stat. § 40.02 (25) (a) 2).
4. Any blind **Employees** of Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.
5. The following in the University of Wisconsin (UW) System and UW Hospitals and Clinics Authority (Wis. Stat. § 40.02 (25) (b)):
    a. Any teacher who is expected to be employed by the UW System for at least six (6) months on a minimum of one-third (33%) full-time appointment.
    b. Any teacher who is a participating **Employee** and who is expected to be employed by the UW System for at least six months on a minimum of one-third (33%) full-time appointment.
    c. Certain visiting faculty members in the UW System.
    d. Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six months for annual (twelve month) appointments.
    e. **Employees**-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one of the following:
        i. one (1) semester for academic year (nine (9) month) appointments
        ii. six months for annual (twelve (12) month) appointments
    f. Short-term academic staff who are employed in positions not covered under the WRS and who are holding a fixed-term terminal, acting/provisional or interim appointment of twenty-eight percent (28%) or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one percent (21%) or more with an expected duration of at least six months but fewer than 12 months if on an annual (12 month) appointment.
    g. Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.
    h. Any person employed as a graduate assistant and other **Employees**-in-training as designated by the board of directors of the UW Hospitals 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 months.
6. **Local Employees** as described in Wis. Stat. § 40.02 (46) or 40.19 (4) (a).
7. **Annuitants** and **Continuants** (Wis. Stat. § 40.02 (25) (b)), which include the following:
    a. Any covered **Participant** who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b. The surviving spouse of a **Subscriber**.
c. Covered **Participants** who terminate employment, have attained minimum retirement age, have 20 years of WRS creditable service, and defer their annuity (if a timely application is submitted).
d. Any participating **State Employee** who terminates employment after attaining 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). See Section 2.I. Re-Enrollment below for more information.
e. Any rehired **Annuitant** electing to return to active WRS participation is immediately eligible to apply for coverage through their **Employer**.
f. Any **Local Employee** under Wis. Stat. § 40.02 (25) (b) 11 who retires and is receiving an annuity under the WRS (but not those only receiving a duty disability **Benefit** under Wis. Stat. § 40.65 or LTDI).
g. Any **Dependent** of a **Local Annuitant**, who is receiving a continuation of the **Local Annuitant's** annuity, and, if eligible, who has acted under Wis. Stat. § 40.51 (10) to elect the **Local Annuitant Health Program (LAHP)**.
h. Any **Local Annuitant** receiving an annuity through a program administered by **ETF** under Wis. Stat. § 40.19 (4) (a).
i. **Participants** who meet federal or **State** continuation provisions. See Section 260.

8. Disabled persons entitled to **Benefits** under Wis. Adm. Code § ETF 50.40 or Wis. Stat. § 40.65 including:
   a. Insured **Employees** or former **Employees** who choose to continue coverage when the **Employee's** LTDI **Benefit** under Wis. Adm. Code § ETF 50.40 or a duty disability **Benefit** under Wis. Stat. § 40.65 is approved.
   b. Previously insured **Employees** or former **Employees** whose coverage lapsed and who are eligible and apply for an LTDI **Benefit** under Wis. Adm. Code § ETF 50.40, or a duty disability **Benefit** under Wis. Stat. § 40.65.

B. Dependent Eligibility

A **Subscriber** may also be able to enroll certain family members in the **GHIP** as a part of their **Plan**. These **Participants** are generally described as **Dependents.** A **Dependent** can be a **Subscriber's:**

1. Spouse.
2. Child.
3. Legal ward who becomes a permanent legal ward of the **Subscriber** or **Subscriber's** spouse prior to age 19.
4. Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
5. Stepchild.
6. Grandchild if the parent is a **Dependent** child.

A **Dependent's** eligibility for coverage may change, based on age or a change in legal relationship to the **Subscriber**. See Section 2.H. Qualifying Life Events for more information on when **Dependent** eligibility for coverage can change.

Most children cease to be eligible for health insurance coverage when they turn 26, but there are some exceptions.

Under Wisconsin law, a **Dependent** child who is called to federal active duty in the military when they are under age 27 and enrolled in full-time higher education can remain covered regardless of age, as long as they are still attending school full time (see Wis. Stat. § 632.885).

Over-Age Disabled Child Eligibility

An unmarried **Dependent** child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued (at least one year) or indefinite duration is an eligible **Dependent**, regardless of age, as long as the child remains disabled and is **Dependent** on you (or the other parent) for at least 50% of their support and maintenance. This is demonstrated by the support test done for federal income tax purposes, to determine whether you can claim the child on your taxes. If you die, your disabled adult **Dependent** must still meet the remaining disabled criteria and be incapable of self-support. Your **Health Plan** will follow up no more than once per year to verify that your child still qualifies for coverage. If your child no longer qualifies because either their disability improves or they become able to support themselves, their coverage under your **Plan** will end. If you disagree with a **Health Plan's** determination of disability, you can appeal that decision to **ETF**.

The **Health Plan** shall notify the **ETF** of individual over-age disabled child reviews per **ETF** submission instructions. The **Health Plan** may perform the annual individual reviews at any time of the year. If it is found that your child no longer meets the criteria for an over-age disabled child, termination of the child's coverage must be prospective. **ETF** must be copied on the notification of the **Health Plan's** review as described in the **Health Plan** submission instructions.

In addition, the **Health Plan** must report and certify to **ETF** the total results from its process to verify the eligibility of over-age disabled children, age twenty–six (26) or older, which includes verifying all of the following:

1. Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year (reviewed annually except if the child has **Medicare Parts A** and **Part B**, or has been found permanently disabled; if so, the medical review must be done at least once every 3 years)
2. Support and maintenance requirement is met (per IRS Publication 501 worksheet 2, the worksheet for determining support) (reviewed annually)
3. Child is not married (reviewed annually)

C. Program Option Eligibility

The **GHIP** offers different **Benefit Plans,** sometimes called Program Options. The **Benefit Plans** available to you will depend upon your status (e.g., **Employee, Annuitant**) and the **Employer** who is providing your **Benefits** (e.g., **Local, State**).

State Employees may choose between two **Benefit Plan** designs – **HDHP** and non-**HDHP**.

To determine which **Benefit Plan** you have, see the **Schedule of Benefits** attached to this **Certificate**, or visit **ETF**'s Benefits Available to Me website and search for your **Employer**.

Annuitants who are eligible for and enrolled in **Medicare** may have different **Benefit Plan** designs available to them. See Section 2.F. Medicare Enrollment for more information.

D. Individual and Family Coverage

Individual Coverage

Individual coverage covers only the **Subscriber**. If you are enrolled in individual coverage, only your health care services will be covered by your policy. You may change between individual and family coverage when you have a qualifying life event or during the annual **Open Enrollment** period.

Family Coverage

Family coverage allows you to cover both yourself (the **Subscriber**) and your **Dependents**. All eligible **Dependents** must be listed on your application and are covered under family coverage. You cannot choose to exclude any eligible **Dependent** from family coverage unless that **Dependent** is already covered under the **GHIP** through either their own policy or another **Subscriber**.

E. No Double Coverage and Spouse-to-Spouse Transfer

A **Dependent** or **Subscriber** cannot be covered at the same time by more than one **Subscriber** of the **Group Health Insurance Program** (including **State** and **Local**). If a **Dependent** on your **Benefit Plan** is covered by another **GHIP Subscriber**, you and the other **Subscriber** will be notified. You will have 30 calendar days to decide which of you will keep your **Dependent** on your **Plan**. Whoever does not keep the **Dependent** must submit an application to remove the **Dependent**. The **Effective Date** of the change will be the first of the month following receipt of the application.

If no application is submitted within the 30 calendar day period, **ETF** will select one **Subscriber** and re-enroll all other **Participants** as **Dependents**.

If you and your spouse are both employed by a **State** or **Local Employer** that offers the **GHIP**, and you are both enrolled under a family policy provided by one **Employer**, you can opt to change which of you is the **Subscriber** for your **GHIP** coverage. This is called a spouse-to-spouse transfer. Note that you will only be able to select the **Benefit Plans** available to you under the **Subscriber's Employer**. If you change mid-year due to a qualifying life event, you may be able to transfer the amounts you have already paid towards your **Benefit** maximums; see Section 3. D. Transfer of Benefit Maximums, Deductibles, and Out-of-Pocket Limits below for more information.

F. Medicare Enrollment for Annuitants and Continuants

If you are an **Annuitant**, you and your **Dependents** (or your surviving **Dependents** if you die) who enroll in **Medicare** may continue your coverage at reduced **Premium** rates.

> **Employees** only: You (and your eligible **Dependents**) do not need to enroll in **Medicare** while you are an active **Employee** of your **State Employer** or participating **Local Employer**. However, if you have End Stage Renal Disease (ESRD) as determined by **Medicare**, you may want to be enrolled in **Medicare Part A** and **Part B,** effective at the end of your 30-month waiting period. If you retire or otherwise leave active employment, you (and your eligible **Dependents**) must enroll in **Medicare Part A** and **Part B** as soon as you are eligible. You must provide your **Medicare** enrollment information to **ETF.**

You and your **Medicare**-eligible **Dependents** must remain enrolled in **Medicare Part A** and **Part B** once you retire. If you are not enrolled in **Part B** when you retire or if you disenroll from **Part B**, you will have to pay out-of-pocket for all of the services you receive that **Part B** would have covered.

If your **Health Plan** discovers that you are eligible for **Medicare Part A** and **Part B** and have either not enrolled in **Part B** coverage or have disenrolled in **Part B** coverage, your **Health Plan** is required to provide information, including the total dollars in claims you have used, and any other documentation needed to **ETF**. Your **Health Plan** will then contact you to explain the financial impacts to you of disenrolling in **Part B** coverage, and will provide assistance to you to re-enroll in **Part B**. If you refuse to re-enroll in **Part B** coverage, your **Health Plan** will notify **ETF** for additional follow up.

If you are an **Annuitant** or **Continuant** who is enrolled in **Medicare Part A** and **Part B**, you are eligible to enroll in the IYC **Medicare Advantage** or **Medicare Plus** for individual coverage. If you would like to enroll in family IYC **Medicare Advantage** or **Medicare Plus** coverage, your **Dependents** must also enroll in **Medicare Parts A** and **B.** If you or a **Dependent** on your family **Plan** is not eligible for and enrolled in **Medicare**, you may be able to split your coverage so that **Participants** with **Medicare** can enroll in the **Medicare Plus** or IYC **Medicare Advantage** plan; and non-**Medicare Participants** can be enrolled in a non-**Medicare Benefit Plan**.

If you or your **Dependent** enroll in IYC **Medicare Advantage**, your **Plan** will verify that you are enrolled in **Medicare Part A** and **Part B** continuously. If you drop either part of **Medicare** while you are enrolled in the IYC **Medicare Advantage Plan**, your **Health Plan** will notify you and **ETF.** If you dropped either part of **Medicare** in error, your **Health Plan** will instruct you on how to apply to regain the **Benefit**. If you do not regain the **Benefit** timely, you will be moved to **Medicare Plus**. In addition, you will be responsible for any claims costs that would have been paid by **Medicare**. **ETF** strongly recommends that you *do not disenroll* from **Part A** or **Part B** once you have enrolled unless you return to work and gain coverage from your **Employer**.

If you remain enrolled in the same **Health Plan** you had when you were an **Employee** after you retire, your **Health Plan** will provide **Benefits** and services as described in this document to you once you are enrolled in **Medicare**, carving out the **Benefits** paid by **Medicare.** This means you will receive the same **Benefit** level provided to you when you were an **Employee**. As a retiree, when you gain eligibility for **Medicare**, you may also opt to enroll in IYC **Medicare Advantage** or **Medicare Plus**; these programs have slightly different **Benefits** but offer robust coverage. See **ETF's** Health Benefits in Retirement webpage for more information (https://etf.wi.gov/retirement/living-retirement/health-benefits-retirement).

G. Exceptions to Mandatory Medicare Enrollment

Mandatory enrollment in **Medicare** is waived if you or your **Medicare** age **Dependent** would be required to pay **Premiums** for **Part A** coverage. However, if you or your **Medicare**-age **Dependent** do not enroll in **Part A**, you will not be eligible for the reduced **Premium** rate or for enrollment in the **Medicare Advantage Plan** regardless of the requirement to pay **Premium**.

If you are an **Annuitant** and you or your spouse are covered under another group **Health Plan** through a different **Employer** (such as your spouse's **Employer**) that **Health Plan** is the primary

payer for **Medicare Part A** and **Part B** charges, therefore you and/or your spouse may delay **Part B** enrollment (to the extent allowed by federal law. More information is available in Section 3. C. Medicare Participant Premiums below.

H. Open Enrollment

Open Enrollment means the time period that occurs at least annually to allow:

1. **Subscribers** the opportunity to change **Health Plans** and/or coverage.
2. Eligible individuals the opportunity to enroll for coverage in the **GHIP**.

I. Qualifying Life Events

If you have recently had a change in marital status, a baby, or a change of home address, you may have the opportunity to enroll or change coverage outside of the annual **Open Enrollment** period. The information below is for the most common activities following a qualifying life event. More information is available online by searching "Life Event" on ETF's website.

Some events may cause your **Dependents** to no longer be eligible for coverage under your **Health Plan.** If you are aware that one of the following events will happen soon, contact your Human Resources department if you are an active **Employee**, or **ETF** if you are an **Annuitant** or **Continuant**. If your **Health Plan** finds that one of your **Dependents** is no longer eligible, the **Health Plan** will also notify **ETF**. If your non-eligible **Dependent** received **Benefits** during a time they should not have been on your policy, their claims will be adjusted, and you or they may be responsible for costs.

Subscribers must provide acceptable documentation for births, marriages, divorces, deaths, and other life events and ensure they are valid. See *Life Change Events and Documentation Requirements* (ET-2846). **Subscribers** must cover all eligible **Dependents**. **Subscribers** who do not provide required documentation (such as marriage or birth certificates) will have 90 calendar days to submit the documentation or the request to add the spouse or child will be declined and coverage will not be effective since there is no proof that the person is an eligible **Dependent**.

1. Marriage

If you get married while you are enrolled in the **GHIP**, you can add your new spouse to your **Health Plan** within 30 calendar days of your marriage. If your new spouse has children, you must also add those children to your family policy.

2. Divorce

If you divorce your spouse while enrolled in the **GHIP**, your spouse and any stepchildren on your **Plan** will no longer be eligible for coverage. Spouses and stepchildren stop being **Dependents** at the end of the month in which a marriage is terminated by either divorce or annulment. For documentation of divorce, you will need to provide the judgment of divorce that is entered or final and has been signed and dated by the clerk of courts. It is the date of this document that determines when the divorce is final.

3. New Dependent

If you gain a new **Dependent** because of a birth, adoption or adoption placement, transfer of custody, paternity order, National Medical Support Notice, or legal guardianship while enrolled in the **GHIP**, you must add that new **Dependent** to your family coverage or you may change

to family coverage if you are enrolled in individual coverage. You must file your application to add your new **Dependent** within 60 calendar days of the life event except for a custody change, where you have 30 calendar days.

a. Children Born Outside of Marriage

A child born outside of marriage becomes your **Dependent** when you provide a birth certificate that lists your name to your **Employer**.

Fathers of children born outside of marriage can also submit documentation of one of the following:

- The date of a court order declaring paternity.
- The date the acknowledgement of paternity is filed with the Wisconsin Department of Health Services (or equivalent if the birth was outside of Wisconsin).

You should file an application within 60 calendar days of the child's birth, court order, or paternity acknowledgement. When an acknowledgment of paternity is filed and an application or online enrollment is received within the 60 calendar days of birth, family coverage is effective on the date of birth.

b. Dependent Grandchildren

If your minor **Dependent** child has a child while they are covered by your **GHIP** policy, you may add your grandchild as a **Dependent**. Your grandchild will no longer be a **Dependent** at the end of the month in which your **Dependent** child (the grandchild's parent) turns age 18.

4. Adult Children Aging Out

Your children cease to be **Dependents** at the end of the month in which they turn 26 years of age, unless they are disabled, or in some cases where a child is called to active duty, as described in Section 2. B. Dependent Eligibility above.

5. Adult Children Who Become Eligible Employees

If your **Dependent** child enrolls in their own **GHIP** insurance policy because they start working for a participating **Employer**, they are no longer eligible to be covered by your policy.

6. Eligibility for Other Coverage

If you become eligible for group coverage through your spouse, you can cancel your **GHIP** coverage. You must file an application to cancel within 30 calendar days of enrolling in the other coverage.

7. Involuntary Loss of Employer Contribution

If you or one of your **Dependents** either lose eligibility for coverage or lose all **Employer** contributions for other health insurance coverage, you may enroll in the **GHIP**. You must file an application to join or change your policy within 30 calendar days of the involuntary loss of coverage or contribution. This does not apply if you or your **Dependent** voluntarily drop coverage.

8. Increased Employer Contribution

If your job changes such that your **Employer** would increase their contribution to your health insurance (e.g., moving from less than half to full time employment), you may enroll in the **GHIP**. You must file your application to join within 30 calendar days of this change.

9. Move to New County or Out-of-State

If you move to a new county where you will be for at least three months, you can change which **Health Plan** you receive your **GHIP** coverage through. You must file to change **Health Plans** within 30 calendar days before or after your move.

10. Retirement

If you were not already covered by the **GHIP** when you decide to retire, you may be able to enroll to help preserve your sick leave credits if that is available to you through your **Employer**. You will be limited to enrolling in the **Access Plan** and you will need to have coverage for one calendar month before you terminate employment, therefore, you should discuss this as soon as possible with your Human Resources department and/or at your **ETF** retirement counseling appointment before you retire. You may choose to cancel the **Access Plan** after you have retired.

If you are covered by the **GHIP** when you become a retiree, you may be able to move from family to single coverage or cancel your coverage. If you do not cancel your coverage, your coverage will automatically continue for you into retirement.

If you are already retired and you become **Medicare** eligible, you must enroll in **Part A** and **Part B** (See Section 2. F. Medicare Enrollment). When you first enroll in **Medicare**, you could also choose to move to a different **Benefit Plan**, such as IYC **Medicare Advantage** or **Medicare Plus**, or you may choose to cancel your **GHIP** coverage. You must submit your application prior to your **Medicare** effective date. This can be sent up to three months in advance. Coverage with your new plan will be effective on the same date as **Medicare**. You may also submit the application up to 30 days after your **Medicare** effective date, but then coverage will be effective the first of the month after ETF receives your application.

11. Death of a Spouse or Dependent

If your spouse or **Dependent** dies while they are enrolled in the **GHIP**, you may change from family coverage to single if no one else is on your policy, you may also change to another **Health Plan**. If you have other **Dependents**, you must keep your family coverage. If you were enrolled in your spouse's non-**GHIP** insurance and lost eligibility or all the **Employer** contribution due to the death, you may enroll in the **GHIP**. You should submit your application within 30 calendar days of losing your other coverage.

If you are enrolled in a **Medicare** coordinated **Benefit Plan** in the family **Premium** category and one or more family members enrolled in **Medicare Part A** and **Part B** dies, the family **Premium** category in effect shall not change solely as a result of the death.

12. Death of Subscriber

If you die with **Dependents** (spouse or children) enrolled on your **Plan**, your **Dependents** can continue coverage under the **GHIP**. If your **Dependent** regains eligibility and was previously

covered under your policy when you die, if you were in the process of adopting a child when you die, or if you have a child who was born within nine months of your death, those **Dependents** will be eligible to enroll in coverage in the **GHIP** for as long as they continue to be eligible. No other new **Dependents** are eligible.

New coverage for your **Dependents** would be effective on the first day of the calendar month following the date of your death. It will continue until coverage would normally end for a **Dependent**. See above for situations that might change a **Dependent's** eligibility.

J. Re-Enrollment (State Employees Only)

Any participating **State Employee** who terminates employment after reaching 20 years of WRS creditable service, remains an inactive WRS **Participant**, and is not eligible for an immediate annuity because they are less than minimum retirement age, may enroll in the **GHIP** after they become eligible for their annuity. They must enroll during the **Open Enrollment** period for coverage effective the following January 1 unless there is a different qualifying event.

K. COBRA / Continuation

If you leave employment, you may be eligible for COBRA Continuation of your **GHIP** coverage. The **COBRA Contractor** will provide you with the paperwork you need to file. You must submit a completed application to **ETF** that is postmarked within 60 calendar days of the date you were notified of the right to continue, or 60 calendar days from the date your coverage would otherwise end, whichever is later.

If you or your **Dependent** ceases to be eligible for coverage, you may elect COBRA continuation for a maximum of 36 months from the date of the qualifying event or the date the **COBRA Contractor** notifies you regarding the end of eligibility, whichever is later.

The COBRA continuation coverage election form will be sent to you by the **COBRA Contractor** or may be included in your end-of-service paperwork. The **COBRA Contractor** is required to send this notice to you within five **Business Days** of notice of your qualifying event. Contact your **Employer** if you have not received this form.

Your continuation coverage will end in the following circumstances:

- When coverage is canceled.
- When **Premiums** are not paid when due.
- When coverage is terminated as permitted by state or federal law.

L. Layoffs and Leaves of Absence

If you are laid off or you take a leave of absence, you may continue your health insurance coverage. You may also choose to let it lapse, meaning you do not pay your **Premiums**. It may not be in your best interest to cancel coverage. You should discuss this with your Human Resources department.

A leave of absence under Wisconsin law is, "any period during which an **Employee** has ceased to render services for a participating **Employer** and receive earnings and there has been no formal termination of the **Employer-Employee** relationship" (see Wis. Stat. § 40.02 (40)). If you are on a leave of absence, you may continue coverage as long as your **Premiums** are paid. A leave of absence cannot last more than three years under Wisconsin law.

You may also continue your coverage if you are laid off. In some cases, **State Employees** may be able to use their accumulated unused sick leave to pay **Premiums** (see Wis. Stat. § 40.02 (40)).

M. Benefits Are Not Assignable

This **Certificate** and the **Schedule of Benefits** is the personal policy for you and your **Dependents**. You cannot give your **Benefits** to any other person not named as a **Participant** on this **Benefit Plan**.

3. Premiums and Financial Responsibility

A. Premium Payment

For **Employees** and most **Annuitants**, your **Premium** payments will be arranged through deductions from salary, your accumulated sick leave account (**State Employees** only), your annuity, or by converting your life insurance under certain circumstances. If you are no longer working and do not have a large enough annuity, sick leave, or converted life insurance policy, you must pay your **Premiums** directly to your **Health Plan.** If you are paying your **Health Plan** directly and you want to cancel, you may either stop paying **Premiums** or inform **ETF** that you no longer want coverage.

B. Premium Tiers

Health Plan Premiums will differ by **Health Plan** due to a variety of factors, including which counties are included in the **Health Plan's** network **Service Area** and what **Provider** systems are included. To help you navigate **Health Plan Premium** costs, **ETF** and the **Board** divide **Premiums** into three tiers. The most efficient **Plans** will be placed in Tier 1, which will have the lowest **Employee Premium** contribution level. Moderately efficient **Plans** will be placed in Tier 2. The least efficient **Plans** will be placed in Tier 3, which will have the greatest **Employee Premium** contribution level.

If you are a **State Employee** or a **Local Employee** whose **Employer** uses tiering**,** your **Premium** contribution will be a fixed amount or percentage per tier, as determined by which **Employer** (**State** or **Local**) you work for. Your **Employer** shall contribute the balance of the total **Premium**. Contact your **Employer** for more information on what your **Premium** contribution will be in a given year.

Retirees pay the full amount of their **Premium**.

For **State Employees** the **State's** contribution toward the total **Premium** for **Employees** (non-retired) for individual and family coverage is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The Division of Personnel Management (DPM) in the Wisconsin Department of Administration sets the **Employee** contribution amounts annually. **State Employees** should watch for information provided as a part of the annual **Open Enrollment** period to determine what the cost is for their **Plan**.

The **Premium** share that **Employees** pay for individual and family coverage levels differs; if you change coverage levels, your share of **Premium** will change. In the case of marriage, coverage level can change on the date of the marriage, versus the first of the month. When this happens, the difference in **Premium** between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

Local Employers may base their **Employer** contribution on a percentage of the average of the lowest cost qualified **Plans** instead of tiering. The **Employer** must pay at least 50% but no more than 88% for qualified **Health Plans** in the **Local Employer's** county (exceptions may apply for **Employees** who are less than half time or **Employees** who are part of a collective bargaining agreement).

C. Medicare Participant Premiums for Retirees

Annuitants who are eligible for **Medicare Part A** and **Part B** pay less for their **GHIP Premiums**. The reduction in **Premium** is effective on the first day of the month on or after the date you and/or your **Medicare**-eligible **Dependents** are eligible for **Medicare Part A** and **Part B** as your primary health **Benefit** coverage and you, the **Subscriber**, are no longer covered as an active **Employee.** This reduced-**Premium** coverage is also referred to as **Medicare** coordinated coverage. In addition to opting for **Medicare** coordinated coverage, you may also choose to enroll in IYC **Medicare Advantage** or **Medicare Plus** . These **Benefit Plan** designs typically have lower **Premiums** than other **Health Plans**, and both have some additional **Benefits** and services that vary from **Uniform Benefits**. Additional information is available in Section 4. Benefits and Coverages below.

As discussed in Section 2. F. Medicare Enrollment, you must enroll in **Medicare Part A** and **Part B** if you are continuing your health insurance coverage when you retire. If you don't, it could affect your health insurance **Premiums** and your overall **Benefits**.

Except in cases of fraud, if you either do not enroll in **Medicare Part B** at the time you enroll in a **Medicare** coordinated **Benefit Plan** and when **Medicare** is first available as the primary payer, or if you cancel **Medicare** coverage, your coverage will be limited, and you will be responsible for any costs that **Medicare** would have paid.

If you or your **Medicare** eligible **Dependent** are enrolled in the IYC **Medicare Advantage Plan** and subsequently cancel **Medicare** coverage, you will be disenrolled from the IYC **Medicare Advantage Plan** and enrolled in **Medicare Plus** effective as of the date of loss of **Medicare** coverage. That **Medicare Plus** coverage will only cover costs beyond what **Medicare** would have paid; you will be responsible for the costs **Medicare** would have covered.

If you are found to have either not enrolled or disenrolled in **Medicare Part B** while on a **Medicare** coordinated **Benefit Plan**, retrospective adjustments to **Premium** or claims shall be limited to the shortest retroactive enrollment limit set by **Medicare** for either medical or prescription drug claims, not to exceed six months. In such a case, you (or your **Medicare** eligible **Dependent**) must enroll in **Medicare Part B** at the next available opportunity.

If you are enrolled in non-**Medicare** coordinated coverage while enrolled in **Medicare Part A** and **Part B** and are retired, **ETF** will refund any **Premium** paid in excess of the **Medicare**-reduced **Premium** for any months for which **Benefits** were coordinated. In such cases, your **Health Plan** will make claims adjustments prospectively. However, **Premium** refunds for retroactive enrollment in a coordinated **Benefit Plan** will correspond with the retroactive enrollment limits and requirements established by **CMS** for medical and/or prescription drug coverage. This may limit the amount of **Premium** refund you are eligible to receive.

There may be additional limitations to retrospective enrollment for the IYC **Medicare Advantage Plan**. You should review your IYC **Medicare Advantage** Evidence of Coverage document and/or contact the IYC **Medicare Advantage Health Plan** to verify these limitations.

D. End Stage Renal Disease and Medicare Enrollment for Employees and Annuitants

Your **GHIP Benefits** will pay as the primary payer for the first 30 months after you become eligible for **Medicare** due to kidney disease, whether or not you or your **Dependent** are enrolled in **Medicare**. The **Premium** rate for non-**Medicare Advantage Health Plans** will be the non-**Medicare** rate during this period.

Medicare becomes the primary payer after the 30-month period ends, upon enrollment in **Medicare Part A** and **Part B**. If you or your **Dependent** have more than one period of **Medicare** enrollment based on kidney disease, there is a separate 30-month period during which the **GHIP** will again be the primary payer. No reduction in **Premium** is available for active **Employees**.

Annuitants are required to enroll in **Medicare Part A** and **Part B. ETF** strongly recommends that **Employees** enroll in both **Medicare Part A** and **Part B** by the end of the 30-month waiting period. If an **Employee** does not enroll by the time that the waiting period ends, **Medicare** may impose a penalty on your **Medicare Premium**.

E. Transfer of Benefit Maximums, Deductibles, and Out of Pocket Limits

As discussed in Section 2. H. Qualifying Life Events, you may have the opportunity to change **Health Plans** or **Benefit Plans** (e.g., change from or to the **HDHP**) during a **Benefit Period** in certain situations. In some cases, you may be able to transfer amounts you have already paid under your former coverage to your new coverage.

The amounts that you have already paid toward your **Deductible** and **Out-of-Pocket Limits (OOPLs)** are referred to as Accumulations. Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** under your **GHIP** coverage will continue to add up for the **Benefit Period** in the following situations if you do not change **Health Plans**:

- If you change the coverage level (e.g., single to family).
- If you change **Benefit Plan designs** (e.g., change from or to the **HDHP**).
- If you have a spouse-to-spouse transfer resulting in a change of **Subscriber**.
- If you have a **Dependent** change (e.g., following a divorce) resulting in a change of **Subscriber**.

Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** will start over at zero ($0) dollars as of the **Effective Date** of the change if you change from being a **Participant** of the **State** program to the **Local** program, or vice versa.

Accumulations to the annual pharmacy and uniform dental (if applicable) **Benefits** continue to accumulate for the **Benefit Period** regardless of a **Benefit Plan**/**Health Plan** change. See your Uniform Pharmacy Benefits document and Uniform Dental Benefits for more information. For **HDHPs**, medical and pharmacy accumulations are combined.

Your **Health Plan** will apply all **Maximum Out-of-Pocket (MOOP)** limits as required by Wisconsin and federal laws.

F. Recovery of Premium Overpayments

If you or your **Dependents** receive coverage or **Benefits** that you were not entitled to, you will need to reimburse your **Health Plan** for those services. You must reimburse your **Health Plan** immediately upon receiving notification from the **Health Plan** and/or **PBM**. At the option of the **Health Plan** and/or **PBM**, payments for future **Benefits** may be reduced by the **Health Plan** and/or **PBM** to offset a balance owed.

4. Benefits and Coverages

This section describes the **Benefits** and services provided under the **GHIP**. Services and **Benefits** are available to you and your enrolled **Dependents** if they are received after the date your enrollment in **GHIP** becomes effective and your **Premiums** are paid.

Medicare Advantage Benefits may differ slightly based upon **CMS** requirements; see your Evidence of Coverage issued by your **Medicare Advantage Health Plan** for details.

A. Services Must be Received In-Network

Except in limited circumstances that are specifically described below in B. Exceptions to In-Network Care Requirement, you and your **Dependents** must receive services from **Providers** that are a part of your **Health Plan's** defined **Provider** network (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). If you are having trouble finding an **In-Network Provider** to provide a service, you should contact your **Health Plan** for assistance.

B. Exceptions to In-Network Care Requirement

1. Specialty Care Not Available In-Network

If you have a medical condition that requires highly specialized care that is not available in your **Health Plan's** network, you may be able to request access to an **Out-of-Network Provider**. All **Out-of-Network** care requires written **Prior Authorization** from your **Health Plan** before any services are received unless you are enrolled in the **Access Plan** or other **PPO Plan**. You should contact your **Health Plan** before receiving any **Out-of-Network** care to verify your coverage.

2. Urgent or Emergency Room Care

If you require **Urgent Care** or **Emergency Room** services, and you are not able to return to your network for services (e.g., you are traveling out of state or out of country), your **Out-of-Network** services will be covered by your **Health Plan**. Please note that only services that require immediate or **Urgent Care** will be covered; services that might safely be delayed in order for you to return to your **Health Plan's Service Area** may be denied by your **Health Plan**.

3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit

Sometimes after a visit to an **Emergency Room** or **Urgent Care**, you may need additional follow-up appointments to manage an **Illness** or **Injury**. In most cases, you will be required to return to your **Health Plan's Service Area** for follow-up care unless you are enrolled in the **Access Plan** or other **PPO Plan**. Some limited exceptions might be granted if you are physically unable to return to the **Service Area**. You must notify your **Health Plan** immediately if follow-up care is necessary, and your **Health Plan** will provide written **Prior Authorization** on a case-by-case basis for any follow-up care that is received from an **Out-of-Network Provider**. If you do not receive written **Prior Authorization** before an **Out-of-Network** follow-up appointment, you will be responsible for the full cost of the visit.

4. Out-of-Network Coverage for Full-Time Students

If your **Dependent** is a full-time student attending school within the State of Wisconsin but outside of your **Health Plan's Service Area**, certain **Outpatient** mental health services and treatment of

alcohol or drug abuse will be covered **Out-of-Network**, as required by Wis. Stat. § 609.655. See Mental Health and Substance Use Disorder Services below for more information.

Your **Dependent** may have a clinical assessment by an **Out-of-Network Provider** with **Prior Authorization** in writing from your **Health Plan**. If **Outpatient** services are recommended, your **Dependent** will be allowed coverage for five (5) visits outside of the **Service Area** with **Prior Authorization** from your **Health Plan**. Your **Health Plan** may approve additional visits. If your student **Dependent** is unable to maintain full-time student status, they must obtain services from an **In-Network Provider** for treatment to be covered unless you are enrolled in the **Access Plan** or other **PPO Plan**.

5. Benefit Plans with Out-of-Network Access

Some **Benefit Plans** offered by **ETF** may include **Out-of-Network** coverage as a part of the **Benefit Plan**; these include the **Access Plan,** and any **Health Plan** that is considered a **PPO**. In addition, **Benefit** designs for the IYC **Medicare Advantage Plan** and **Medicare Plus Plan** also offer **Out-of-Network** coverage. Please refer to your **Access Plan Schedule of Benefits** or your **Evidence of Coverage** if you are enrolled in **Medicare Advantage** or the **Certificate** for **Medicare Plus** (ET-4113). For the **Access** and **PPO Plans**, see the **Provider** directory supplied by your **Health Plan** for information about **In-Network Providers.**

6. Balance Billing When Out-of-Network

In cases where you are eligible for **Out-of-Network** coverage (e.g., your **Health Plan** has given **Prior Authorization** for care at an **Out-of-Network Provider**), the amount your **Health Plan** determines is reasonable to pay for your **Out-of-Network** services may be less than the amount your **Provider** billed. In these cases, you are **Held Harmless** for the difference between the billed and paid **Charge(s)**, other than the **Copayments**, **Coinsurance,** or **Deductibles** specified on your **Schedule of Benefits**.

The only exception to this is if you accepted financial responsibility in writing for specific treatment or services (that is, diagnosis and/or procedure code(s) and related **Charges**) before receiving services. This provision applies to all **Participants** including those in the **Access Plan** or other **PPO Plan**.

You may be responsible for costs beyond **Usual and Customary Charges** for services obtained from **Out-of-Network Providers** that are non-**Emergency** or non-**Urgent** and which were not previously approved for **In-Network** reimbursement by your **Health Plan** unless you are a **Participant** in the **Access Plan** or other **PPO Plan**.

If you receive **Emergency** or **Urgent Care,** or if you receive ancillary services from an **Out-of-Network Provider** as part of an **In-Network** service (for example, an **Out-of-Network** anesthesiologist for a surgery by an **In-Network** surgeon), you cannot be charged any more than your **In-Network Copayments, Coinsurance,** or **Deductible**. In the case of **Emergency** care, this includes **Post-Stabilization Care**. For more information about ancillary service coverage, see 4.F. Covered Services.

C. Cost Sharing May Apply

Your **Benefits** may be subject to the **Copayments**, **Coinsurance, Deductible**, and other limitations shown in the **Schedule of Benefits** for your **Benefit Plan.** If you are unsure whether a service is subject to cost sharing, refer to your **Schedule of Benefits** that can be found when you visit **ETF's** website at http://etf.wi.gov/benefits-by-employer and search for your **Employer**. You may also contact your **Health Plan** to verify.

D. Medical Necessity

All services must be medically necessary, as determined by your **Health Plan.** A service, treatment, procedure, equipment, drug, device or supply that is provided by a **Hospital**, physician or other health care **Provider** and is required to identify or treat a **Participant's Illness** or **Injury** is considered medically necessary when all of the following apply:

a. It is consistent with the symptom(s) or diagnosis and treatment of the **Participant's Illness** or **Injury.**
b. It is appropriate under the standards of acceptable medical practice to treat that **Illness** or **Injury**.
c. It is not solely for the convenience of the **Participant**, physician, **Hospital** or other health care **Provider**.
d. It is 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.

Your **Health Plan** will determine if all the above criteria have been met to determine which services are covered. If you or your **Provider** disagree with the determination made by your **Health Plan**, you may seek external review. See Section 8. Grievances and Appeals below.

E. Disease Management, Prior Authorizations, and Utilization Review

Your **Health Plan** will collaborate with other vendors who provide your **GHIP Benefits** to provide disease management services. Disease management programs support you in managing your medical conditions, and in some cases provide nursing or other health professional support to find strategies to improve your overall health.

Your **Health Plan** may require **Prior Authorization** for some services. **Prior Authorization** is intended to help ensure that the services you receive are the most appropriate for your condition. Your **Health Plan** will use an evidence based medical policy development process to determine **Prior Authorization** criteria and will provide you a copy of these policies on request.

Your **Health Plan** may also require a **Referral** from your **PCP** for you to obtain certain specialty services. In many cases, the **Referral** must be in writing and on the **Health Plan's Prior Authorization** form and approved by the **Health Plan** in advance of a **Participant's** treatment or service. **Referral** requirements are determined by each **Health Plan**. The authorization from the **Health Plan** will state the type or extent of treatment authorized, the number of visits, and the period of time during which the authorization is valid. In most cases, it is the **Participant's** responsibility to ensure a **Referral**, when required, is approved by the **Health Plan** before services are rendered.

In some cases, your **Health Plan** may use a process called utilization management or utilization review to ensure that the services you receive are evidence-based and focus on quality, positive

health outcomes, and cost savings. The **Health Plan** must demonstrate effective and appropriate means of identifying, monitoring, and directing **Participant's** care by providers such as utilization review (UR), chronic care/disease management, and wellness/prevention programs.

F. Covered Services

The following services and supplies are covered under your **GHIP Benefits** if they are medically necessary for the treatment of an **Injury** or **Illness.** See Section 4. D. Medical Necessity for details on how services are determined to be medically necessary.

1. Advance Care Planning

Your policy covers **Advance Care Planning,** which can include developing healthcare directives, living wills, healthcare proxies, and a healthcare power of attorney.

To assist you with documenting your future healthcare wishes in case of **Illness**, accident, or sudden medical event, please contact your **Health Plan** or your **Provider** for more information.

2. Ambulance Services

Your **Plan** covers licensed professional ambulance services (or comparable **Emergency** transportation if authorized by your **Health Plan**) when transportation to a **Hospital** is an **Emergency** or **Urgent** and medical attention is required enroute. This includes licensed professional air ambulance when another mode of ambulance service would endanger the **Participant's** health. **Emergency** air ambulance services are limited to only those services necessary for transport to the nearest medical facility equipped to handle the **Emergency**. Ambulance services include medically necessary transportation and all associated supplies and services provided therein. If the **Participant** is not in the **Health Plan's Service Area**, the **Health Plan** should be contacted, if possible, before transport.

3. Ancillary Services

Ancillary services are those services that are generally provided in conjunction with another medically necessary service. Some examples include anesthesia provided for a surgery or a lab test to diagnose an **Illness**. If you receive anesthesiology, radiology, or pathology services (including all lab tests) at an **In-Network** clinic or **Hospital**, those services will be covered at the **In-Network** level of **Benefits,** even if the service is not provided by an **In-Network Provider**.

4. Anesthesia Services

Anesthesia services are covered when provided in connection with other medical and surgical services covered under this **Certificate**.

5. Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m) and the Federal Mental Health Parity and Equity Act (MHPAEA). Autism spectrum disorder means any of the following:

a. Autism disorder.
b. Asperger's syndrome.
c. Pervasive developmental disorder not otherwise specified.

Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following **In-Network Providers** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services):

a. Psychiatrist
b. Psychologist
c. Social worker
d. Behavior analyst
e. Paraprofessional working under the supervision of any of the above four types of **Providers**
f. Professional working under the supervision of an **Outpatient** mental health clinic
g. Speech-language pathologist
h. Occupational therapist

Physical Therapy, Occupational Therapy, and Speech-Language Therapy limits do not apply to this **Benefit**.

6. Back Surgeries

Prior Authorization may be required for **Referrals** to orthopedists and neurosurgeons if you have a history of low back pain but have not completed an optimal regimen of conservative care. **Prior Authorization** is not required if you have a clinical diagnosis that requires immediate or expedited orthopedic, neurosurgical, or other specialty **Referral,** or for **Medicare Advantage**-enrolled **Participants**.

7. Bariatric Surgery

Bariatric surgery is covered for **Participants** with a body mass index (BMI) of 35 or greater, provided the **Participant** meets all criteria established by the **Health Plan**. Surgeries may be covered for **Participants** with a BMI of less than 35 as approved by the **Health Plan**. All bariatric surgery services may require **Prior Authorization** to obtain the surgery and associated preparatory services. **Prior Authorization** criteria is determined by the **Health Plan**.

8. Biofeedback

Biofeedback is covered when provided to treat the following conditions:

a. Headaches
b. Spastic torticollis
c. Urinary incontinence
d. Fecal incontinence
e. Chronic constipation
f. Refractory severe tinnitus related to mental health parity

Biofeedback is not covered for treatment of any other conditions; see Section 5. Exclusions, for additional information.

9. Cancer Clinical Trials

Your policy will cover routine patient care administered if you participate in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

10. Cardiac Rehabilitation

Phase I and Phase II cardiac **Rehabilitation Services** are covered by your **Benefit Plan.** Phase II services may require **Prior Authorization** from your **Health Plan** and that they must be provided in an **Outpatient** department of a **Hospital**, in a medical center, or through a clinic program.

11. Case Management / Alternate Treatment

Your **Health Plan** employs a professional staff to provide case management services to help you manage complex medical conditions. As part of this case management, your **Health Plan** or your **Provider** may recommend that you consider receiving treatment for an **Illness** or **Injury** which differs from your current treatment if it appears that all of the following are true:

a. The recommended treatment offers at least equal medical therapeutic value.
b. The current treatment program may be changed without jeopardizing your health.
c. The costs (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If your **Health Plan** agrees to the **Provider's** recommendation, or if you or your authorized representative and the **Provider** agree to your **Health Plan's** recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which **Benefits** are not otherwise payable, payment of **Benefits** will be as determined by the **Health Plan**.

12. Chiropractic Services

Chiropractic services are covered when performed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services) to treat an acute **Injury** or **Illness**. **Maintenance Care** is not covered. Your **Health Plan** may periodically review the treatment progress information from your **Provider** to ensure that your treatment plan is progressing.

13. Colorectal Cancer Screenings and Tests

Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m) and the Affordable Care Act are covered by your policy. Screening tests may be provided at no cost to you if you are in the age group recommended by the United States Preventive Services Task Force (USPSTF). Diagnostic tests or tests done outside of the recommended age group may be subject to cost sharing. See your **Schedule of Benefits** for details.

14. Congenital Defects and Birth Abnormalities

Treatment of **Congenital** defects and birth abnormalities is covered as required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d). Coverage includes treatment for the repair or restoration of any body part when necessary to achieve normal functioning. If required by Wisconsin law, this includes orthodontia and dental procedures if necessary to restore normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

15. Diagnostic Services

Medically necessary testing and evaluations are covered, including, but not limited to:

a. Radiology and lab tests given with general physical examinations.
b. Vision and hearing tests to determine if correction is needed.

c. Annual routine mammography screening.
d. Home or laboratory sleep studies when ordered and performed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

Prior Authorization may be required for high-tech radiology tests including MRI, CT scans, and PET scans, except for **Medicare Advantage**-enrolled **Participants**. **Prior Authorization** may be required for other diagnostic services as determined by the **Health Plan**.

16. Drugs Administered in a Home Health or Health Care Setting

Your **Health Plan**, not the **PBM**, will be responsible for covering prescription drugs that are administered during **Home Care**, in an office setting, during a **Confinement**, **Emergency** room visit or **Urgent Care** setting, if those drugs are covered under the **GHIP**. Injectable and infusible medications, except for **Self-Administered Injectable** medications, are included in this coverage.

Prescriptions for covered drugs written in any of the above settings that do not require an office visit to administer will be the responsibility of the **PBM** and payable as provided under the terms and conditions of Uniform Pharmacy **Benefits**. See Prescription Drugs and Other Benefits Administered by the PBM below for additional information.

17. Durable Diabetic Equipment and Related Supplies

Durable diabetic equipment and the supplies that are required for use with the durable diabetic equipment will be covered when prescribed by and purchased from an **In-Network Provider** for treatment of diabetes (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services). Cost sharing may apply; see your **Schedule of Benefits** for more information.

Durable diabetic equipment includes automated injection devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year.

Glucometers and continuous glucose monitoring (CGM) devices are available through the **PBM** except for **Annuitants** and their covered **Dependents** who are eligible for **Medicare Part A** and **Medicare Part B**. CGMs are covered for these **Participants** under **Medicare Part B** and the **Health Plan**. Refer to the Uniform Pharmacy **Benefits** document for more information.

Durable diabetic equipment and supplies may require **Prior Authorization** from your **Health Plan.**

18. Durable Medical Equipment and Medical Supplies

When prescribed by an **In-Network Provider** for treatment of a diagnosed **Illness** or **Injury** and purchased from an **In-Network Provider** outside of a **Hospital** setting, **Medical Supplies** and **Durable Medical Equipment** will be covered subject to cost sharing as outlined in the **Schedule of Benefits** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services).

All **Durable Medical Equipment** purchases, or monthly rentals may require **Prior Authorization** as determined by your **Health Plan**. In addition, the following **Durable Medical Equipment** and **Medical Supplies** may require **Prior Authorization** by your **Health Plan:**

a. Initial acquisition of artificial limbs, including replacements due to significant physiological changes, such as physical maturation, when medically necessary and when refitting of any existing prosthesis is not possible.
b. Casts, splints, trusses, crutches, prostheses, orthopedic braces, and appliances.
c. Custom-made orthotics, limited to one orthotic per foot per calendar year.
d. Rental or, at the option of the **Health Plan**, purchase of equipment including, but not limited to, wheelchairs and **Hospital**-type beds.
e. IUDs and diaphragms.
f. An initial external lens per eye when determined medically necessary to heal from surgery or needed due to a malformation of or **Injury** to the eye. Any subsequent lenses after the first lens will not be covered (See Section 5. Exclusions).
g. Elastic support hose, for example, JOBST, when prescribed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may prescribe and provide covered services). Limited to two pairs per calendar year.
h. One hearing aid per ear, as described in the **Schedule of Benefits**. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
i. Ostomy and catheter supplies.
j. Oxygen and respiratory equipment for home use.
k. Other medical equipment and supplies as approved by your **Health Plan**. Rental or purchase of equipment/supplies is at the option of the **Health Plan**.
l. Repairs, maintenance, and replacement of covered **Durable Medical Equipment** and **Medical Supplies**, including replacement of batteries. When determining whether to repair or replace the **Durable Medical Equipment** or **Medical Supplies**, your **Health Plan** will consider whether:
    1. The equipment/supply is still useful or has exceeded its lifetime under normal use, or
    2. Your condition has significantly changed such that the original equipment is inappropriate (for example, due to growth or development).

Durable Medical Equipment models or devices that have features over and above that which are medically necessary will be limited to the standard model as determined by your **Health Plan**. This includes the upgrade of equipment, models, or devices to better or newer technology when the existing equipment, models, or devices are sufficient and there is no change in your condition nor is the existing equipment, model, or device in need of repair or replacement.

Cost sharing will apply as described in your **Schedule of Benefits**.

19. Emergency and Urgent Care

a. Emergency Care

Medical care for an **Emergency** is covered under your policy. When you go to an **Emergency** room, you may receive additional tests or treatments as a part of the **Emergency** room visit. Those tests or treatments are often billed separately from the visit itself, and you may be responsible for a **Copayment** or **Coinsurance** associated with those tests and treatments, in

addition to your **Emergency** room visit **Copayment**. See your **Schedule of Benefits** for more details.

You should use an **In-Network Emergency** room whenever possible. If you are not able to go to an **In-Network Emergency** room, go to the nearest appropriate medical facility. You will be **Held Harmless** for any **Charges** unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will work with **Out-of-Network Emergency Providers** to settle claims and manage or reduce costs.

If you must go to an **Out-of-Network Emergency** room for care, you should call your **Health Plan** as soon as possible and tell your **Health Plan** where you received **Emergency** care. You must receive non-urgent follow-up care from an **In-Network Provider** unless you have received written **Prior Authorization** from your **Health Plan** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services without **Prior Authorization**)**.** If you have not received written **Prior Authorization** for **Out-of-Network** follow up care from your **Health Plan**, it will not be covered (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services without **Prior Authorization**). **Prior Authorization** for the follow-up care is at the sole discretion of the **Health Plan**. See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

To help ensure that your claims process correctly, it's recommended that you or another person on your behalf notify your **Health Plan** of any **Hospital** admissions or facility **Confinements** that happen following an **Out-of-Network Emergency** room visit as soon as reasonably possible.

Emergency services include reasonable accommodations for repair of **Durable Medical Equipment** if repairs are medically necessary.

b. Urgent Care.

If you experience an **Illness** or **Injury** that is not an **Emergency** but cannot safely wait to be treated until you can see your regular **PCP**, you may choose to seek **Urgent Care** instead. You should seek care at an **In-Network Urgent Care** whenever possible. If you are not able to go to an **In-Network Urgent Care** because you are outside of your **Health Plan's Service Area**, you should visit the nearest, appropriate facility unless you are able to travel back to your **Health Plan's Service Area**.

If you must go to an **Out-of-Network Urgent Care**, you should notify your **Health Plan** by the next **Business Day** or as soon as otherwise possible and tell your **Health Plan** where you received care. This will help ensure your claims are paid. You will be **Held Harmless** for any **Charges** unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will work with **Out-of-Network Urgent Care Providers** to settle claims and manage or reduce costs. Any follow-up care you need must be received from an **In-Network Provider** unless **Prior Authorization** was given by your **Health Plan** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network**

Provider may provide covered services without **Prior Authorization**). See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

20. Extraction and Replacement of Teeth Due to Injury

Total extraction and/or total replacement (limited to bridge, denture or implant) of **Natural Teeth** by an **In-Network Provider** is covered when these services are needed because of an **Injury** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). Crowns or caps for broken teeth instead of extraction and replacement may be considered if **Prior Authorization** was given by the **Health Plan** before the service is performed.

Your policy covers one retainer or mouth guard when medically necessary as part of prep work provided prior to covered tooth repair. **Injuries** caused by chewing or biting are not considered to be accidental for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

21. Gender Confirmation Treatments

Based on a permanent injunction issued on October 11, 2018, and the summary judgment decision issued on September 18, 2018 by the federal district court for the Western District of Wisconsin, all procedures, services, and supplies related to surgery and sex hormones associated with gender confirmation should be reviewed by the **Health Plan** for medical necessity. See Section 4. D. Medical Necessity for more information on this determination.

22. Genetic Testing/Genetic Counseling

Genetic testing and genetic counseling will only be covered when necessary to diagnose and treat an **Illness**. Testing for informational purposes that cannot reasonably lead to a course of treatment will not be covered.

23. Home Care Benefits

Home Care Benefits may be covered when medically necessary with a plan of care in place. An **In-Network Provider** must establish the plan of care, approve it in writing, and review it at least every two months unless the **Provider** determines that less frequent reviews are sufficient (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may establish the plan of care).

You are eligible for a maximum of 50 visits per calendar year. Fifty additional visits per calendar year may be available when **Prior Authorization** is received from the **Health Plan**.

Home Care Benefits means one or more of the following:

a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
c. Physical, occupational and speech therapy. These apply to the therapy maximum described in your **Schedule of Benefits.**
d. **Medical Supplies**, drugs, and medicines prescribed by an **In-Network Provider** and lab services by or for a **Hospital** (for **Access Plan** or other **PPO Plan Participants**, an **Out-**

of-Network Provider may prescribe covered supplies, etc.). These are covered to the same extent as if you were **Confined** in a **Hospital**.

e. Nutritional counseling provided or supervised by a registered dietician.

This **Certificate** also covers the assessment of the need for a **Home Care** plan and its development. A registered nurse, physician extender, or medical social worker must do this. An attending physician must ask for or approve this service.

Home Care Benefits will not be covered unless the attending physician certifies that:

a. **Hospital Confinement** or **Confinement** in a **Skilled Nursing Facility** would be needed if **Home Care** were not provided.
b. The patient's **Immediate Family**, or others living with the patient, cannot provide the needed care and treatment without undue hardship.
c. A state licensed or **Medicare**-certified home health agency or certified rehabilitation agency will provide or coordinate the **Home Care**.

If you are under **Hospital Confinement** when **Home Care** is requested, the **Home Care** plan must be approved at its start by the **Provider** who was the primary **Provider** of care during your **Hospital Confinement**.

Each visit by a person providing services under a **Home Care** plan, evaluating current needs, or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one **Home Care** visit.

Your **Health Plan** may give **Prior Authorization** for up to 50 additional **Home Care** visits per calendar year if the visits continue to be medically necessary and are not otherwise excluded.

24. Hospice Care

Hospice Care, which may be **Inpatient** or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. **Hospice Care** is covered if your **PCP** certifies that your life expectancy is six months or less and the care is palliative in nature. **Hospice Care** must be authorized by your **Health Plan**. **Hospice Care** includes, but is not limited to, **Medical Supplies** and services, counseling, bereavement counseling for one year after the patient's death, **Durable Medical Equipment** rental, home visits, and **Emergency** transportation. Coverage may be continued beyond a six-month period if authorized by the **Health Plan**.

Hospice Care is available to you when you are **Confined**. **Inpatient Charges** are payable for up to a total lifetime maximum of 30 calendar days of **Confinement** in a **Health Plan**-approved or **Medicare** certified **Hospice Care** facility.

Benefits payable under this **Hospice Care Benefit** subsection that also fall under the **Home Care Benefits** subsection shall not reduce any **Benefits** payable under the **Home Care** subsection.

Hospice Care must be provided through a licensed **Hospice Care Provider** approved by the **Health Plan**.

25. Hospital Services and Inpatient Confinements

Hospital services must be received at an **In-Network Hospital** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). In the case of non-**Emergency** care, your **Health Plan** reserves the right to determine in a reasonable manner the **Provider** to be used. In cases of **Emergency** or **Urgent Care** services, **In-Network Providers** and **Hospitals** must be used whenever possible and reasonable (See Emergency and Urgent Care sections above). However, your **Health Plan** must **Hold** you **Harmless** from any effort by third parties to collect from the amount above the **Usual and Customary Charges** for services.

Hospital swing bed **Confinement** is considered the same as **Confinement** in a **Skilled Nursing Facility**.

Services necessary for your admission to a **Hospital**, as well as diagnosis and treatment are covered when they are provided by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). When you are in a health care facility, you agree to conform to the rules and regulations of that institution. Your **Health Plan** may require that your **Hospital** services receive **Prior Authorization.**

When you are **Confined** as an **Inpatient** in a **Hospital**, the **GHIP** covers a semi-private room, ward or intensive care unit, and medically necessary miscellaneous associated **Hospital** expenses, including prescription drugs administered during the **Confinement**. A private room is payable only if medically necessary, as determined by the **Health Plan**.

If you are transferred or discharged to another facility for continued treatment of the same or a related condition, it is considered one **Confinement** for the purposes of determining coverage. Your **Health Plan** will administer claims and medical management services if you transfer between facilities.

Charges for **Hospital** or other institutional **Confinements** are incurred on the date of admission. The **Benefit** levels that apply on the **Hospital** admission date apply to the **Charges** for the covered expenses incurred for the entire **Confinement**, regardless of changes in **Benefit** levels that might occur during the **Confinement**.

If you change **Health Plans** while you are **Confined** as an **Inpatient**, your coverage at the current facility will continue under your prior **Health Plan**.

Except in cases where your coverage ends because you have voluntarily canceled your policy or you have not paid your **Premiums,** your **Benefits** will continue if you are **Confined** as an **Inpatient** until your attending physician determines that **Confinement** is no longer medically necessary, your maximum **Benefit** is reached, the end of 12 months after the date of termination, or the **Confinement** ceases, whichever occurs first.

26. Kidney Disease Treatment

Inpatient and **Outpatient** kidney disease treatment is covered. This **Benefit** is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis,

transplantation (additional information in Transplants below), donor-related services, and related physician **Charges**.

Treatments for end stage renal disease are also covered by your policy. If you are eligible for **Medicare** due to permanent kidney failure or end-stage renal disease, see Section 3.D. End Stage Renal Disease and Medicare Enrollment to learn more about how this may impact your **Premium** costs.

27. Mastectomy and Breast Reconstruction (Women's Health and Cancer Act of 1998)

Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical **Benefits** with respect to mastectomies associated with breast cancer treatment includes all of the following:

a. Reconstruction of the breast on which a mastectomy was performed.
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
c. Prostheses (see Durable Medical Equipment) and physical complications of all stages of mastectomy, including lymphedemas.
d. Breast implants.

28. Mental Health and Substance Use Disorder Services

Following the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, services to diagnose and treat mental health and substance use disorder are covered by the **GHIP**. Coverage includes:

a. **Outpatient** services, meaning non-residential services provided by **In-Network Providers**, as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This **Benefit** also includes services for a full-time student attending school in Wisconsin but out of the **Service Area,** as required by Wis. Stat. § 609.655.

   Outpatient services can include, but are not limited to:
   - Evaluation, diagnosis, medical services, and psychotherapy
   - Intervention and presentation efforts
   - Day treatment
   - Lab tests, such as bloodwork
   - Consultations or follow-ups with a specialist

b. Transitional Services, meaning services provided in a less restrictive manner than **Inpatient** services but in a more intensive manner than **Outpatient** services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA.
   - An example includes, but is not limited to, when a patient leaves one care setting (e.g., **Hospital**, nursing home, assisted living facility, **Skilled Nursing Facility**, **Primary Care Physician**, home health, or specialist) and moves to another.

   Inpatient services, provided by an **In-Network Provider** as described in **Schedule of Benefits** and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This includes court-ordered services as required by Wis. Stat. § 609.65, and these services are covered if performed by an **Out-of-Network Provider** if provided as required by an **Emergency** detention or on an

Emergency basis. The **Provider** must notify the **Health Plan** within 72 hours after the initial provision of service.

Inpatient services include, but are not limited to:

- **Hospital** setting
- Residential treatment environment
  - Psychiatric residential centers
  - Alcohol and drug rehabilitation facilities
- Detoxification services
- Methadone treatment

c. Family Counseling when it is part of developing or supporting you or your **Dependent's** treatment plan (For **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

Prescription drugs used for the treatment of mental health and alcohol and drug abuse will be covered under the Uniform Pharmacy **Benefit**, subject to the **Benefits** provided under the Uniform Pharmacy Benefit Certificate of Coverage.

29. Nutritional Counseling

Nutritional Counseling is covered when provided by a participating registered dietician or an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

Nutritional Counseling consists of the following services:

a. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by a physician.
b. Re-assessment and intervention (individual and group).
c. Diabetes **Outpatient** self-management training services (individual and group sessions).
d. Dietitian visit.

Coverage limitations apply (See Section 5. Exclusions and Limitations below for detail).

30. Oral Surgery and Other Dental Services

Oral Surgery is covered in limited situations by your **GHIP** policy. You should contact your **Health Plan** prior to any oral surgery to determine if the service will be covered and if **Prior Authorization** by the **Health Plan** is required.

When performed by **In-Network Providers** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services), approved surgical procedures are as follows:

a. Surgical removal of impacted teeth and surgical or non-surgical removal of third molars.
b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, when such conditions require a pathological examination.
c. Frenotomy (Incision of the membrane connecting tongue to floor of mouth).
d. Surgical procedures required to correct accidental **Injuries** to the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

e. Apicoectomy (Excision of apex of tooth root).
f. Excision of exostoses of the jaws and hard palate.
g. Intraoral and extraoral incision and drainage of cellulitis.
h. Incision of accessory sinuses, salivary glands, or ducts.
i. Reduction of dislocations of, and excision of, the temporomandibular joints.
j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related medically necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.
k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under this **Certificate**) and associated osseous (removal of bony tissue) surgery.
l. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
m. Retrograde fillings when medically necessary following covered oral surgery procedures.

Oral surgery **Benefits** shall not include **Benefits** for procedures not listed above; for example, root canal procedures, filling, capping, or recapping.

Coverage under the **GHIP** will also include **Hospital** or **ASC Charges** and related anesthetics for dental care if services are provided to a **Participant** who is under 5 years of age, has a medical condition that requires hospitalization or general anesthesia for dental care, or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

31. Palliative Care

A **Participant's Palliative Care** team may include **Providers** such as doctors, nurses, or social workers. These services are coordinated by a **Palliative Care Provider** and must be medically necessary.

Note: **Prior Authorization** may be required for in-home **Palliative Care** services.

32. Physical, Speech, and Occupational Therapy

Habilitation or **Rehabilitation Services** and treatment that result from an **Illness** or **Injury** will be covered if provided by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). **Providers** must be registered and must not live in your home or be a family member.

Up to 50 visits per **Participant** for all therapies combined are covered per calendar year. Your **Health Plan** may review utilization and clinical information during the initial 50 visits to verify medical necessity (See Section 4. E. Disease Management, Prior Authorizations, and Utilization Review for additional information). Additional visits may be available with **Prior Authorization** from your **Health Plan**, up to a maximum of 50 additional visits per therapy, per **Participant,** per calendar year.

33. Prescription Drugs and Other Benefits Administered by the PBM

Your coverage for most medications under the **GHIP** is provided by a **PBM.** You must obtain pharmacy **Benefits** at a **PBM Participating Pharmacy**, except when not reasonably possible

because of **Emergency** or **Urgent Care**. For full detail on services covered by the **PBM**, please see the Uniform Pharmacy Benefits Certificate of Coverage.

34. Preventive Care and Immunizations

The **GHIP** covers all preventive care services that have received an A or B grade by the United States Preventive Services Task Force (USPSTF) without cost sharing to you when received from an **In-Network Provider** as required by the Affordable Care Act, regardless of the **Benefit Plan** in which you are enrolled. Check with your **Provider** and your **Health Plan** to verify which services are recommended for you and your family.

Preventive services include routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

Preventive care also includes well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

35. Primary Care

You are required to select a **PCP** or **PCC** when you enroll in the **GHIP** and when you change **Health Plans**. You must select your **PCP** or **PCC** from your **Health Plan's** list of **In-Network Providers**. Your **PCP** may be a physician, physician assistant, nurse practitioner or other **Provider** if that **Provider** is managing your primary care services. Primary care includes ongoing responsibility for preventive health care, treatment of **Illness** and **Injuries**, and the coordination of access to needed specialty **Providers** or other services. Your **PCP** or **PCC** shall either furnish or arrange for most of your health care needs, including well check-ups, office visits, **Referrals**, **Outpatient** surgeries, hospitalizations, and health-related services.

Your **Health Plan** is required by **ETF** to ensure you have an assigned, **In-Network PCP** or **PCC**. If you do not choose a **PCP** or **PCC**, or your **PCP** or **PCC** is no longer available, your **Health Plan** will assign a **PCP** or **PCC**, notify you in writing, and provide instructions for changing the assigned **PCP** or **PCC** if you are not satisfied with their selection.

If you select a **PCP** or **PCC** that is **Out-of-Network**, your **Health Plan** will contact you within five **Business Days** and will assist you in selecting an **In-Network PCP** or **PCC**.

36. Pulmonary Rehabilitation Therapy

Phase I and Phase II pulmonary **Rehabilitation Services** are covered as medically necessary by your **Benefit Plan** when provided by physicians, therapists, and other qualified **Providers.** Phase II services may require **Prior Authorization** from the **Health Plan** and be provided in an **Outpatient** department of a **Hospital**, in a medical center, or through a clinic program.

37. Radiation Therapy and Chemotherapy

These services are covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes, and chemotherapy drugs. They are administered and billed by an **In-Network Provider** (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

38. Reproductive Services and Contraceptives

The services included in this section do not require a **Referral** to an **In-Network Provider** who specializes in obstetrics and gynecology; however, your **Health Plan** may require that you obtain **Prior Authorization** for some services or they may not be covered.

a. Maternity Services

Maternity services for prenatal and postnatal care are covered, including services such as normal deliveries, ectopic pregnancies, cesarean sections, abortions allowable under Wis. Stat. §40.03 (6) (m), and miscarriages. Maternity **Benefits** are also available for a **Dependent** child who is covered under the **GHIP** as a **Participant**. However, this does not extend coverage to the newborn if the **Dependent** child is age 18 or older at the time of the birth.

In accordance with the federal Newborns' and Mothers' Health Protection Act, an **Inpatient** stay for a birth will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer **Inpatient** stay is medically necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician and in consultation with the mother.

If you are in your second or third trimester of pregnancy when your **Provider** ends participation in your **Health Plan's Service Area**, you will continue to have access to that **Provider** until completion of postpartum care for you and your baby. **Prior Authorization** is not required for the delivery, but the **Health Plan** may request notification of the **Inpatient** stay prior to the delivery or shortly thereafter.

b. Contraceptive Services

Elective sterilization is covered by this policy, as are contraceptive methods as required by Wis. Stat. § 632.895 (17), including, but not limited to:

i. Oral contraceptives, or cost-effective **Formulary** equivalents as determined by the **PBM**, and diaphragms, as described under the prescription drug **Benefit** in the Uniform Pharmacy Benefit.
ii. IUDs and diaphragms, as described under the Durable Medical Equipment section of this document.
iii. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

39. Second Opinions/Consults

In advance of a surgery or following a diagnosis, you may wish to seek a second opinion before proceeding with treatment. A second opinion is covered from an **In-Network Provider** or another **Provider** when **Prior Authorization** is received by your **Health Plan**.

40. Skilled Nursing Facilities

Confinement in a licensed **Skilled Nursing Facility** is covered as long as you are admitted within 24 hours of discharge from a **Hospital** for continued treatment of the same condition. Only **Skilled Care** is covered; **Custodial Care** is excluded.

Benefits include prescription drugs administered during the **Confinement**. **Confinement** in a swing bed in a **Hospital** is considered the same as a **Skilled Nursing Facility Confinement**. A maximum of 120 calendar days per **Benefit Period** is covered for **Skilled Care**.

41. Speech and Hearing Screening Exams

Speech and hearing screening examinations are limited to the routine screening tests performed by an **In-Network Provider** for the purpose of determining the need for correction (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services).

42. Smoking Cessation

Coverage includes pharmacy products that require a written prescription and are described under the prescription drug **Benefits** in Uniform Pharmacy Benefits. Coverage also includes one office visit for counseling and to obtain a prescription, and four telephonic counseling sessions per calendar year. Additional counseling and/or extension of pharmacological products may require **Prior Authorization** by the **Health Plan**.

43. Surgical Services

Surgical procedures, wherever performed, are covered when needed to care for an **Illness** or **Injury**. Coverage includes **Preoperative Care**, **Postoperative Care**, and needed services of surgical assistants or consultants.

Prior Authorization may be required for **Referrals** to orthopedists and neurosurgeons for surgeries related to back pain for any **Participant** who has not completed an optimal regimen of conservative care for low back pain. **Prior Authorization** is not required for a **Participant** who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical, or other specialty **Referral**. This limitation does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

Participants seeking surgical treatment of low back pain must participate in a credible **Shared Decision-Making** program provided by the **Health Plan** or its contracted **Providers** consistent with the **Prior Authorization** requirement. This requirement does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

44. Telemedicine and Remote Care

Your **GHIP** coverage includes coverage for services provided remotely. Such services must provide, at minimum, consultation services that assist you in determining whether additional treatment for a condition should be sought. Such consultation services that result in a **Referral** to a different site of care rather than definitive treatment must be provided at no cost to you. Services that have definitive diagnoses and/or treatment may result in a cost. See your **Schedule of Benefits** for details.

The **Telemedicine** and remote care service types listed below are covered when provided by an **In-Network Provider** and they result in no reduction in quality, safety, or effectiveness (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** provide covered services). **Health Plans** may create a review process to ensure that services provided by any of these methodologies meet quality, safety, and effectiveness standards.

a. E-Visits

E-Visits are covered by your **Plan**. An **E-Visit** must be initiated by the **Participant** seeking services, not the **Provider**, to be covered. **E-Visits** are covered when the same service would be covered if provided in person when performed by:

i. A doctor
ii. A nurse practitioner
iii. A physician assistant
iv. Licensed clinical social workers
v. Clinical psychologists or psychiatrists
vi. Physical therapists
vii. Occupational therapists
viii. Speech language pathologists

Because **E-Visits** can be completed via messaging services, they may happen over several hours or even days.

b. Remote Patient Monitoring

Remote Patient Monitoring is covered by your **Plan** under certain circumstances. The remote monitoring device that is used for services must be a home-use medical device as defined by the Food and Drug Administration (FDA) and must be provided as a part of the monitoring services, not billed separately. Devices are provided as a lease to you, and cannot be lease-to-own, purchased to own, or already owned by you. **Remote Patient Monitoring** is intended for long term conditions for which regular measurements need to be taken and must take place for a minimum of 16 calendar days for the service to be covered. Monitoring for shorter time periods will not be covered. Devices may require **Prior Authorization** by your **Health Plan** to be covered.

c. Telehealth

Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care **Provider** who is located elsewhere using interactive two-way, real-time audio and video technology. **Telehealth** can be provided in your home, as well as at a health care facility.

Telehealth will be covered by your **Health Plan** if those services are delivered:

i. Outside of your physical presence (e.g., remotely).
ii. With both audio and video elements are present.
iii. With no reduction in the quality, safety, or effectiveness of the service.

If you and your **Provider** determine that you cannot successfully complete a **Telehealth** visit with full audio and video, you may opt to change to a **Telephone Visit**.

Any service that is currently covered by your **Benefit Plan** and that can be administered remotely with no reduction in quality, safety, or effectiveness is covered when provided via **Telehealth**.

d. Telephone Visits

Telephone Visits will be covered if your **Provider** can successfully provide the service without a reduction in quality, safety, or effectiveness. **ETF** encourages **Participants** and **Providers** to determine the best technology solutions to fit their care needs. **Health Plans** may create review processes and criteria to ensure that services provided using only audio meet quality, safety, and effectiveness standards.

e. Virtual Check-Ins

Virtual Check-ins will be covered on their own if they are not related to a medical visit within the past seven calendar days, and as long as they do not lead to a medical visit within the next 24 hours or the next available appointment.

45. Temporomandibular Disorders

With **Prior Authorization**, as required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures involving a bone, joint, muscle, or tissue, and for any medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a. A **Congenital**, developmental, or acquired deformity, disease, or **Injury** caused the condition.
b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care **Provider** rendering the service.
c. The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.

This includes coverage of non-surgical treatment but does not include coverage for cosmetic or elective orthodontic, periodontic, or general dental care. Intraoral splints are covered under this provision but are subject to the **Durable Medical Equipment Coinsurance** as outlined in your **Schedule of Benefits**. **Benefits** for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

46. Transplants

Transplants and related services are covered when ordered by a physician. All transplants except corneal transplants may require **Prior Authorization**. The medical necessity and appropriateness of a transplant will be determined by medical professionals reviewing each case on behalf of the **Health Plan**.

Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ procurement costs include organ transplantation, compatibility testing, hospitalization, and surgery (when a live donor is involved).

Donor expenses are covered only when the recipient of the transplant is a **Participant** in the **GHIP** and when such **Charges** are included as part of the **Participant's** (as the transplant recipient) bill.

Transplants must be performed at a facility designated by the **Health Plan**.

47. Travel-Related Preventive Care

Medically necessary travel-related preventive treatment is covered by your **GHIP** policy. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever, and Hepatitis A vaccinations are covered if determined to be medically appropriate by your **Health Plan**. Coverage does not apply to travel required for work (See Section 5. Exclusions below for more information).

48. Vision Services

Coverage is limited to one routine eye exam per **Participant** per calendar year. Non-routine eye exams are covered as medically necessary, as determined by your **Health Plan**. Contact lens fittings are not part of the routine exam and are not covered.

Vision screenings for **Participants** aged 5 and younger are considered preventive and are not subject to **Deductible** or office visit **Copayments** when provided by an **In-Network Provider**.

Vision screenings for **Participants** aged 6 and older are not considered preventive and are subject to **Deductible** and specialty **Provider** office visit **Copayment** as applicable.

Twelve visits for orthoptic eye training are covered per lifetime per **Participant**. All additional visits are excluded.

5. Exclusions and Limitations

The following is a list of services, treatments, equipment, or supplies that are excluded, meaning no **Benefits** are payable under the **GHIP**, or have some limitations on the **Benefit** provided. All exclusions listed below apply to **Benefits** offered by your **Health Plan** and the **PBM**. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy **Benefit** administered by the **PBM**. Some of the service listed exclusions may be medically necessary, but still are not covered under the **GHIP**. Others may be examples of services which are not medically necessary or not medical in nature, as determined by your **Health Plan** and/or **PBM**. As discussed in Section 4. D. Medical Necessity above, the determination of medical necessity is ultimately reached by your **Health Plan.**

A. Excluded Services

The services described in this section are specifically not covered by the **GHIP**.

1. Administrative and Clerical Charges

a. Charges for any missed appointment.
b. Expenses for medical reports, including preparation and presentation.

2. Care Needed for Employment

a. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, Smallpox vaccinations, etc.).
b. Vocational rehabilitation including work hardening programs.
c. Physical exams for employment.

3. Cosmetic Treatments and Services

a. Treatment, services, and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to **Congenital** bodily disorders or conditions or when associated with covered reconstructive surgery due to an **Illness** or accidental **Injury** (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
b. Removal of skin tags.

4. Durable Medical Equipment, Durable Diabetic Equipment, and Medical Supplies

a. **Durable Medical Equipment, Durable Diabetic Equipment,** or **Medical Supplies** that have not received **Prior Authorization** by your **Health Plan.**
b. **Durable Medical Equipment** and **Medical Supplies** that are provided solely for comfort, and personal hygiene and convenience items. Examples of these items include, but are not limited to:
    i. wigs
    ii. hair prostheses
    iii. air conditioners
    iv. air cleaners

v. humidifiers
vi. physical fitness equipment
vii. physician's equipment
viii. disposable supplies
ix. alternative communication devices (for example, electronic keyboard for a hearing impairment)
x. self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons
xi. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts
xii. Customization of buildings for accommodation (for example, wheelchair ramps)
xiii. Replacement or repair of **Durable Medical Equipment** or **Medical Supplies** damaged or destroyed by the **Participant** or lost or stolen
xiv. Cold therapy and continuous passive motion devices
xv. Home testing and monitoring supplies unless **Prior Authorization** is received from your **Health Plan**
xvi. Equipment required for **Telehealth** visits

5. Experimental and Investigational Treatments

a. **Experimental** services, treatments, procedures, equipment, drugs, devices or supplies, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
b. The criteria that the **Health Plan** and/or **PBM** uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be **Experimental** or investigative include, but are not limited to:
   i. whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis
   ii. whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that **Illness** or **Injury** by the medical profession in the United States
   iii. the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply
   iv. whether other, more conventional methods of treating the **Illness** or **Injury** have been exhausted by the **Participant**
   v. whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated
   vi. whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by **Medicare, Medicaid**, and other insurers and self-insured **Plans**
c. Coma stimulation programs.

6. Holistic/Homeopathic Treatments

a. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
b. Hypnotherapy.

7. Hospital Inpatient Services
   a. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an **Outpatient** basis.
   b. **Hospital** stays which are extended for reasons other than medical necessity.
   c. A continued **Hospital** stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, **Skilled Nursing Facility**.

8. Included or Bundled Services
   a. Treatment, services and supplies for which the **Participant** has no obligation to pay or which would be furnished to a **Participant** without charge. These include services or supplies that are typically billed as a part of another service when the service cannot be provided without using the supply or service (e.g., gauze used during surgeries, remote monitoring appliance, etc.). These are sometimes referred to as "bundled services."

9. Informational Medical Exams and Testing
   a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in Section 4. F. Covered Services.
   b. Genetic testing and/or genetic counseling services not medically necessary to diagnose and treat and **Illness**.

10. Injuries Resulting from Military Action
   a. **Injury** or **Illness** caused by an atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
   b. 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.

11. Non-Medically Necessary Residential and Personal Care Services
   a. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the **GHIP**.
   b. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
   c. Residential care except residential care and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.
   d. Private Duty Nursing / Personal Care.
   e. Services provided by members of the **Subscriber's Immediate Family** or any person residing with the **Subscriber**.

12. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in Section 4.F. Covered Services, Oral Surgery and Other Dental Services above, or which would be covered if it was performed by a physician and is within the scope of the dentist's license.
b. All dental, periodontal, endodontic, or oral surgical procedures not specifically listed in Section 4.F. Covered Services above.

13. Other Non-Covered Services

a. Services provided by **Out-of-Network Providers**, unless you are enrolled in the **Access Plan** or other **PPO Plan**. This includes non-physician services provided by an **Out-of-Network Provider**, unless you have received **Prior Authorization** from your **Health Plan**, the service is an **Emergency** or **Urgent Care** service outside of the **Service Area**, or an **Emergency** in the **Service Area** when your **PCP** cannot be reached. See Section 4. B. Exceptions to In-Network Care Requirement for more information.
b. Services of a specialist without an **In-Network Provider's** written **Referral**, except in an **Emergency** or by written **Prior Authorization** of the **Health Plan.**
c. Any **Hospital** or medical care or service not provided for in this document unless authorized by the **Health Plan**.
d. Charges directly related to a non-covered service, except when a complication results from the non-covered service that could not be reasonably expected, and the complication requires medically necessary treatment that is performed by an **In-Network Provider** or has received **Prior Authorization** from the **Health Plan**. The treatment of the complication must be a covered **Benefit** of the **Health Plan** and **PBM**.
e. Any smoking cessation program, treatment, or supply that is not specifically covered in Section 4. F. Covered Services, Smoking Cessation.
f. Marriage/couples/family counseling. See Mental Health and Substance Use Disorder Services for exceptions.

14. Reproductive Services

a. Infertility services which are not for treatment of **Illness** or **Injury** (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an **Illness**.
b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
c. Services for storage or processing of sperm; donor sperm.
d. Harvesting of eggs and their cryopreservation.
e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related **Hospital**, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
f. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
g. Services of home delivery for childbirth.
h. Sexual counseling services related to infertility.
i. Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

15. Routine Foot Care

a. The examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet.
b. Cutting, trimming or other nonoperative partial removal of toenails. *Note:* This exclusion does not apply when services are intended to treat a metabolic or peripheral disease or a skin or tissue infection.
c. Treatment of flexible flat feet.

16. Services Covered by Other Payors

a. Services to the extent the **Participant** is eligible for all **Medicare Benefits**, regardless of whether the **Participant** is actually enrolled in **Medicare** or not. This exclusion only applies if the **Participant** enrolled in **Medicare** coordinated coverage and does not enroll in **Medicare Parts A and/or B** when they are first available as the primary payor, or who subsequently cancels **Medicare** coverage, or is not enrolled in a **Medicare Part D Plan**. See Section 2. F. Medicare Enrollment.
b. Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which the **GHIP** 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.
c. Treatment, services, and supplies to which the **Participant** would be entitled to have furnished or paid for, fully or partially, under any law, regulation, or agency of any government.
d. Treatment, services, and supplies to which the **Participant** 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.
e. Services that a child's school is legally obligated to provide, whether the school actually provides the services and whether the **Participant** chooses to use those services.
f. Services to the extent a **Participant** receives or is entitled to receive, any **Benefits**, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means the **Participant** is actually insured under Worker's Compensation.

17. Services Not Medically Necessary

a. Any service, treatment, procedure, equipment, drug, device, or supply which is not reasonably and medically necessary or is not required in accordance with accepted standards of medical, surgical or psychiatric practice.
b. Personal comfort or convenience items or services such as in-**Hospital** television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.
c. **Maintenance Care**. The determination of what constitutes "**Maintenance Care**" is made by the **Health Plan** after reviewing an individual's case history or treatment plan submitted by a **Provider**.

18. Services Outside of Enrollment

a. Expenses incurred prior to the **Effective Date** of coverage by the **Health Plan** and/or **PBM**, or services received after the **Health Plan** and/or **PBM** coverage or eligibility terminates.

19. Services Related to the Commission of a Crime

a. Treatment or service in connection with any **Illness** or **Injury** caused by a **Participant** either engaging in an illegal occupation or the commission of, or attempt to commit, a felony.
b. Services related to an **Injury** that was self-inflicted for the purpose of receiving **Health Plan** and/or **PBM Benefits**.

20. Therapies Not Covered

a. Treatment, services, or supplies used in educational or vocational training; care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL); except for services covered under the **Habilitation Services** therapy **Benefit**, and mandated therapy **Benefits** for autism spectrum disorders under Wis. Stat. § 632.895 (12m).
b. Physical fitness or exercise programs.
c. Biofeedback, except for treatment of headaches, spastic torticollis, and urinary incontinence.
d. Massage therapy.

21. Transplants and Donor-Related Services

a. Services in connection with covered transplants that have not received **Prior Authorization**, when required, from the **Health Plan**.
b. Costs related to a failed transplant that is otherwise covered under the global fee.
c. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
d. All separately billed donor-related services, except for kidney transplants.
e. Non-human organ transplants or artificial organs.
f. Transplants not performed at a facility designated by the **Health Plan**.
g. Services of a blood donor. Medically necessary autologous blood donations are not considered to be services of a blood donor.

22. Travel and Transportation

a. Charges for, or in connection with, travel, except for ambulance transportation as outlined in Section 4.F. Covered Services. This includes but is not limited to meals, lodging and transportation.

23. Weight Loss, Diet Programs, and Food or Supplements

a. Weight loss programs unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan**. This does not include **Nutritional Counseling** as provided in Section 4.F. Covered Services, Nutritional Counseling.
b. Any diet control program, treatment, or supply for weight reduction unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan.**

c. Food or food supplements except when provided during a covered **Outpatient** treatment or **Inpatient Confinement**.

24. Vision Correction

a. Eyeglasses or corrective contact lenses and fitting of those contact lenses, except lenses that are medically necessary to heal from a surgery or are needed due to a malformation of or **Injury** to the eye.
b. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens.
c. Keratorefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.

B. Coverage Limitations

1. Major Disaster, Epidemic, or Pandemic

If a major disaster, epidemic, or pandemic occurs, **In-Network Providers** and **Hospitals** must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the **PBM** and its **Participating Pharmacies**.

During a major disaster, epidemic, or pandemic, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** if services are unavailable from **In-Network Providers** and/or **Participating Pharmacies**. Any novel services developed that receive emergency authorization or other short-term clearance from applicable federal agencies for use to address the disaster, epidemic, or pandemic, may be covered by the **Health Plan**, subject to instruction by **ETF**.

2. Circumstances Beyond the Health Plan's Control

If, due to circumstances not reasonably within the control of the **Health Plan**, such as a complete or partial insurrection, labor disputes not within the control of the **Health Plan**, disability of a significant part of **Hospital** or medical group personnel, or similar causes, the provision of services and other **Benefits** covered hereunder is delayed or rendered impractical, the **Health Plan**, **In-Network Providers** and/or the **PBM** will use their best efforts to provide services and other **Benefits** covered hereunder. In this case, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** so long as services remain disrupted.

6. Coordination of Benefits

A. Applicability

This **Coordination of Benefits** (**COB**) provision applies to the **GHIP** when a **Participant** has health care 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**:

1. Shall not be reduced when, under the order of **Benefit** determination rules, the **GHIP** determines its **Benefits** before another **Plan**, but
2. May be reduced when, under the order of **Benefit** determination rules, another **Plan** determines its **Benefits** first. This reduction is described in Section C. Effect on the Benefits of The GHIP.

B. 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:

1. The other **Plan** has rules coordinating its benefits with those of the **GHIP**, and
2. 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**
   a. 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**.

2. **Dependent** Child/Parents Not Separated or Divorced
   Except as stated in paragraph 3. below, when the **GHIP** and another **Plan** cover the same child as a **Dependent** of different persons, called "parents":
   a. 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
   b. 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 subparagraph a. 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.

3. **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:
   a. First, the **Plan** of the parent with custody of the child;
   b. Then, the **Plan** of the spouse of the parent with the custody of the child; and

c. 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 2. 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.

4. Active/Inactive Employee
   The **Benefits** of a **Plan** which covers a person as an **Employee** who is neither laid off nor retired or 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 4. is ignored.

5. 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:
   a. First, the benefits of a **Plan** covering the person as an **Employee**, member, or **Subscriber** or as a **Dependent** of an **Employee**, member, or **Subscriber**.
   b. Second, the **Benefits** under the continuation coverage.

   If the other **Plan** does not have the rule described in subparagraph a. above, and if, as a result, the **Plans** do not agree on the order of **Benefits**, this paragraph 5. is ignored.

6. 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.

C. 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**:

1. The **Benefits** that would be payable for the **Allowable Expenses** under the **GHIP** in the absence of this COB provision; and
2. 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 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**.

D. 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.

E. Facility of Payment

A payment made under another **Plan** may include an amount which 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.

F. 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:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

G. Subrogation

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

1. The third party or any liability or other insurance covering the third party;
2. The **Participant's** own uninsured motorist insurance coverage;
3. Under-insured motorist insurance coverage; and
4. Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

The **Health Plan'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 **Health Plan's** or **ETF's** prior written consent shall be deemed to prejudice the **Health Plan's** or **ETF's** rights. Each **Participant** shall promptly advise the **Health Plan** or **ETF** in writing whenever a claim against another party is made on behalf of a **Participant** and shall further provide to the **Health Plan** or **ETF** such additional information as is reasonably requested by the **Health Plan** or **ETF**. The **Participant** agrees to fully cooperate in protecting the **Health Plan's** or **ETF's** rights against a third party. The **Health Plan** 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 **Health Plan** or **ETF** and the **Participant** over the question of whether or not the **Participant** has been "made whole", the **Health Plan** or **ETF** reserves the right to a judicial determination whether the insured has been "made whole."

In the event the **Participant** can recover any amounts, for an **Injury** or **Illness** for which the **Health Plan** or **ETF** provides **Benefits**, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability **Benefit** act, or other **Employee Benefit** act, the **Participant** shall either assert and process such claim and immediately turn over to the **Health Plan** or **ETF** the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the **Health Plan** or **ETF** in writing to prosecute such claim on behalf of and in the name of the **Participant**, in which case the **Health Plan** 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 benefit act, or other **Employee Benefit** act, as part of settlement or otherwise, the **Participant** shall reimburse the **Health Plan** or **ETF** for all amounts theretofore or thereafter paid by the **Health Plan** or **ETF** which would have otherwise been recoverable under such acts and the **Health Plan** 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 **Health Plan** 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 benefit act, or other **Employee Benefit** act.

7. Member Rights and Responsibilities

Your **Health Plan** shall comply with and abide by the Patient's Rights and Responsibilities as provided in **ETF's** annual **Open Enrollment** materials. **Health Plans** that have their own Patient's Rights and Responsibilities may use them unless there is a conflict with the **ETF's** materials. In this case, the Patient's Rights and Responsibilities which are more favorable to the **Participant** will apply.

A. New Rights to Benefits Transparency (Rules Pending)

In 2021, the U.S. Congress passed the No Surprises Act. This Act adds new rights to benefits coverage transparency, such as **Advanced Explanations of Benefits (A-EOBs),** searchable **Provider** directory requirements, and access to price comparison tools through your **Health Plan**. While the law states that these rights are effective January 1, 2022, the federal government is still writing the rules that your **Health Plan** must follow to comply with the new requirements. Your **Health Plan** will notify you when each of these new services or features become available. In the meantime, you can check out https://etf.wi.gov/no-surprises-act to find more information on the provisions of the law and any updates on when changes will be implemented.

B. Disenrollment Due to Fraud

No person other than a **Participant** is eligible for health **Benefits** under this policy. The **Subscriber's** rights to group health **Benefits** coverage is forfeited if a **Participant** assigns or transfers such rights or aids any other person in obtaining **Benefits** to which they are not entitled, or otherwise fraudulently attempts to obtain **Benefits**. Coverage terminates the beginning of the month following action of the **Board**. Re-enrollment is possible only if the person is employed by an **Employer** where the coverage is available and is limited to occur during the annual **Open Enrollment** period. Re-enrollment options may be limited under the **Board's** authority.

The **Board** may forfeit a **Subscriber's** rights to participate in the **GHIP** if a **Participant** fraudulently or inappropriately assigns or transfers rights to an ineligible individual, aids any other person in obtaining **Benefits** to which they are not entitled, or otherwise fraudulently attempts to obtain **Benefits**.

ETF may at any time request such documentation as it deems necessary to substantiate **Subscriber** or **Dependent** eligibility. Failure to provide such documentation upon request may result in the suspension of **Benefits**.

The **Health Plan** shall report to **ETF** any suspected or identified **Participant** fraud. The **Health Plan** must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the **ETF**. Fraud may result in the reprocessing of claims and recovery of overpayments.

C. Enrollment Change Due to Member Behavior

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 **PCP**,

disenrollment efforts may be initiated by the **Health Plan** or the **Board**. The **Subscriber's** disenrollment is effective the first of the month following completion of the **Grievance** process and approval of the **Board**. Coverage and enrollment options may be limited by the **Board**.

D. Right to Obtain and Provide Information

Each **Participant** agrees that the **Health Plan** and/or **PBM** may obtain from the **Participant's** health care **Providers** the information (including medical records) that is reasonably necessary, relevant and appropriate for the **Health Plan** and/or **PBM** to evaluate in connection with its treatment, payment, or health care operations. Each person claiming **Benefits** must, upon request by the **Health Plan**, provide any relevant and reasonably available information which the **Health Plan** believes is necessary to determine **Benefits** payable. Failure to provide such information may result in denial of the claim at issue.

Each **Participant** agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the **Health Plan** and/or **PBM** but also disclosures to:

1. Health care **Providers** as necessary and appropriate for treatment;
2. Appropriate **ETF Employees** as part of conducting quality assessment and improvement activities, or reviewing the **Health Plan's** or **PBM's** claims determinations for compliance with contract requirements, or other necessary health care operations; and
3. The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

E. Physical Examination

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

F. Proof of Claim

It is the **Participant's** responsibility to notify their **Providers** of participation in the **Health Plan** and **PBM**.

The **Participant's** failure to notify an **In-Network Provider** of membership in the **GHIP** may result in claims not being filed on a timely basis (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network Provider** may provide covered services). This could result in a delay in the claim being paid.

If a **Participant** received allowable covered services (in most cases only emergencies or urgent care) from an **Out-of-Network Provider** outside the **Service Area**, the **Participant** must obtain and submit an itemized bill and submit to the **Health Plan** clearly indicating the **Provider's** name and address (for **Access Plan** or other **PPO Plan Participants**, an **Out-of-Network**

Provider may submit claims for covered services to the vendor). If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of the claim.

Claims for services must be submitted to the **Health Plan** and/or **PBM** within 12 months, or later, as determined by the **Department** as soon as reasonably possible after the services are received. If the **Health Plan** and/or **PBM** does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the **Health Plan** and/or **PBM** may deny coverage of the claim.

8. Grievances and Appeals

A. Grievance Process

All participating **Health Plans** and the **PBM** are required to make a reasonable effort to resolve **Participants'** problems and complaints. If the **Participant** has a complaint regarding the **Health Plan**'s and/or **PBM's** administration of these **Benefits** (for example, denial of claim or **Referral**), the **Participant** should contact the **Health Plan** and/or **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 **Health Plan** and/or **PBM**. Contact the **Health Plan** and/or **PBM** for specific information on its **Grievance** procedures.

If the **Participant** exhausts the **Health Plan's** and/or **PBM's Grievance** process and remain dissatisfied with the outcome, the **Participant** may appeal to the **ETF** by completing an ETF Insurance Complaint form (ET-2405). The **Participant** should also submit copies of all pertinent documentation including the written determinations issued by the **Health Plan** and/or **PBM**. The **Health Plan** and/or **PBM** will advise the **Participant** of their right to appeal to the **ETF** within 60 calendar days of the date of the final **Grievance** decision letter from the **Health Plan** and/or **PBM**. Ombudsperson Services can provide additional information and assistance with this process.

However, the **Participant** may not appeal to **ETF** issues which do not arise under the terms and conditions of this **Certificate**, for example, determination of 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 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 **Health Plan** and/or **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.

B. Appeals to the Group Insurance Board

After exhausting the **Health Plan's** or **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 which do not arise under the terms and conditions of this **Certificate**, for example, determination of 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 external review process available under applicable federal or State law. These appeals are reviewed only to determine whether the **Health Plan** and/or **PBM** breached its contract with the **Board**.

Medicare Plus
Certificate of Coverage
Insured by UnitedHealthcare

2026 State of Wisconsin Group Health Insurance Program

ET-4113 Revised 4/3/2025

TABLE OF CONTENTS

MEDICARE PLUS Coverage

Medicare Plus BENEFITS

This is the CERTIFICATE OF COVERAGE for MEDICARE PLUS BENEFITS and applies to PARTICIPANTS enrolled in MEDICARE PLUS. PARTICIPANTS covered under this section should be enrolled in MEDICARE Parts A and B. If they are not, they will have greater out-of-pocket costs for BENEFITS as shown in Section 9. Exclusions, c. and p.

PARTICIPANTS who are employed with a State or participating Wisconsin Public Employer (Local) employer are not eligible to enroll in MEDICARE PLUS. Retired State or participating Local PARTICIPANTS who are over age 65 and/or are eligible for MEDICARE are eligible to enroll.

A PARTICIPANT insured on a State or participating Local retiree policy who is enrolled in the ACCESS PLAN or SMP, loses that coverage with MEDICARE eligibility and automatically becomes a PARTICIPANT under the MEDICARE PLUS coverage.

All BENEFITS are paid according to the terms of the contract. The Schedule of Benefits below describes certain essential dollar or visit limits of a PARTICIPANT'S coverage and certain rules, if any, a PARTICIPANT must follow to obtain covered services. In some situations (for example, additional services received from a NON-PARTICIPATING PROVIDER), BENEFITS will be paid according to the USUAL AND CUSTOMARY CHARGES.

The Group Insurance Board contracts with a PHARMACY BENEFIT MANAGER (PBM) to provide prescription drug BENEFITS. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Pharmacy Benefits for those who are covered under the HEALTH BENEFIT PROGRAM.

1. Definitions

The following additional definitions apply to the MEDICARE PLUS BENEFITS:

ACCESS PLAN: means the nationwide Preferred Provider Organization (PPO) BENEFIT PLAN offering available to all Participants. Participants may use In-Network or Out-of-Network Providers for covered services.

AMBULATORY SURGERY CENTER (ASC): means an outpatient free-standing facility where surgeries are performed that allows patients to go home the same day. In most cases, ambulatory surgical centers release patients within 24 hours. ASCs might be part of a HOSPITAL system, but they are not usually physically attached to a HOSPITAL. ASCs might also be known as Surgery Centers or Outpatient Surgery Centers.

ANNUITANT: Means a retiree of the Wisconsin Retirement System. See SUBSCRIBER for more information.

ASSIGNMENT: Means that a PARTICIPANT'S physician or health care PARTICIPATING PROVIDER agrees (or is required by law) to accept the MEDICARE-approved amount as full payment for covered health care services.

BALANCE BILL: Means seeking to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against a PARTICIPANT or any person acting on the PARTICIPANT'S behalf for health care costs for which the PARTICIPANT is not liable. The prohibition on recovery does not affect the PARTICIPANT'S liability for any deductibles, coinsurance, or copayments, or for PREMIUM owed under the HEALTH BENEFIT PROGRAM.

BENEFIT PERIOD: Means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 DAYS.

BENEFIT PLAN: Means the package of coverage and cost-sharing levels that you are enrolled in under the State of Wisconsin GHIP.

BENEFITS: Means the services that are paid for as a part of your coverage under the GHIP.

BOARD: Means the Group Insurance Board.

BUSINESS DAY: means each calendar day except Saturday, Sunday, and official State of Wisconsin holidays, as listed under Wis. Stat. § 230.35(4)(a).

CERTIFICATE OF COVERAGE: Means this document, which may be updated as required by the DEPARTMENT, and includes details on the services that are covered by your BENEFIT PLAN under the GHIP.

CHARGES: Means the reasonable charges for items or services set by MEDICARE. The HEALTH PLAN treats CHARGES for stays in a HOSPITAL or licensed skilled nursing facility as incurred on the date of admission. The HEALTH PLAN treats all other CHARGES as incurred on the date the PARTICIPANT gets the service or item. BENEFITS are payable only up to the reasonable charge set by MEDICARE, except as stated in Section 3. BENEFITS Available, below. No agreement between the PARTICIPANT (or someone acting for the PARTICIPANT) and any other person, group, or PROVIDER of services will cause the HEALTH BENEFIT PROGRAM to pay more.

CMS: Means Centers for Medicare & Medicaid Services in the U.S. Department of Health and Human Services.

CONTINUANT: Means any SUBSCRIBER enrolled under federal COBRA or State continuation provisions.

CONFINEMENT/CONFINED: Means (a) the period of time between admission at an INPATIENT facility, or outpatient to a HOSPITAL, covered residential center, skilled nursing facility or licensed AMBULATORY SURGICAL CENTER on the advice of the PARTICIPANT'S physician; and discharge therefrom, or (b) the time spent receiving emergency care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the

same as CONFINEMENT in a skilled nursing facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The BENEFIT levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in BENEFIT levels during the CONFINEMENT.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, home care provided by family members and non-skilled personal care, like help with activities of daily living such as bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, MEDICARE doesn't pay for custodial care.

DAY(S) means calendar day(s) unless otherwise indicated.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1. Spouse.[1]
2. Child. [2, 3, 4]
3. Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse prior to age 19. [2, 3, 4]
4. Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896. [2, 3, 4]
5. Stepchild.[1, 2, 3, 4]
6. Grandchild if the parent is a DEPENDENT child. [2, 3, 4, 5]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except when:

a. An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is DEPENDENT on the

SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The HEALTH PLAN will monitor eligibility annually, notifying the DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

b. After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

[3] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 BUSINESS DAYS of the birth.

[4] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE employee of the State or participating Local employer.

[5] A grandchild ceases to be a DEPENDENT at the end of the month in which the Dependent child (parent) turns age 18.

DEPARTMENT: Means the State of Wisconsin Department of Employee Trust Funds.

E-VISIT: MEDICARE covers E-visits to allow you to talk with your provider using an online patient portal without going to the provider's office. Providers who can give these services include doctors, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, occupational therapists, speech-language pathologists; and for mental health care, providers include licensed clinical social workers, clinical psychologists, marriage and family therapists, and mental health counselors. To get an E-visit, you must request one with your doctor or other provider.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CERTIFICATE OF COVERAGE.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the HEALTH PLAN and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet

recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY.

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 Drugs and Non-Preferred Drugs before coverage applies. Drugs that are not included in the FORMULARY are not covered by the BENEFITS of the GHIP.

GRIEVANCE: Means a written complaint filed with the HEALTH PLAN and/or PBM concerning some aspect of the HEALTH PLAN and/or PBM.

GROUP HEALTH INSURANCE PROGRAM (GHIP): Means the BENEFITS program offered by the Group Insurance Board that provides medical, pharmacy, and wellness BENEFITS to enrolled current and former public workers.

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.

HEALTH PLAN: means the health insurer that is under contract with the BOARD to provide BENEFITS and services to PARTICIPANTS in the GHIP.

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

b. Qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission (formerly known as the Joint Commission on 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 conditions which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses.

INPATIENT: Means semi-private hospital rooms, meals, general nursing, drugs (including methadone to treat an Opioid Use Disorder), and other hospital services and supplies as part of your inpatient treatment. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, psychiatric care in inpatient psychiatric facilities, and inpatient care for a qualifying clinical research study.

This doesn’t include private-duty nursing, a television or phone in your room (if there’s a separate charge for these items), personal care items (like razors or slipper socks), or a private room, unless medically necessary.

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

LIFETIME RESERVE DAYS: Means additional DAYS that MEDICARE will pay for when the PARTICIPANT is in a HOSPITAL for more than ninety (90) DAYS. The PARTICIPANT has a total of sixty (60) LIFETIME RESERVE DAYS that can be used during their lifetime. For each LIFETIME RESERVE DAY, MEDICARE pays all covered costs except for a daily coinsurance.

LIMITING CHARGE: The highest amount of money you can be charged for a covered service by NON-PARTICIPATING PROVIDERS (doctors and other health care suppliers who don't accept assignment). When providers accept Medicare assignment, that means the PROVIDER agrees to accept the Medicare-approved amount as full payment for covered services, limiting the amount they can charge the patient. The limiting charge is 15% over MEDICARE'S approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

MEDICAID: Medicaid is a joint federal and state program that helps cover medical costs for some people with limited income and resources. Medicaid offers benefits not normally covered by MEDICARE, like nursing home care and personal care services. The rules regarding who is eligible for Medicaid are different in each state.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT (DME): Means items which are, as determined by the HEALTH PLAN:

a. Used primarily to treat an ILLNESS or INJURY, and

b. generally, not useful to a person in the absence of an ILLNESS or INJURY, and

c. the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

d. prescribed by a PROVIDER.

Note: DME is defined as equipment that meets these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Typically only useful to someone who is sick or injured
- Used in your home
- Expected to last at least 3 years

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:

a. Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

b. appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

c. not solely for the convenience of the PARTICIPANT, physician, HOSPITAL, or other health care PROVIDER, and

d. 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: Refers to 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. MEDICARE Part B refers to coverage for outpatient services. Medicare Part D refers to prescription drug coverage. The PBM provides Part D benefits.

MEDICARE PART A: In general, Medicare Part A helps pay for INPATIENT care you get in hospitals and skilled nursing facilities. It also helps cover hospice care and some home health care.

MEDICARE PART B helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)

MEDICARE PART A ELIGIBLE EXPENSES AND MEDICARE PART B ELIGIBLE EXPENSES: Means health care expenses that are covered by MEDICARE Part A or Part B, recognized as MEDICALLY NECESSARY and reasonable by MEDICARE, and that may or may not be fully reimbursed by MEDICARE.

MEDICARE PLUS: Is a fee-for-service MEDICARE supplement plan administered by the HEALTH PLAN for retirees enrolled in MEDICARE Parts A and B and pays for BENEFITS defined under this section.

NON-AFFILIATED PROVIDER: Means (1) a physician or health care PROVIDER that has decided not to provide services through MEDICARE and MEDICARE will not cover those services; or (2) a licensed health care PROVIDER who is not allowed to bill Medicare for services.

NON-PARTICIPATING PROVIDER: Means that a physician or health care PROVIDER has not signed an agreement to accept assignment for all MEDICARE covered services, but they can still choose to accept assignment for individual services.

OPEN ENROLLMENT: Means the yearly period when all members in the GHIP may make changes to their BENEFITS. The dates for this time period are set each year by the DEPARTMENT and the BOARD.

PARTICIPANT: Means a SUBSCRIBER, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for MEDICARE PLUS coverage has been made and for whom the appropriate PREMIUM has been paid.

PARTICIPATING PROVIDER: Means that a physician or health care PROVIDER that has signed an agreement to accept assignment for all MEDICARE covered services.

PHARMACY BENEFIT MANAGER (PBM): Means a third-party administrator that is contracted with the BOARD to administer the Part D prescription drug BENEFITS under the GHIP. The PBM is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

PREMIUM: Means the amount to be paid for health insurance every month.

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.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

State Maintenance Plan (SMP): means a Plan offered as a qualified tier 1 Plan, as determined by the BOARD. SMP is a Preferred Provider Organization (PPO) BENEFIT PLAN. PARTICIPANTS are encouraged to use In-Network Providers for covered services as the Out-of-Pocket costs for Out-of-Network Providers can be high, as described on the SMPdescription page. The SMP offers Uniform Benefits and the High Deductible Health Plan Uniform Benefits.

SUBSCRIBER: Means an eligible ANNUITANT or his/her surviving DEPENDENTS who have been specified by the DEPARTMENT to the BENEFIT PLAN for enrollment and who is entitled to BENEFITS.

TELEHEALTH: Medicare covers certain telehealth services you get from a doctor or other health care provider who's located elsewhere using technology to communicate with you in real time. Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and certain other medical or health services.

USUAL AND CUSTOMARY CHARGES: Means an amount for a health care service that is reasonable, as determined by the HEALTH PLAN. The HEALTH PLAN takes into consideration, among other factors (including national sources) determined by the HEALTH PLAN: (1) amounts charged by health care PROVIDERS for similar health care services when provided in the same geographical area; (2) the HEALTH PLAN'S methodology guidelines; (3) pricing guidelines of any third party responsible for pricing a claim; and (4) the negotiated rate determined by the HEALTH PLAN in accordance with the applicable contract between the HEALTH PLAN and a health care PROVIDER. As used herein, the term "area" means a county or other geographical area which the HEALTH PLAN determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. Also, the amount the HEALTH PLAN determines as reasonable may be less than the amount billed. In these situations, the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S) unless the PARTICIPANT accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services.

2. Schedule of BENEFITS

Services and Supplies	**Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)**	**Medicare Plus Pays (2025 information. Updated annually.)**
HOSPITAL Semiprivate room and board and miscellaneous HOSPITAL services and supplies such as drugs, x-rays, lab tests and operating room	First 60 DAYS, all but $1,676* 61st to 90th DAY, all but $419* per DAY 91st to 150th DAY, all but $838* per DAY (LIFETIME RESERVE) If LIFETIME RESERVE DAYS are exhausted, $0	Initial $1,676* deductible $419* per DAY $838* 100% from the 91st to 120th DAY of CONFINEMENT
Licensed Skilled Nursing Facility** MEDICARE covered services in a MEDICARE Approved Facility**	Requires a 3-DAY period of HOSPITAL stay	Requires a 3-DAY period of HOSPITAL stay

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
	First 20 DAYS, 100% of costs 21st - 100th DAYS, all but $209.50 per DAY Beyond 100 DAYS, $0	Not Applicable $209.50* per DAY All covered services up to a maximum of 120 DAYS per BENEFIT PERIOD CUSTODIAL CARE is not covered
Licensed Skilled Nursing Facility** **(Non-MEDICARE Approved Facility)** If admitted within 24 hours following a HOSPITAL stay	Covers only the same type of expenses normally covered by MEDICARE in a MEDICARE Approved Facility $0	Covers only the same type of expenses normally covered by MEDICARE in a MEDICARE Approved Facility Maximum daily rate for up to 30 DAYS per CONFINEMENT
Home Health Care** Under a doctor for part-time skilled nursing care, part-time home health aide care, physical therapy, occupational therapy, speech-language pathology services, medical social services.	100% of CHARGES for visits considered MEDICALLY NECESSARY by MEDICARE. Generally fewer than 7 DAYS a week, less than 8 hours a DAY and 28 or fewer hours per week for up to 21 DAYS.	Up to 365 visits per year

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
Hospice Care MEDICARE certified program of terminal ILLNESS care for pain relief and symptom management. Includes: nursing care; physician services; physical, occupational and speech therapy; social worker services; home health aids; homeworker services; medical supplies. First 180 DAYS and any MEDICARE approved extension	All covered services	Coinsurance or copayments for all MEDICARE Part A Eligible Expenses
Hospice Facility	All but very limited coinsurance for INPATIENT respite care	MEDICARE copayment/coinsurance up to the equivalent USUAL AND CUSTOMARY CHARGES of a skilled nursing facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance; prosthetic devices; DURABLE MEDICAL EQUIPMENT	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Physician's Services Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Telemedicine, TELEHEALTH, or E-VISIT service	After annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses

Services and Supplies	Medicare Pays per Benefit Period (2025 information. Updated annually per CMS.)	Medicare Plus Pays (2025 information. Updated annually.)
Drugs and Biologicals (non-hospitalization) Immunosuppressive drugs during the first year following a covered transplant Self-administered drugs prescribed by a physician	 After annual $257* MEDICARE deductible, 80% of allowable CHARGES Not covered	 Initial $257 deductible and 20% of MEDICARE approved expenses Refer to Pharmacy Benefit Manager portion of booklet for pharmacy BENEFITS
Outpatient Hospital Services In an emergency room or outpatient clinic, diagnostic lab and x-rays; medical supplies such as casts, splints, and drugs which cannot be self-administered	After the annual $257* MEDICARE deductible, 80% of allowable CHARGES	Initial $257* deductible and 20% of MEDICARE approved expenses
Psychiatric Treatment Other than HOSPITAL INPATIENT	After the annual $257* MEDICARE deductible, 80% of the allowable CHARGES	Initial $257* deductible and the amount, which combined with the MEDICARE BENEFIT, equals 20% of the USUAL AND CUSTOMARY CHARGES
Private Duty Nursing While hospitalized and provided by an RN or LPN	$0	$0
Blood	After annual $257* MEDICARE deductible, 80% of costs except non-replacement fees (blood deductible) 1st 3 pints in each BENEFIT PERIOD	Initial $257* deductible and 20% of MEDICARE approved expenses

* Federal MEDICARE deductibles are adjusted annually. Amounts shown above are for 2025. MEDICARE PLUS BENEFITS are also adjusted annually to pay these deductibles**.**

** CUSTODIAL CARE as defined is not covered.

3. BENEFITS Available

BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for the services and supplies described in Sections 4. through 8. below on or after the EFFECTIVE DATE according to the

terms, conditions and provisions of the CONTRACT, if those services and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by the HEALTH PLAN.

When services are provided by a NON-PARTICIPATING PROVIDER, BENEFITS are payable for amounts in excess of the MEDICARE-approved charge up to the lesser of the actual amount charged by the NON-PARTICIPATING PROVIDER and the LIMITING CHARGE.

The BENEFITS listed below will automatically change to coincide with any changes in applicable MEDICARE deductible amounts and coinsurance percentage factors.

4. Hospital INPATIENT BENEFITS

BENEFITS are payable for the MEDICARE Part A deductible during the first sixty (60) DAYS of CONFINEMENT.

a. BENEFITS are payable for the MEDICARE Part A HOSPITAL daily coinsurance from the 61st to the 90th DAY of a PARTICIPANT'S CONFINEMENT.

b. After a PARTICIPANT has been in a HOSPITAL for ninety (90) DAYS**,** MEDICARE pays an extra sixty (60) LIFETIME RESERVE DAYS during the PARTICIPANTS lifetime. BENEFITS are payable for the MEDICARE Part A HOSPITAL coinsurance for each reserve DAY used by the PARTICIPANT. If the PARTICIPANT has exhausted the LIFETIME RESERVE DAYS during a previous BENEFIT PERIOD, BENEFITS will continue to be payable for an additional thirty (30) DAYS of CONFINEMENT beginning on the 91st DAY of CONFINEMENT. The PROVIDER shall accept the HEALTH PLAN'S payment as payment in full and may not BALANCE BILL the PARTICIPANT.

c. After MEDICARE pays its one hundred ninety (190) DAY lifetime HOSPITAL INPATIENT psychiatric care BENEFITS, the BENEFIT PLAN will pay the MEDICARE PART A ELIGIBLE EXPENSES for INPATIENT psychiatric HOSPITAL care for each DAY a PARTICIPANT is confined for psychiatric care beyond the MEDICARE lifetime limit but not to exceed a lifetime limit of one hundred seventy-five (175) DAYS CONFINEMENT under the BENEFIT PLAN. BENEFITS will not exceed a total of three hundred sixty-five (365) DAYS for the PARTICIPANT'S lifetime.

d. BENEFITS are payable for the MEDICARE Part A ELIGIBLE EXPENSES for blood to the extent not covered by MEDICARE.

5. Services in a Licensed Skilled Nursing Facility

For CONFINEMENT in a licensed skilled nursing facility certified by and participating in MEDICARE, while the CONFINEMENT is covered by MEDICARE, BENEFITS are payable for such a CONFINEMENT, provided:

a. a PARTICIPANT receives care in a MEDICARE approved licensed skilled nursing facility and remains under continuous active medical supervision; and

b. the PARTICIPANT was a HOSPITAL INPATIENT for at least three (3) DAYS prior to CONFINEMENT in a licensed skilled nursing facility.

BENEFITS are payable for up to a maximum of one hundred twenty (120) DAYS per BENEFIT PERIOD beginning on the first day of admission to the licensed skilled nursing facility.

For CONFINEMENT in a licensed skilled nursing facility not participating in MEDICARE, or when the CONFINEMENT is not covered by MEDICARE, BENEFITS are payable provided the PARTICIPANT is transferred within 24 hours of release from a HOSPITAL. BENEFITS are payable up to the maximum daily rate established for SKILLED CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to thirty (30) DAYS per CONFINEMENT. BENEFITS are payable only if the attending physician certifies that the SKILLED CARE MEDICALLY NECESSARY. The physician must recertify this every seven (7) DAYS. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without charge or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

6. Hospice Care

The HEALTH PLAN shall pay a PARTICIPANT'S coinsurance or copayments for all MEDICARE Part A ELIGIBLE EXPENSES for Hospice Care and respite care. Hospice Care is available as long as the PARTICIPANT'S physician certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of MEDICARE.

7. Professional and Other Services

MEDICARE PLUS shall pay the MEDICARE Part B deductible and all MEDICARE Part B Eligible Expenses, to the extent not paid by MEDICARE, or in the case of HOSPITAL outpatient department services paid under a prospective payment system, the copayment amount, for the following services:

a. Cataract lenses following cataract surgery and one pair of eyeglasses with standard frames (or one set of contract lenses) after cataract surgery that implants an intraocular lens.

b. Chemotherapy in a physician's office, freestanding clinic or HOSPITAL outpatient setting.

c. Prescription drugs covered by MEDICARE such as injections that can't be self-administered that a PARTICIPANT receives in a physician's office, certain oral cancer drugs, drugs used with some types of DURABLE MEDICAL EQUIPMENT, and under very

limited circumstances, certain drugs a PARTICIPANT receives in a HOSPITAL outpatient setting.

d. Physical therapy, speech-language pathology services and occupational therapy when recommended by a physician.

e. Oxygen and rental of equipment and supplies for its administration.

f. Professional licensed ambulance service necessary to transport a PARTICIPANT to or from a HOSPITAL or licensed skilled nursing facility. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a physician as being MEDICALLY NECESSARY.

g. Medical Supplies prescribed by a physician.

h. Rental of or purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, walkers and hospital-type beds.

i. Outpatient cardiac rehabilitation services.

j. Facility fees for approved surgical procedures in an AMBULATORY SURGICAL CENTER.

k. Blood processing and handling services for every unit of blood a PARTICIPANT receives.

l. Chiropractic services limited to those services to help correct a subluxation using manipulation of the spine. BENEFITS are not payable for any other services or tests ordered by a chiropractor (including x-rays or massage therapy).

m. X-rays, MRIs, CT scans, EKGs, and other diagnostic tests, other than laboratory tests.

n. Diabetes supplies and self-management training.

o. Physician services that are MEDICALLY NECESSARY or provided in connection with preventive services covered by MEDICARE. BENEFITS are also payable for services provided by health care PROVIDERS, such as physician assistants, nurse practitioners, social workers, and psychologists.

p. Foot exams and treatment if a PARTICIPANT has diabetes-related nerve damage and/or meets certain conditions determined by MEDICARE.

q. Kidney dialysis services and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, BENEFITS are

also payable for CHARGES for kidney disease education services prescribed by a physician.

r. Outpatient mental health care services. Coverage includes services generally provided in an outpatient setting, including visits with a psychiatrist or other physician, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker.

s. Outpatient HOSPITAL services, outpatient medical and surgical services and supplies.

t. Prosthetic and orthotic items including arm, leg, back and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part of function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a physician or other health care PROVIDER.

u. Pulmonary rehabilitation programs if a PARTICIPANT has moderate to severe chronic obstructive pulmonary disease prescribed by a physician.

v. Services for treatment of a surgical or surgically treated wound.

w. Tobacco smoking cessation counseling if a PARTICIPANT is diagnosed with an ILLNESS caused or complicated by tobacco use or takes a medicine that is affected by tobacco.

x. Physician services for heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a MEDICARE-certified facility. Also covered are immunosuppressive drugs if the transplant was eligible for MEDICARE payment, or an employer or union group health plan was required to pay before MEDICARE paid for the transplant.

y. Glaucoma tests once every twelve (12) months for PARTICIPANTS at high risk for glaucoma.

z. Telehealth services.

8. Additional Services

Foreign Travel. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for MEDICALLY NECESSARY health care services received by a PARTICIPANT in a foreign country.

Immunizations. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for immunizations not covered by MEDICARE.

Chiropractic Services. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for chiropractic services provided by a chiropractor within the scope of his/her license and not covered by MEDICARE per Wis. Stat. 632.875.

Home Care. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES for home care services described below:

a. **Covered Services**. Home Care Sections 8.a. and 8.b. apply only if charges for home care services are not covered elsewhere under the CERTIFICATE OF COVERAGE. A state licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the home care services. A PARTICIPANT should make sure the agency meets this requirement before services are provided. BENEFITS are payable for CHARGES for the following services when MEDICALLY NECESSARY for treatment:

   i. Part time or intermittent home nursing care by or under supervision of a registered nurse;
   ii. Part time or intermittent home health aide services when MEDICALLY NECESSARY as part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
   iii. Physical, respiratory, occupational or speech therapy;
   iv. Medical Supplies, prescription drugs and Biologicals prescribed by a physician required to be administered by a professional PROVIDER; laboratory services by or on behalf of a HOSPITAL, if needed under the home care plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;
   v. Nutrition counseling provided or supervised by a registered dietician;
   vi. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending physician must request or approve this evaluation.

   Note: MEDICARE BENEFITS will not be duplicated.

b. **Limitations**. The following limitations apply to Home Care services:

   i. Home care is not covered unless the PARTICIPANT'S attending physician certifies that: (a) hospitalization or CONFINEMENT in a licensed skilled nursing facility would be needed if the PARTICIPANT didn't have home care; and (b) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;
   ii. If the PARTICIPANT was hospitalized just before home care started, the PARTICIPANT'S physician during the PARTICIPANT'S HOSPITAL stay must also approve the home care plan;
   iii. BENEFITS are payable for CHARGES for up to three hundred sixty-five (365) home care visits in any 12-month period per PARTICIPANT. Each visit by a person providing

services under a home care plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide service counts as one home care visit.

iv. If home care is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has home care coverage under the BENEFITS and another source;

v. The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED CARE in a licensed skilled nursing facility, as determined by the HEALTH PLAN.

Wellness. SUBSCRIBERS and their insured spouses may use Renew Active, a fitness program that includes access to a free gym membership at in-network gyms.

Equipment and Supplies for Treatment of Diabetes. BENEFITS are payable at 100% of the USUAL AND CUSTOMARY CHARGES incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and USUAL AND CUSTOMARY CHARGES for diabetic self-management education programs. This BENEFIT is limited to the purchase of one pump per calendar year. The PARTICIPANT must use the pump for at least thirty (30) DAYS before the pump is purchased. MEDICARE BENEFITS won't be duplicated.

Benefits for Kidney Disease. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for INPATIENT, outpatient, and home treatment of kidney disease, if not covered elsewhere under the HEALTH BENEFIT PROGRAM. These services must be necessary for a PARTICIPANT'S diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There is a maximum of $30,000 per year for these BENEFITS. The HEALTH PLAN will not pay for any CHARGES paid for, or covered by, MEDICARE.

Breast Reconstruction. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for breast reconstruction of the affected tissue incident to a mastectomy.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care. BENEFITS are payable for USUAL AND CUSTOMARY CHARGES for HOSPITAL or AMBULATORY SURGERY CENTER CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided in a HOSPITAL or AMBULATORY SURGERY CENTER, if any of the following applies:

a. The PARTICIPANT is a child under the age of 5;

b. The PARTICIPANT has a chronic disability that meets all of the conditions under s. 230.04(9r) (a) 2. a., b. and c., Wisconsin Statutes; or

c. The PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

Health Care Services Provided by a Non-Affiliated Provider. If a PARTICIPANT receives services from a NON-AFFILIATED PROVIDER, BENEFITS will be payable for USUAL AND CUSTOMARY CHARGES for those services provided the services are covered under this Section.

9. Exclusions

The following services are excluded from BENEFITS, except as otherwise specifically provided:

a. Health care services MEDICARE does not cover, unless the HEALTH BENEFIT PROGRAM specifically provides for them.

b. Health care services which neither a PARTICIPANT nor a party on the PARTICIPANT'S behalf has a legal obligation to pay in the absence of insurance.

c. Health care services to the extent that they are paid for by MEDICARE or would have been paid for by MEDICARE if a PARTICIPANT is enrolled in MEDICARE Parts A and B; health care services to the extent that they are paid for by another government entity or program, directly or indirectly. This means that except in cases of fraud, if the PARTICIPANT either does not enroll in MEDICARE Parts A and B at the time the PARTICIPANT enrolls in a MEDICARE coordinated BENEFIT PLAN and when MEDICARE is first available as the primary payer, or if the PARTICIPANT cancels MEDICARE coverage, the PARTICIPANT'S coverage will be limited, and the PARTICIPANT will be responsible for any costs that MEDICARE would have paid.

d. Personal comfort items. Examples include: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

e. CUSTODIAL CARE, including maintenance care and supportive care.

f. Cosmetic surgery.

g. Health care services received by a PARTICIPANT before his/her coverage becomes effective or after coverage ends.

h. Health care services that are deemed unreasonable and unnecessary by MEDICARE. This includes, but is not limited to, the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services including drugs or devices, not considered safe and effective because they are EXPERIMENTAL or investigational except for the HIV drugs as described in Section 632.895(9) Wis. Stat. as amended.

i. Health care services received outside the United States, except as specifically stated in Section 8. Additional Services.

j. Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in this MEDICARE PLUS BENEFITS - CERTIFICATE OF COVERAGE.

k. Health care services that are not MEDICALLY NECESSARY as determined by the HEALTH PLAN, except for such health care services that MEDICARE covers.

l. Routine physical exams and any related diagnostic X-ray and laboratory tests not covered by MEDICARE.

m. Private duty nursing.

n. Routine dental care.

o. Hearing aids; exams for fitting of hearing aids.

p. Services to the extent the PARTICIPANT is eligible for all MEDICARE BENEFITS, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

10. Miscellaneous Provisions

a. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the HEALTH PLAN and/or PBM may obtain from the PARTICIPANT'S health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the HEALTH PLAN and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming BENEFITS must, upon request by the HEALTH PLAN, provide any relevant and reasonably available information which the HEALTH PLAN believes is necessary to determine BENEFITS payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters to the HEALTH PLAN and/or PBM but also disclosures to:

i. Health care PROVIDERS as necessary and appropriate for treatment,

ii. Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the HEALTH PLAN'S or PBM'S claims determinations for compliance with contract requirements, or other necessary health care operations,
iii. The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

b. Physical Examination

The HEALTH PLAN, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine their eligibility for claimed services or BENEFITS (including, without limitation, issues relating to subrogation and coordination of BENEFITS). By execution of an application for coverage under the HEALTH BENEFIT PROGRAM, each PARTICIPANT shall be deemed to have waived any legal rights they may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

c. Case Management/Alternate

The HEALTH PLAN may employ professional staff to provide case management services. As part of this case management, the HEALTH PLAN or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

i. The recommended treatment offers at least equal medical therapeutic value, and
ii. The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and
iii. The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the HEALTH PLAN agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the HEALTH PLAN'S recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which BENEFITS are not otherwise payable (for example, biofeedback, acupuncture), payment of BENEFITS will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

d. Disenrollment

No person other than a PARTICIPANT is eligible for BENEFITS. The SUBSCRIBER'S rights to 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 the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during

the annual 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.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the BOARD. Coverage and enrollment options may be limited by the BOARD.

e. Recovery of Excess Payments

The HEALTH PLAN and/or PBM might pay more than the HEALTH PLAN and/or PBM owes under this AGREEMENT. If so, the HEALTH PLAN and/or PBM can recover the excess from the PARTICIPANT. The HEALTH PLAN and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the HEALTH PLAN and/or PBM.

Each PARTICIPANT agrees to reimburse the HEALTH PLAN and/or PBM for all payments made for BENEFITS to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the HEALTH PLAN and/or PBM. At the option of the HEALTH PLAN and/or PBM, BENEFITS for future CHARGES may be reduced by the HEALTH PLAN and/or PBM as a set-off toward reimbursement.

f. Limit on Assignability of BENEFITS

A PARTICIPANT cannot assign any benefit to another person other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for the PARTICIPANT.

g. Severability

If any part of the policy is ever prohibited by law, it will no longer apply. The rest of the policy will continue in full force.

h. Subrogation

Each PARTICIPANT agrees that the payer under MEDICARE PLUS plan, whether that is the HEALTH PLAN or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the BENEFITS the HEALTH PLAN provides under this AGREEMENT, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The HEALTH PLAN'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

i. The third party or any liability or other insurance covering the third party.
ii. The PARTICIPANT'S own uninsured motorist insurance coverage.
iii. Under-insured motorist insurance coverage.
iv. Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the HEALTH PLAN or DEPARTMENT to such extent.

The HEALTH PLAN'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the HEALTH PLAN'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the HEALTH PLAN'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the HEALTH PLAN or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the HEALTH PLAN or DEPARTMENT such additional information as is reasonably requested by the HEALTH PLAN or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the HEALTH PLAN'S or DEPARTMENT'S rights against a third party. The HEALTH PLAN or DEPARTMENT 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 HEALTH PLAN or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the HEALTH PLAN or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an ILLNESS or INJURY for which the HEALTH PLAN or DEPARTMENT provides BENEFITS, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT 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 the policy, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT

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 the. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for BENEFITS under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

i. Proof of Claim

It is the PARTICIPANT'S responsibility to notify their PROVIDER of the PARTICIPANT'S participation in the MEDICARE PLUS plan. Failure to do so could result in a delay in the PARTICIPANT'S claim being paid.

If the services were received outside the United States, the PARTICIPANT must indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of the PARTICIPANT'S claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the HEALTH PLAN and/or PBM does not receive the PARTICIPANT'S claim within twelve (12) months, or if later, as soon as reasonably possible, after the date the service was received, the HEALTH PLAN and/or PBM may deny coverage of the claim.

j. GRIEVANCE Process

The HEALTH PLAN and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If the PARTICIPANT has a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of BENEFITS (for example, denial of claim or referral), the PARTICIPANT should contact the HEALTH PLAN and/or 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 HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If the PARTICIPANT exhausts the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remains dissatisfied with the outcome, the **Participant** may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form (ET-2405). The PARTICIPANT should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise the PARTICIPANT of the right to appeal to the DEPARTMENT within sixty (60) DAYS of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM. Ombudsperson Services can provide additional information and assistance with this process.

However, the PARTICIPANT may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions, for example, determination of MEDICALLY

NECESSARY care, appropriate care, 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 or Independent Review Process. The PARTICIPANT may request an external review pursuant to federal law. In this event, the PARTICIPANT must notify the HEALTH PLAN and/or PBM of their request. In accordance with federal law, any decision by an HHS-administered federal external review is final and binding. The PARTICIPANT shall have no further right to administrative review once the external review decision is rendered.

k. Appeals to the BOARD

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the BOARD, unless an HHS-administered federal 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 which do not arise under the terms and conditions of BENEFITS under this CERTIFICATE OF COVERAGE, for example, determination of MEDICALLY NECESSARY care, appropriate care, 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. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the BOARD.

Group Health Insurance Program for Members

Health Plan

Schedule of Benefits for

Effective January 1, 2026

State of Wisconsin Retirees with Medicare	Local Traditional Plan Employees/Retirees/COBRA (PO2/12)	Local Retirees with Medicare* Including LAHP (PO6/16, 7/17, 08)

***Note:** This Schedule of Benefits does not apply to Local Deductible Health Plan (PO4/14) retirees.*

The Schedule of Benefits explains what medical services the Group Health Insurance Program (GHIP) covers and what you pay for covered services. See your Uniform Benefits Certificate of Coverage (ET-2180) for complete coverage details. The Schedule of Benefits is divided into the following sections:

Annual Limits

Annual Medical Deductible

The amount you would owe during a coverage period (usually one year) for covered health care services before your plan begins to pay.

Individual: $0

Family: $0

Annual Medical Coinsurance

The percentage of costs for a covered service.

You pay: $0

Does not apply to:

- × Durable Medical Equipment & Medical Supplies which has 20% coinsurance, up to $500 per person

Annual Medical Out-of-Pocket Limit (OOPL)

The most you would pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Individual: $500 per person for Durable Medical Equipment & Medical Supplies

Family: (See above)

- This Plan uses a provider network. You may have no coverage or have greater out-of-pocket costs if you get care outside of the plan's provider network. Check your provider directory before you receive services.
- The OOPL is for Durable Medical Equipment & Medical Supplies only and applies per person enrolled in the plan.

Applies to:

✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

× Prescription drugs

Annual Maximum Out-of-Pocket Limit (MOOP)

This is the yearly amount set by the federal government as the most an Individual or Family is required to pay in cost sharing during the plan year for covered, in-network services.

Individual: $10,150

Family: $20,300

- The most you would pay for services you receive from in-network providers. Your out-of-pocket costs for services received from in-network providers will count toward this limit.
- The MOOP is embedded for family plans – no one family member will contribute more than the individual amount to the family MOOP.

Covered Services

Commonly used services appear below. This is not a complete list. If you have questions about other specific benefits, contact your health plan.

Ambulance

Also known as paramedic services, these are emergency services that provide urgent pre-hospital treatment and stabilization for serious illness, injuries, and transport to definitive care.

You pay: $0

Chiropractic Care

Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). This also includes Occupational therapy (helping with daily living tasks caused from illnesses and injuries to your brain and body).

You pay: $0

× Maintenance visits are not covered.

Cochlear Implant Devices – Under Age 18

An electronic device that partially restores hearing. For coverage for participants over the age of 18, see Cochlear Implant Devices – Over Age 18 in the Additional Covered Services section.

You pay: $0

✓ Includes all charges related to implantation surgery and follow-up training sessions.

Diagnostic Services and Labs

Tests to figure out what your health problem is. Make sure to verify anticipated costs with your provider prior to receiving services. Note: some advanced imaging like MRI or CT scans may require prior authorization.

You pay: $0

Covered diagnostic services include:

- ✓ Diagnostic radiology (x-rays, PET, MRI, MRA, and CT scans)
- ✓ Lab tests

Durable Medical Equipment and Medical Supplies

Equipment and supplies ordered by a health care provider for everyday or extended use.

You pay: 20% coinsurance, up to $500 per person

- ✓ Includes Durable Diabetic Equipment and related Medical Supplies. May include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
- ✓ Intraoral splints for treatment of TMJ disorder

Does not apply to the following. See Additional Covered Services.

- × Adult hearing aids
- × Adult cochlear implant devices
- × Dental implants

Emergency and Urgent Care

Certain medical conditions require expedited medical care. You can work with your provider to determine the best level of care to meet your urgent or emergent needs.

Emergency Care

Care for a life-threatening illness, injury, or condition that requires immediate attention. You should seek care at an in-network Emergency Room whenever possible.

You pay: $60 copayment per visit

- The copayment is waived if you are admitted as an inpatient or for observation for 24 hours or more.
- You may be responsible for other charges in addition to the visit copayment. See Durable Medical Equipment and Medical Supplies for more details on items that may be prescribed for you to take home.

Urgent Care Visit

Care for an illness, injury, or condition serious enough that it requires attention within 24 hours but is not life-threatening. You should seek care at an in-network Urgent Care whenever possible.

You pay: $0

Hearing Aids – Under Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants over the age of 18, see Hearing Aids – Over Age 18 in the Additional Covered Services section

You pay: $0

Home Care Benefits

Medically necessary nursing care, home health aide services, and other home care benefits provided by a medical professional at home as part of a care plan.

You pay: $0

- Up to 50 visits per participant per calendar year
- Your plan may review your first 50 visits to verify progress is being made
- Up to a maximum of 50 additional visits per participant, per calendar year may be available with prior authorization from your health plan

Inpatient Hospital Services

Services necessary for your admission to a hospital, as well as diagnosis and treatment.

You pay: $0

- Your health plan may require prior authorization for hospital and/or inpatient services.
- This includes inpatient hospitalization for medical and/or mental health needs.
- Your plan covers a semi-private room, ward, or intensive care unit, as well as any medically necessary miscellaneous hospital expenses, including prescription drugs administered during the confinement.
- Private rooms are only covered if medically necessary, as determined by your health plan.

Mental Health Counseling Visits

These services include behavioral health, psychiatric counseling, and substance use disorder services.

You pay: $0

Applies to:

- ✓ Individual therapy office visits
- ✓ Outpatient groups
- ✓ Telehealth visits

Occupational, Physical, and Speech Therapy

Physical therapy (PT) involves treatments for the prevention and management of injuries or disabilities. PT helps to relieve pain, promote health, and restore function/movement. This includes Occupational therapy (OT), which helps with daily living tasks caused from illnesses and injuries to the brain and body; and Speech/Language therapy (ST), which helps to relearn how to communicate and swallow to prevent aspiration.

You pay: $0

- Up to 50 visits per participant for all therapies combined per calendar year.
- Up to a maximum of 50 additional visits per therapy, per participant, per calendar year may be available with prior authorization from your health plan.

Applies to:

- ✓ Comprehensive outpatient rehabilitation facility visits
- ✓ Hospital outpatient department visits
- ✓ Independent therapist office visits

Outpatient Cardiac Rehabilitation

Rehabilitation following an inpatient hospital stay for a heart attack, bypass surgery, angina, heart valve surgery, angioplasty, or heart transplant.

You pay: $0

Outpatient Hospital & Ambulatory Surgery Center Services

Services necessary for your admission to an outpatient hospital or Ambulatory Surgery Center, as well as diagnosis and treatment.

You pay: $0

- You may be prescribed Durable Medical Equipment and Medical Supplies to be taken home during an outpatient hospital facility visit, which could be billed separately and subject to coinsurance.

Preventive Care Services

Routine health care, including screening, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems – as required by federal law. Federal law specifies at what age and how frequently a service can be paid with no cost to you. See healthcare.gov/preventive-care-benefits for more details.

You pay: $0

- Services for specific conditions found during a preventive exam may be subject to the Durable Medical Equipment & Medical Supply coinsurance.
- Your preventive check-up can be used to fulfill activities for the annual Well Wisconsin incentive program. See https://etf.wi.gov/well-wisconsin-members for more details.

The plan covers the following federally required preventive services including but not limited to:

- ✓ Alcohol misuse counseling
- ✓ Breast cancer screening (mammogram)
- ✓ Cholesterol screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ HIV screening
- ✓ Immunizations, including flu, hepatitis A & B, pneumococcal and other shots
- ✓ Obesity screening and counseling
- ✓ Blood pressure screening
- ✓ Cervical cancer screening
- ✓ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- ✓ Hepatitis C screening
- ✓ Lung cancer screening
- ✓ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- ✓ Well child exam

Primary Care

Primary care includes preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. Your primary care provider (PCP) or primary care clinic (PCC) will provide or arrange for most of your health care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

You pay: $0

- You must select a PCP or PCC at the time or enrollment or when you change health plans; your PCP may be a physician, physician assistant, nurse practitioner, or any other provider that manages your primary care services.
- If you do not choose a PCP or PCC, or your selection is no longer available, your health plan will assign a PCP or PCC for you.
- Contact your health plan directly to change your current PCP or PCC selection.

Skilled Nursing Facility

Admission to a licensed Skilled Nursing Facility for continued treatment after a hospital stay.

You Pay: $0

✓ Up to 120 calendar days per benefit period

Telemedicine and Remote Care

Certain telehealth and remote care services are covered. These remote services should maintain the quality, safety, and effectiveness of an in-person visit. You should work with your provider to determine the best technology solution(s) to meet your care needs.

E-Visit

An evaluation and treatment by a provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An E-Visit is also called a digital visit or a virtual visit.

You pay: $0

- Must be initiated by the member seeking services, not the provider, in order to be covered.
- E-Visits are covered when the same service would be covered if provided in person when performed by one of the following provider types:
  - Doctor
  - Nurse practitioner
  - Physician assistant
  - Licensed clinical social worker
  - Clinical psychologist or psychiatrist
  - Occupational therapist
  - Speech / language pathologist

Telehealth

Telehealth is a service delivered via real-time audio and video. Telehealth may also be called telemedicine, online or virtual evaluation and management, or a video visit. Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care provider who is located elsewhere using interactive two-way, real-time audio and video technology. Telehealth can be provided in your home, as well as at a health care facility.

You pay: $0

- Telehealth will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.

If you and your provider determine that you cannot successfully complete a Telehealth visit with full audio and video, you may opt to change to a Telephone Visit.

Telephone Visit

Telephone Visit is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

You pay: $0

- Telephone visits will be covered if the provider can successfully provide the service without a reduction in quality, safety, or effectiveness.

Remote Patient Monitoring

Remote Patient Monitoring is a series of services whereby a provider collects and interprets a person's physiologic data that is sent digitally to support treatment and management of medical conditions.

You pay: $0 for initial setup of device including patient education

- Device must meet home-use medical device as defined by the Food and Drug Administration and be provided as part of the monitoring service.
- Devices are provided as a lease; they cannot be lease-to-own, purchased to own, or already owned.

Virtual Check-In

A brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than Telehealth, Telephone Visits, or E-Visits.

You pay: $0

- Covered as a Virtual Check-In as long as the check-in is not related to another medical visit within the past 7 days, and as long as the check-in does not lead to a medical visit within the next 24 hours or the next available appointment.

Vision Services

Yearly eye exam to diagnose and treat diseases and conditions of the eye. Does not include frames or any other vision related expenses. For supplemental vision coverage, including prescription glasses and contacts, see the Supplemental Vision Benefit.

You pay: $0

- Coverage is limited to one eye exam per participant per calendar year
- Non-routine eye exams are covered if considered medically necessary by your health plan
- Child vision screenings:
  - Under age 5 – Federally covered and considered preventive are not subject to deductible or copayment
  - Age 6 or older – Not considered preventive, subject to provider and specialist provider office visit copayment

Additional Covered Services

Cochlear Implant Devices – Over Age 18

An electronic device that partially restores hearing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.

You pay: 20% coinsurance for implant devices, professional surgery for implantation, and follow-up device training

0% coinsurance for hospital services

Applies to:

✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

× Annual Out-of-Pocket Limit (OOPL)

Dental Implants

Dental implants are artificial tooth roots placed in the jaw to hold a replacement tooth or bridge after the loss of a tooth or teeth.

You pay: $0

- × Dental implants are only covered following accident or injury.
- × Maximum benefit plan payment of $1,000 per tooth.

Applies to:
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:
- × Annual Out-of-Pocket Limit (OOPL)

Hearing Aids – Over Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants under the age of 18, see Hearing Aids – Under Age 18 in the Covered Services section.

You pay: 20% coinsurance

- One hearing aid per ear, no more than once every 3 years.
- Maximum benefit plan payment of $1,000 per hearing aid.

Applies to:
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:
- × Annual Out-of-Pocket Limit (OOPL)

Temporomandibular Joint Disorders – Diagnosis and Non-Surgical Treatment

Coverage for diagnostic procedures and medically necessary surgical or non-surgical for the correction of temporomandibular disorders, provided all coverage criteria are met.

You pay: $0

- Maximum benefit plan payment of $1,250 per participant per plan year

Applies to:
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:
- × Annual Out-of-Pocket Limit (OOPL)

Dental, Pharmacy, and Supplemental Plans

Dental Benefit

The Uniform and Preventive Dental Benefit provides coverage for basic procedures such as cleanings, fluoride treatments, fillings, and orthodontia. This benefit is offered through Delta Dental. Learn more at deltadentalwi.com/state-of-wi.

Uniform Dental Benefit

If your employer offers this benefit as part of your health insurance, you may enroll in the Uniform Dental Benefit (UDB). Premiums are included in your health insurance rates. If you have individual health insurance coverage, you will have individual UDB coverage. If you have family, you will have family.

Preventive Dental Benefit
If your employer offers this Delta Dental benefit. You are solely responsible for premiums in this plan. Your employer will not provide any contribution. You may select any level of coverage, that is individual or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage.
If your employer offers these Delta Dental benefits, you can enhance your UDB or Preventive plan with supplemental dental. You can enroll in a supplemental dental benefit without enrolling in UDB or Preventive. You are solely responsible for premiums in this plan. Your employer will not provide any contribution. You may select any level of coverage, that is individual, individual plus spouse, individual plus child(ren) or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage. You may only enroll in either the Select Plan or Select Plus Plan, not both.
Select Plan
Covers dental services considered Major and Restorative Dental Services. Examples of this are crowns, bridges, dentures and implants. This plan does not cover orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.
Select Plus Plan
In addition to coverage of dental services considered Major and Restorative Dental Services like crowns, bridges, dentures and implants, this plan also covers orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this benefit.
Uniform Pharmacy Benefit
Your coverage for most medications is provided by Navitus Health Solutions, a Pharmacy Benefit Manager (PBM). You must obtain pharmacy benefits at a participating Navitus pharmacy, except when not reasonably possible because of Emergency or Urgent Care. For full detail on services covered by the PBM, please see the Uniform Pharmacy Benefits Certificate of Coverage.
Supplemental Vision Benefit
The supplemental DeltaVision Plan provides coverage for eye exams, prescription glasses, contacts, and more. This benefit is offered through Delta Dental of Wisconsin, in partnership with EyeMed Vision Care. Learn more at visiting deltadentalwi.com/state-of-wi-vision.
Accident Plan
Provides employees and their dependents with a cash payment to help cover out-of-pocket expenses regardless of any other insurance coverage. Your employer has to opt-in to offer this to you. This plan does not disqualify you for medical coverage. Learn more at Accident Plan.

Wellness and Chronic Condition Management

Uniform Wellness Benefits
The Uniform Wellness Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include a health assessment, health screenings, flu vaccines, unlimited health coaching (weight management, nutrition, exercise, tobacco cessation, stress resiliency, sleep hygiene, alcohol use), digital well-being education, challenges, and learning modules. Participants can earn an annual incentive. For more details on services included in the program, please see the Well Wisconsin for Members webpage.

Uniform Chronic Condition Management Benefits

The Uniform Chronic Condition Management Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include unlimited coaching for asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. A diabetes prevention program, and resources for chronic pain management are also available. For more details on services included in the program, please see the Well Wisconsin for Members webpage.

Group Health Insurance Program for Members in the

Local Deductible Plan

- Employees
- all Retirees and
- COBRA Continuants

Schedule of Benefits

Effective January 1, 2026

The Schedule of Benefits explains what medical services the Group Health Insurance Program (GHIP) covers and what you pay for covered services. See your Uniform Benefits Certificate of Coverage (ET-2180) for complete coverage details. The Schedule of Benefits is divided into the following sections:

Annual Limits

Annual Medical Deductible

The amount you would owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services.

Individual: $500

Family: $1,000

- The family deductible is embedded – no one family member will contribute more than the individual amount to the family deductible.

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Preventive services
- × Prescription drugs

Annual Medical Coinsurance

The percentage of costs for a covered service you pay after meeting your deductible.

You pay: 0% after deductible is met except as noted below

Plan pays: 100% after deductible is met except as noted below

Applies to:

- ✓ Annual Out-of-Pocket Limit (OOPL)
- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Durable Medical Equipment & Medical Supplies which has 20% coinsurance, up to $500 per person
- × Preventive services
- × Prescription drugs

Annual Medical Out-of-Pocket Limit (OOPL)

The most you would pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Individual: $500 per person for Durable Medical Equipment & Medical Supplies after deductible is met

Family: (See above.)

- This Plan uses a provider network. You may have no coverage or have greater out-of-pocket costs if you get care outside of the plan's provider network. Check your provider directory before you receive services.

Applies to:

- ✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

- × Prescription drugs

Annual Maximum Out-of-Pocket Limit (MOOP)

This is the yearly amount set by the federal government as the most an Individual or Family is required to pay in cost sharing during the plan year for covered, in-network services.

Individual: $10,150

Family: $20,300

- The most you would pay for services you receive from in-network providers. Your out-of-pocket costs for services received from in-network providers will count toward this limit.
- The MOOP is embedded for family plans – no one family member will contribute more than the individual amount to the family MOOP.

Covered Services

Commonly used services appear below. This is not a complete list. If you have questions about other specific benefits, contact your health plan.

Ambulance

Also known as paramedic services, these are emergency services that provide urgent pre-hospital treatment and stabilization for serious illness, injuries, and transport to definitive care.

You pay: Deductible, then 0% coinsurance

- ✓ Applies to each one-way trip.

Chiropractic Care

Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). This also includes Occupational therapy (helping with daily living tasks caused from illnesses and injuries to your brain and body).

You pay: Deductible, then 0% coinsurance

- × Maintenance visits are not covered.

Cochlear Implant Devices – Under Age 18

An electronic device that partially restores hearing. For coverage for participants over the age of 18, see Cochlear Implant Devices – Over Age 18 in the Additional Covered Services section.

You pay: Deductible, then 0% coinsurance

- ✓ Includes all charges related to implantation surgery and follow-up training sessions.

Diagnostic Services and Labs

Tests to figure out what your health problem is. Make sure to verify anticipated costs with your provider prior to receiving services. Note: some advanced imaging like MRI or CT scans may require prior authorization.

You pay: Deductible, then 0% coinsurance

Covered diagnostic services include:

- ✓ Diagnostic radiology (x-rays, PET, MRI, MRA, and CT scans)
- ✓ Lab tests

Durable Medical Equipment and Medical Supplies

Equipment and supplies ordered by a health care provider for everyday or extended use.

You pay: Deductible, then 20% coinsurance, up to $500 per person

- ✓ Includes Durable Diabetic Equipment and related Medical Supplies.
- ✓ Intraoral splints for treatment of TMJ disorder

Does not apply to the following. See Additional Covered Services.

- × Adult hearing aids
- × Adult cochlear implant devices
- × Dental implants

Emergency and Urgent Care

Certain medical conditions require expedited medical care. You can work with your provider to determine the best level of care to meet your urgent or emergent needs.

Emergency Care

Care for a life-threatening illness, injury, or condition that requires immediate attention. You should seek care at an in-network Emergency Room whenever possible.

You pay: $60 copayment per visit

- The copayment is waived if you are admitted as an inpatient or for observation for 24 hours or more.
- You may be responsible for other charges in addition to the visit copayment that apply to the deductible. Also see Durable Medical Equipment (DME) and Medical Supplies for details on items that may be prescribed for you to take home.

Copayment does not apply to:

- × Deductible

Urgent Care Visit

Care for an illness, injury, or condition serious enough that it requires attention within 24 hours but is not life-threatening. You should seek care at an in-network Urgent Care whenever possible.

You pay: Deductible, then 0% coinsurance

Hearing Aids – Under Age 18

Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants over the age of 18, see Hearing Aids – Over Age 18 in the Additional Covered Services section

You pay: Deductible, then 0% coinsurance

Home Care Benefits

Medically necessary nursing care, home health aide services, and other home care benefits provided by a medical professional at home as part of a care plan.

You pay: Deductible, then 0% coinsurance

- Up to 50 visits per participant per calendar year
- Your plan may review your first 50 visits to verify progress is being made
- Up to a maximum of 50 additional visits per participant, per calendar year may be available with prior authorization from your health plan

Inpatient Hospital Services

Services necessary for your admission to a hospital, as well as diagnosis and treatment.

You pay: Deductible, then 0% coinsurance

- Your health plan may require prior authorization for hospital and/or inpatient services.
- This includes inpatient hospitalization for medical and/or mental health needs.
- Your plan covers a semi-private room, ward, or intensive care unit, as well as any medically necessary miscellaneous hospital expenses, including prescription drugs administered during the confinement.
- Private rooms are only covered if medically necessary, as determined by your health plan.

Mental Health Counseling Visits

These services include behavioral health, psychiatric counseling, and substance use disorder services.

You pay: Deductible, then 0% coinsurance

Applies to:

- ✓ Individual therapy office visits
- ✓ Outpatient groups
- ✓ Telehealth visits

Occupational, Physical, and Speech Therapy

Physical therapy (PT) involves treatments for the prevention and management of injuries or disabilities. PT helps to relieve pain, promote health, and restore function/movement. This includes Occupational therapy (OT), which helps with daily living tasks caused from illnesses and injuries to the brain and body; and Speech/Language therapy (ST), which helps to relearn how to communicate and swallow to prevent aspiration.

You pay: Deductible, then 0% coinsurance

- ✓ Up to 50 visits per participant for all therapies combined per calendar year.
- ✓ Up to a maximum of 50 additional visits per therapy, per participant, per calendar year may be available with prior authorization from your health plan.

Applies to:

- ✓ Comprehensive outpatient rehabilitation facility visits
- ✓ Hospital outpatient department visits
- ✓ Independent therapist office visits

Outpatient Cardiac Rehabilitation

Rehabilitation following an inpatient hospital stay for a heart attack, bypass surgery, angina, heart valve surgery, angioplasty, or heart transplant.

You pay: Deductible, then 0% coinsurance

Outpatient Hospital & Ambulatory Surgery Center Services

Services necessary for your admission to an outpatient hospital or Ambulatory Surgery Center, as well as diagnosis and treatment.

You pay: Deductible, then 0% coinsurance

- You may be prescribed Durable Medical Equipment and Medical Supplies to be taken home during an outpatient hospital facility visit, which could be billed separately and subject to deductible and coinsurance.

Preventive Care Services

Routine health care, including screening, check-ups, and patient counseling to prevent or discover illness, disease, or other health problems – as required by federal law. Federal law specifies at what age and how frequently a service can be paid with no cost to you. See healthcare.gov/preventive-care-benefits for more details.

You pay: $0

- Services – diagnostic or otherwise – for specific conditions found during a preventive exam may be subject to Deductible and the Durable Medical Equipment & Medical Supply coinsurance.
- Your preventive check-up can be used to fulfill activities for the annual Well Wisconsin incentive program. See https://etf.wi.gov/well-wisconsin-members for more details.

The plan covers the following federally required preventive services including, but not limited to:

- ✓ Alcohol misuse counseling
- ✓ Breast cancer screening (mammogram)
- ✓ Cholesterol screening
- ✓ Depression screening
- ✓ Diabetes screening
- ✓ HIV screening
- ✓ Immunizations, including flu, hepatitis A & B, pneumococcal and other shots
- ✓ Obesity screening and counseling
- ✓ Blood pressure screening
- ✓ Cervical cancer screening
- ✓ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- ✓ Hepatitis C screening
- ✓ Lung Cancer screening
- ✓ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- ✓ Well child exam

Primary Care

Primary care includes preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. Your primary care provider (PCP) or primary care clinic (PCC) will provide or arrange for most of your health care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

You pay: Deductible, then 0% coinsurance

- You must select a PCP or PCC at the time or enrollment or when you change health plans; your PCP may be a physician, physician assistant, nurse practitioner, or any other provider that manages your primary care services.
- If you do not choose a PCP or PCC, or your selection is no longer available, your health plan will assign a PCP or PCC for you.
- Contact your health plan directly to change your current PCP or PCC selection.

Skilled Nursing Facility

Admission to a licensed Skilled Nursing Facility for continued treatment after a hospital stay.

You pay: Deductible, then 0% coinsurance

- ✓ Up to 120 calendar days per benefit period

Telemedicine and Remote Care

Certain telehealth and remote care services are covered. These remote services should maintain the quality, safety, and effectiveness of an in-person visit. You should work with your provider to determine the best technology solution(s) to meet your care needs.

E-Visit

An evaluation and treatment by a provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An E-Visit is also called a digital visit or a virtual visit.

You pay: Deductible, then 0% coinsurance

- Must be initiated by the member seeking services, not the provider, in order to be covered.
- E-Visits are covered when the same service would be covered if provided in person when performed by one of the following provider types:
  - Doctor
  - Nurse practitioner
  - Physician assistant
  - Licensed clinical social worker
  - Clinical psychologist or psychiatrist
  - Occupational therapist
  - Speech / language pathologist

Telehealth

Telehealth is a service delivered via real-time audio and video. Telehealth may also be called telemedicine, online or virtual evaluation and management, or a video visit. Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care provider who is located elsewhere using interactive two-way, real-time audio and video technology. Telehealth can be provided in your home, as well as at a health care facility.

You pay: Deductible, then 0% coinsurance

- Telehealth will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.

If you and your provider determine that you cannot successfully complete a Telehealth visit with full audio and video, you may opt to change to a Telephone Visit.

Telephone Visit

Telephone Visit is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

You pay: Deductible, then 0% coinsurance

- Telephone visits will be covered if the provider can successfully provide the service without a reduction in quality, safety, or effectiveness.

Remote Patient Monitoring

Remote Patient Monitoring is a series of services whereby a provider collects and interprets a person's physiologic data that is sent digitally to support treatment and management of medical conditions.

You pay: Deductible, then 0% coinsurance

- Device must meet home-use medical device as defined by the Food and Drug Administration and be provided as part of the monitoring service.
- Devices are provided as a lease; they cannot be lease-to-own, purchased to own, or already owned.

Virtual Check-In

A brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than Telehealth, Telephone Visits, or E-Visits.

You pay: Deductible, then 0% coinsurance

- Covered as a Virtual Check-In as long as the check-in is not related to another medical visit within the past 7 days, and as long as the check-in does not lead to a medical visit within the next 24 hours or the next available appointment.

Vision Services

Yearly eye exam to diagnose and treat diseases and conditions of the eye. Does not include frames or any other vision related expenses. For supplemental vision coverage, including prescription glasses and contacts, see the Supplemental Vision Benefit.

You pay: Deductible, then 0% coinsurance

- Coverage is limited to one eye exam per participant per calendar year
- Non-routine eye exams are covered if considered medically necessary by your health plan
- Child vision screenings:
  - Under age 5 – Federally covered and considered preventive are not subject to deductible
  - Age 6 or older – Not considered preventive, subject to deductible

Additional Covered Services

Cochlear Implant Devices – Over Age 18

An electronic device that partially restores hearing. For coverage for participants under the age of 18, see Cochlear Implant Devices – Under Age 18 in the Covered Services section.

You pay: Deductible, then 20% coinsurance for implant devices, professional surgery for implantation, and follow-up device training

0% coinsurance for hospital services

Applies to:

✓ Maximum Out-of-Pocket Limit (MOOP)

Does not apply to:

✗ Annual Out-of-Pocket Limit (OOPL)

Dental Implants
Dental implants are artificial tooth roots placed in the jaw to hold a replacement tooth or bridge after the loss of a tooth or teeth. You pay: Deductible, then 0% coinsurance Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)
• Dental implants are only covered following accident or injury. • Maximum benefit plan payment of $1,000 per tooth.
Hearing Aids – Over Age 18
Electronic amplifying devices designed to bring sound more effectively into the ear. For coverage for participants under the age of 18, see Hearing Aids – Under Age 18 in the Covered Services section. You pay: Deductible, then 20% coinsurance Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)
• One hearing aid per ear, no more than once every 3 years. • Maximum benefit plan payment of $1,000 per hearing aid.
Temporomandibular Joint Disorders – Diagnosis and Non-Surgical Treatment
Coverage for diagnostic procedures and medically necessary surgical or non-surgical for the correction of temporomandibular disorders, provided all coverage criteria are met. You pay: Deductible, then 0% coinsurance • Maximum benefit plan payment of $1,250 per participant per plan year Applies to: ✓ Maximum Out-of-Pocket Limit (MOOP) Does not apply to: × Annual Out-of-Pocket Limit (OOPL)

Dental, Pharmacy, and Supplemental Plans

Dental Benefit (Program Option 04 Only)
The Uniform and Preventive Dental Benefits provide coverage for basic procedures such as cleanings, fluoride treatments, fillings, and orthodontia. These benefits are offered through Delta Dental. Learn more at deltadentalwi.com/state-of-wi.
Uniform Dental Benefit
If your employer offers this benefit as part of your health insurance, you may enroll in the Uniform Dental Benefit (UDB). Premiums are included in your health insurance rates. If you have individual health insurance coverage, you will have individual UDB coverage. If you have family health insurance coverage, you will have family UDB coverage.

Preventive Dental Benefit
If your employer offers this benefit, you are solely responsible for premiums in this benefit; your employer will not provide any contribution. You may select any level of coverage, that is individual or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage.
If your employer offers the Delta Dental Select Plan or the Select Plus Plan, you may enhance your UDB or Preventive Dental Benefit with a supplemental dental insurance plan (Select Plan or Select Plus Plan). You may enroll in the Select Plan or the Select Plus Plan without enrolling in the UDB or the Preventive Dental Benefit. You are solely responsible for premiums for the Select Plan and Select Plus Plan. Your employer will not provide any contribution. You may select any level of coverage, that is individual, individual plus spouse, individual plus child(ren) or family, regardless of your health insurance coverage (individual or family) or if you did not enroll in health insurance coverage. You may only enroll in either the Select Plan or Select Plus Plan, not both.
Select Plan
Covers dental services considered Major and Restorative Dental Services. Examples of this are crowns, bridges, dentures, and implants. This plan does not cover orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this plan.
Select Plus Plan
In addition to coverage of dental services considered Major and Restorative Dental Services like crowns, bridges, dentures and implants, this plan also covers orthodontia services. Your employer must opt-in with Delta Dental in order for you to enroll in this plan.
Uniform Pharmacy Benefit
Your coverage for most medications is provided by Navitus Health Solutions, a Pharmacy Benefit Manager (PBM). You must obtain pharmacy benefits at a participating Navitus pharmacy, except when not reasonably possible because of Emergency or Urgent Care. For full detail on services covered by the PBM, please see the Uniform Pharmacy Benefits Certificate of Coverage.
Supplemental Vision Benefit
The supplemental DeltaVision Plan provides coverage for eye exams, prescription glasses, contacts, and more. This benefit is offered through Delta Dental of Wisconsin, in partnership with EyeMed Vision Care. Learn more at visiting deltadentalwi.com/state-of-wi-vision.
Accident Plan
Provides employees and their dependents with a cash payment to help cover out-of-pocket expenses regardless of any other insurance coverage. Your employer has to opt-in to offer this to you. This plan does not disqualify you for medical coverage. Learn more at Accident Plan.

Wellness and Chronic Condition Management

Uniform Wellness Benefits
The Uniform Wellness Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include a health assessment, health screenings, flu vaccines, unlimited health coaching (weight management, nutrition, exercise, tobacco cessation, stress resiliency, sleep hygiene, alcohol use), digital well-being education, challenges, and learning modules. Participants can earn an annual incentive. For more details on services included in the program, please see the Well Wisconsin for Members webpage.
Uniform Chronic Condition Management Benefits
The Uniform Chronic Condition Management Benefit is available to Subscribers and Spouses. Services, provided by WebMD, include unlimited coaching for asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. A diabetes prevention program, and resources for chronic pain management are also available. For more details on services included in the program, please see the Well Wisconsin for Members webpage.

MEDICARE BENEFIT PLAN DESIGNS **2026**	**Medicare for State Health Plan & PO2/12, PO6/16, PO7/17, P08**	**Medicare Advantage for State & PO2/12, PO6/16, PO7/17, P08**	**PO4/14 Local Deductible Plan Medicare**	**PO4/14 Local Deductible Medicare Advantage**
Annual Medical Deductible (individual/family) **-Applies to all covered items and services unless specified (e.g. Office Visit Copayments)**	None	None	$500/$1,000	$500/$1,000
Embedded deductible:	N/A	N/A	Yes	Yes
Deductible applies to OOPL:	N/A	N/A	Yes	Yes
Deductible applies to MOOP:	N/A	N/A	Yes	Yes
Deductible applies before office visit copayments:	N/A	N/A	N/A	N/A
Deductible applies to preventive services:	N/A	N/A	No	No
Deductible applies to prescription drugs:	N/A	N/A	No	No
Annual Medical Coinsurance (plan/participant)	See detail below	See detail below	See detail below	See detail below
Coinsurance applies after deductible met:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Separate 20% coinsurance for DME:	Yes	Yes	Yes	Yes
Separate 20% coinsurance for Medical Supplies:	Yes	Yes	Yes	Yes
Separate 20% coinsurance for cochlear implants for participants age 18 and older:	Yes	Yes	Yes	Yes
Coinsurance applies to office visit copayments:	N/A	N/A	N/A	N/A
Coinsurance applies to preventive services:	N/A	N/A	N/A	N/A
Coinsurance applies to prescription drugs:	N/A	N/A	N/A	N/A
Annual Medical Out-Of-Pocket Limit (individual/family)	$500 (per participant - Durable Medical Equipment only)	$500 (per participant - Durable Medical Equipment only)	$500 (per participant - Durable Medical Equipment only)	$500 (per participant - Durable Medical Equipment only)
Embedded OOPL:	No	No	Yes for Deductible No for DME	Yes for Deductible No for DME
OOPL applies to MOOP:	Yes	Yes	Yes	Yes
Prescription drugs apply to OOPL:	No	No	No	No
Level 3 prescription drug coinsurance paid past OOPL to federal MOOP:	N/A	N/A	N/A	N/A
OOPL only applies to DME and Medical Supplies:	Yes	Yes	No	No
Annual Maximum Out-Of-Pocket (individual/family)	$10,150/$20,300	$6,700 per person	$10,150/$20,300	$6,700 per person
Embedded MOOP:	Yes	Yes	Yes	Yes
OOPL applies to MOOP:	Yes	Yes	Yes	Yes
Prescription drugs apply to MOOP:	Yes	Yes	Yes	Yes
Preventive Services (as required by federal law)	No out of pocket costs	No out of pocket costs	No out of pocket costs	No out of pocket costs
Copayment per visit:	N/A	N/A	N/A	N/A
Annual deductible applies:	N/A	N/A	No	No
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Primary Care/Chiropractic/Mental Health Counseling Office Visit - Copay applies to mental health therapy visits including outpatient groups and telehealth - Additional services such as lab work, assessments, etc., are subject to deductible and coinsurance. See	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Visit applies to annual deductible:	N/A	N/A	Yes	Yes
Copayment per visit:	N/A	N/A	N/A	N/A
Copayment applies to annual deductible:	N/A	N/A	N/A	N/A
Copayment applies to OOPL:	N/A	N/A	N/A	N/A
Copayment applies to MOOP:	N/A	N/A	N/A	N/A
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Telemedicine, Telehealth, Virtual Check Ins, or E-Visit Service - Includes Remote Patient Monitoring (RPM) deemed primary care • RPM Device must be approved by FDA and be leased	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met, no out of pocket costs post-deductible	Participant pays full allowed charge until deductible is met, no out of pocket costs post-deductible
Visit/services apply to annual deductible:	N/A	N/A	Yes	Yes
Copayment per visit:	N/A	N/A	N/A	N/A
Copayment applies to deductible:	N/A	N/A	N/A	N/A
Copayment applies to OOPL:	N/A	N/A	N/A	N/A
Copayment applies to MOOP:	N/A	N/A	N/A	N/A
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A

MEDICARE BENEFIT PLAN DESIGNS **2026**	**Medicare for State Health Plan & PO2/12, PO6/16, PO7/17, P08**	**Medicare Advantage for State & PO2/12, PO6/16, PO7/17, P08**	**PO4/14 Local Deductible Plan Medicare**	**PO4/14 Local Deductible Medicare Advantage**
Specialist Office Visit / Urgent Care Visit - Includes yearly eye/vision exam. Screenings for children age 5 and under as required under federal law. -Orthoptic training lifetime limit of 12 visits per participant - Additional services such as lab work, assessments, etc., are subject to deductible and coinsurance. See Illness/Injury Related Services Beyond the Office Visit or Emergency Room Visit section for more information. -*Urgent Care subject to In-Network OOPLs	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Visit applies to annual deductible:	N/A	N/A	Yes	Yes
Copayment per visit:	N/A	N/A	N/A	N/A
Copayment applies to deductible:	N/A	N/A	N/A	N/A
Copayment applies to OOPL:	N/A	N/A	N/A	N/A
Copayment applies to MOOP:	N/A	N/A	N/A	N/A
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Emergency Room Visit - Additional services such as lab work, assessments, etc., are subject to deductible and coinsurance. See Illness/Injury Related Services Beyond the Office Visit or Emergency Room Visit section for more information. -Emergency Room services including all ambulances are subject to In-Network OOPLs				
Copayment per visit:	$60	$60	$60	$60
Copayment waived if admitted as an inpatient directly from ER or for observation for 24 hours or longer:	Yes	Yes	Yes	Yes
Copayment applies to annual deductible:	N/A	N/A	No	No
Copayment applies to OOPL:	N/A	N/A	N/A	N/A
Copayment applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Illness/Injury Related Services Beyond the Office Visit or Emergency Room Visit **Visit copays may apply before deductible and coinsurance**	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Visit charge applies to annual deductible:	N/A	N/A	Yes	Yes
Visit charge applies to OOPL:	N/A	N/A	Yes	Yes
Visit charge applies to MOOP:	N/A	N/A	Yes	Yes
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Occupational/Physical/Speech Therapy Visit -Up to 50 visits per participant for all therapies combined are covered per calendar year. -Additional visits may be available with prior authorization from the health plan, up to a maximum of 50 additional visits per therapy, per participant, per calendar year.	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Visit applies to annual deductible:	N/A	N/A	Yes	Yes
Copayment per visit:	N/A	N/A	N/A	N/A
Copayment applies to annual deductible:	N/A	N/A	N/A	N/A
Copayment applies to OOPL:	N/A	N/A	N/A	N/A
Copayment applies to MOOP:	N/A	N/A	N/A	N/A
Coinsurance per visit:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Inpatient Hospital Services and Skilled Nursing Facility (SNF) **- SNF care limited to 120 calendar days per benefit period**	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	N/A	N/A	No	No
Charge applies to MOOP:	N/A	N/A	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A

MEDICARE BENEFIT PLAN DESIGNS **2026**	**Medicare for State Health Plan & PO2/12, PO6/16, PO7/17, P08**	**Medicare Advantage for State & PO2/12, PO6/16, PO7/17, P08**	**PO4/14 Local Deductible Plan Medicare**	**PO4/14 Local Deductible Medicare Advantage**
Home Care - Up to 50 visits per participant per calendar year - Your plan may review your first 50 visits to verify progress is being made - Up to a maximum of 50 additional visits per participant, per calendar year may be available with prior authorization from your health plan	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	N/A	N/A	No	No
Charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies - Excludes hearing aids and cochlear implants for adults and all dental implants - Includes intraoral splints for treatment of TMJ disorder - Elastic support hose (JOBST) limited to 2 pairs per year	Participant pays 20% up to $500 OOPL per individual, after OOPL: $0	Participant pays 20% up to $500 OOPL per individual, after OOPL: $0	Participant pays full allowed charge until deductible is met, then 20% coinsurance up to $500 OOPL per individual, after OOPL $0	Participant pays full allowed charge until deductible is met, then 20% coinsurance up to $500 OOPL per individual, after OOPL $0
Charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	Yes	Yes	Yes	Yes
Charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	20%	20%	20%	20%
Coinsurance applies to OOPL:	Yes	Yes	Yes	Yes
Coinsurance applies to MOOP:	Yes	Yes	Yes	Yes
Cochlear Implants for participants under age 18 - Includes all charges related to implant and follow-up training sessions - Coinsurance as required by Wis. Stat. §632.895 (16)	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	N/A	N/A	N/A	N/A
Charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	Yes	Yes
Cochlear Implant Devices, Professional Surgery for Implantation, and Follow-Up Device Training for participants age 18 and older - Includes all charges related to professional surgical implantation and follow-up training sessions	20% coinsurance does not apply to DME OOPL	20% coinsurance does not apply to DME OOPL	Participant pays full allowed charge until deductible is met, then coinsurance applies, does not apply to DME OOPL	Participant pays full allowed charge until deductible is met, then coinsurance applies, does not apply to DME OOPL
Cochlear implant charge applies to annual deductible:	N/A	N/A	Yes	Yes
Cochlear implant charge applies to OOPL:	No	No	No	No
Cochlear implant charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	20%	20%	20%	20%
Coinsurance applies to OOPL:	No	No	No	No
Coinsurance applies to MOOP:	Yes	Yes	Yes	Yes
Cochlear Implant Hospital Charges for participants age 18 and older	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Hospital charge applies to annual deductible:	N/A	N/A	Yes	Yes
Hospital charge applies to OOPL:	N/A	N/A	No	No
Hospital charge applies to MOOP:	N/A	N/A	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Hearing Aids for participants under age 18 **- Coinsurance as required by Wis. Stat. §632.895 (16)**	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Hearing aid charge applies to annual deductible:	N/A	N/A	Yes	Yes
Hearing aid charge applies to OOPL:	N/A	N/A	Yes	Yes
Hearing aid charge applies to MOOP:	N/A	N/A	Yes	Yes
Coinsurance:	No	No	No	No
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Hearing aid limit:	N/A	N/A	N/A	N/A

MEDICARE BENEFIT PLAN DESIGNS **2026**	**Medicare for State Health Plan & PO2/12, PO6/16, PO7/17, P08**	**Medicare Advantage for State & PO2/12, PO6/16, PO7/17, P08**	**PO4/14 Local Deductible Plan Medicare**	**PO4/14 Local Deductible Medicare Advantage**
Maximum benefit plan payment:	N/A	N/A	N/A	N/A
Hearing Aids for participants age 18 and older	Coinsurance applies until plan pays $1,000, then Participant pays 100% of the charges	Coinsurance applies until plan pays $1,000, then Participant pays 100% of the charges	Participant pays full allowed charge until deductible is met, then coinsurance applies until plan pays $1,000, then Participant pays 100% of the charges	Participant pays full allowed charge until deductible is met, then coinsurance applies until plan pays $1,000, then Participant pays 100% of the charges
Hearing aid charge applies to annual deductible:	N/A	N/A	Yes	Yes
Hearing aid charge applies to OOPL:	No	No	No	No
Hearing aid charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	20%	20%	20%	20%
Coinsurance applies to OOPL:	No	No	No	No
Coinsurance applies to MOOP:	Yes	Yes	Yes	Yes
Hearing aid limit:	One aid per ear no more than once every 3 years	One aid per ear no more than once every 3 years	One aid per ear no more than once every 3 years	One aid per ear no more than once every 3 years
Maximum benefit plan payment:	$1,000 per hearing aid	$1,000 per hearing aid	$1,000 per hearing aid	$1,000 per hearing aid
Diagnosis and Non-Surgical Treament of Temporomandibular Joint Disorders **- Intraoral splints covered as Durable Medical Equipment**	Plan pays up to maximum limit, then participant pays all remaining out-of-pocket costs	Plan pays up to maximum limit, then participant pays all remaining out-of-pocket costs	Participant pays charge until the deductible is met, then Plan pays up to maximum limit, then Participant pays all remaining OOP costs	Participant pays charge until the deductible is met, then Plan pays up to maximum limit, then Participant pays all remaining OOP costs
Charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	No	No	No	No
Charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Maximum benefit plan payment :	$1,250 per participant per calendar year	$1,250 per participant per calendar year	$1,250 per participant per calendar year	$1,250 per participant per calendar year
Dental Implants **- Only covered following accident or injury**	Plan pays up to maximum benefit plan payment, then Participant pays all remaining out-of-pocket costs	Plan pays up to maximum benefit plan payment, then Participant pays all remaining out-of-pocket costs	Participant pays full allowed charge until deductible is met, then plan pays up to maximum benefit plan payment, then Participant pays all remaining OOP costs	Participant pays full allowed charge until deductible is met, then plan pays up to maximum benefit plan payment, then Participant pays all remaining OOP costs
Dental implant charge applies to annual deductible:	N/A	N/A	Yes	Yes
Dental implant charge applies to OOPL:	No	No	No	No
Dental implant charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Maximum benefit plan payment:	$1,000 per tooth per year	$1,000 per tooth per year	$1,000 per tooth per year	$1,000 per tooth per year
Transplants -Transplants and related services are coverd when ordered by a physician. - All transplants except corneal transplants require Prior Authorization. - The Medical Necessity and appropriateness of a transplant will be determined by medical professionals reviewing each case on behalf of the Health Plan - See Program Agreement for additional details and exclusions	No out of pocket costs	No out of pocket costs	Participant pays full allowed charge until deductible is met	Participant pays full allowed charge until deductible is met
Transplant charge applies to annual deductible:	N/A	N/A	Yes	Yes
Charge applies to OOPL:	N/A	N/A	Yes	Yes
Charge applies to MOOP:	Yes	Yes	Yes	Yes
Coinsurance:	N/A	N/A	N/A	N/A
Coinsurance applies to OOPL:	N/A	N/A	N/A	N/A
Coinsurance applies to MOOP:	N/A	N/A	N/A	N/A
Exclusions and Limitations **See Uniform Benefits Certificate of Coverage (ET-2180)**				

State of Wisconsin Medicare 2026 Pricing Workbook

Instructions

· Please provide information requested in the yellow shaded areas.

· Separate experience exhibits for State and Local are included for:
  - Medical Claims by service category - completion factors are included inputs
  - Medical Detail on Cost and Revenue - claims should not include completion factors

· A Completion factor is the coefficient applied to the incurred & paid claims to estimate the total incurred claims.

· All rates must be exactly divisible by 2 and rounded to the nearest hundredth of a dollar.
  - No other rate structure is permitted.
  - If an invalid rate is entered into a yellow cell an ERROR warning will appear to the right of the cell.

Submit the electronic excel copy of all your bids to Zachary Vieira at zvieira@segalco.com for the Preliminary and Best & Final bids.

Submit the signed copy as follows: scan and e-mail a signed copy of your bid sheets to Zachary Vieira at zvieira@segalco.com. Please be sure to include your plan name in the title of the document.

1. Provide an email to ETFSMBInsuranceSubmit@etf.wi.gov as a notification they are making their file submission to ETF; and
2. Upload the actual submission file to the secured sFTP site at ETF.

Medicare Advantage Medical Claims - State & Local

Base Period Data Information

Incurred from date	10/01/23
Incurred to date	09/30/24
Paid through date	12/31/24
Completion Factor (estimated total incurred % actual incurred & paid)	1.0183
Member Months	211,184
Risk Score	0.86

*For consistency this tab is full year data
Incurred from date
1/1/2024
Incurred to date
12/31/2024
Paid through date
3/21/2025

Service Category	Utilization Type	Base Period Data: Total Number Services	Total Allowed Charges	Total Member Cost Share	Plan Paid	Completion Factor: Utilization	Allowed Per Service	Period Experience: Utilization Per 1,000	Allowed Per Service	Allowed PMPM
Inpatient Facility	Admissions	2,277	$36,485,426	$3,475	$36,481,951	1.004	1.016	130	$16,276	$176.14
Skilled Nursing Facility	Admissions	419	$3,547,714	$0	$3,547,714	1.023	1.026	24	$8,687	$17.63
Home Health	Other	12,181	$2,674,857	$1,894	$2,672,963	1.002	1.012	694	$222	$12.84
Ambulance	Other	2,550	$1,529,902	$7,082	$1,522,820	1.000	1.007	145	$604	$7.29
DME/Prosthetics/Supplies	Other	40,011	$3,986,321	$898,007	$3,088,314	1.000	1.007	2,274	$100	$19.01
OP Facility - Emergency	Other	4,956	$4,378,718	$523,410	$3,855,307	1.000	1.007	282	$890	$20.89
OP Facility - Surgery	Other	10,043	$30,059,979	$13,531	$30,046,448	1.000	1.016	571	$3,040	$144.60
OP Facility - Other	Other	124,743	$35,802,937	$128,856	$35,674,080	1.003	1.020	7,112	$293	$173.43
Primary Care Physician Visit	Vists	69,887	$9,690,777	$66,912	$9,623,865	1.008	1.014	4,001	$141	$46.88
Specialist Physician Visit	Vists	225,144	$34,738,525	$188,284	$34,550,241	1.008	1.014	12,889	$156	$168.07
Radiology	Other	89,742	$12,877,314	$26,802	$12,850,512	1.005	1.009	5,122	$145	$61.82
Lab Services	Other	204,726	$5,021,713	$358	$5,021,355	1.002	1.013	11,655	$25	$24.12
Part B Rx	Scripts	34,293	$3,465,164	$0	$3,465,164	1.000	1.000	1,949	$101	$16.41
Other Medicare Part B					$0			-	$0	$0.00
Ancillary	Other	12,000	$8,109,298	$0	$8,109,298	1.000	1.000	682	$676	$38.40
Other (Specify Category)					$0			-	$0	$0.00
Other (Specify Category)					$0			-	$0	$0.00
Other (Specify Category)					$0			-	$0	$0.00
Other (Specify Category)					$0			-	$0	$0.00
Total Medical Expenses			**$192,368,644**	**$1,858,612**	**##########**					**$927.54**
Total Medical Expenses - PMPM			**$910.91**	**$8.80**	**$902.10**					

Medicare Advantage Medical Detail - State & Local

	Medical								
	Total Members	Allowed Claims	Member Cost Sharing	Member Cost Sharing as a % of Allowed Claims	Plan Paid	Federal CMS Revenue	Risk Score	State Premium	Total Revenue
Oct-2022	13,397	$12,234,376	$82,823	0.68%	$12,151,553	$10,124,155	0.7883	$744,662	$10,868,817
Nov-2022	13,445	$12,018,122	$80,274	0.67%	$11,937,847	$10,151,565	0.7848	$746,980	$10,898,545
Dec-2022	13,490	$11,436,491	$83,579	0.73%	$11,352,912	$10,098,880	0.7798	$628,859	$10,727,739
Jan-2023	16,112	$13,030,229	$150,712	1.16%	$12,879,517	$14,170,574	0.8707	$975,362	$15,145,936
Feb-2023	16,182	$11,788,768	$124,768	1.06%	$11,664,000	$14,129,497	0.8649	$979,895	$15,109,392
Mar-2023	16,236	$13,555,248	$161,051	1.19%	$13,394,197	$14,063,922	0.8590	$983,432	$15,047,354
Apr-2023	16,295	$13,360,328	$115,158	0.86%	$13,245,170	$14,029,982	0.8549	$986,815	$15,016,796
May-2023	16,340	$14,389,794	$130,568	0.91%	$14,259,226	$14,005,314	0.8508	$989,841	$14,995,154
Jun-2023	16,445	$14,193,858	$150,789	1.06%	$14,043,068	$14,016,559	0.8458	$995,995	$15,012,554
Jul-2023	16,513	$13,296,379	$123,113	0.93%	$13,173,266	$13,975,808	0.8392	$998,451	$14,974,259
Aug-2023	16,558	$14,660,416	$137,691	0.94%	$14,522,725	$13,986,885	0.8375	$1,003,172	$14,990,058
Sep-2023	16,614	$14,165,785	$139,447	0.98%	$14,026,338	$13,999,057	0.8360	$1,006,445	$15,005,502
Oct-2023	16,654	$15,874,057	$138,151	0.87%	$15,735,906	$13,997,203	0.8326	$1,009,024	$15,006,226
Nov-2023	16,699	$15,555,149	$128,697	0.83%	$15,426,452	$13,879,122	0.8237	$1,011,014	$14,890,137
Dec-2023	16,732	$14,859,233	$124,784	0.84%	$14,734,449	$13,869,234	0.8205	$1,035,843	$14,905,078
Jan-2024	17,309	$15,372,328	$180,639	1.18%	$15,191,688	$15,900,521	0.8906	$1,308,134	$17,208,655
Feb-2024	17,404	$14,637,034	$145,410	0.99%	$14,491,624	$15,781,997	0.8823	$1,315,502	$17,097,499
Mar-2024	17,451	$14,970,876	$178,044	1.19%	$14,792,833	$15,741,984	0.8776	$1,319,007	$17,060,991
Apr-2024	17,485	$16,578,848	$155,965	0.94%	$16,422,883	$15,697,839	0.8742	$1,321,899	$17,019,738
May-2024	17,539	$17,181,667	$177,620	1.03%	$17,004,047	$15,668,402	0.8695	$1,325,675	$16,994,078
Jun-2024	17,555	$15,686,165	$125,508	0.80%	$15,560,657	$15,636,283	0.8673	$1,327,425	$16,963,708
Jul-2024	17,643	$15,629,817	$136,558	0.87%	$15,493,259	$15,622,620	0.8615	$1,333,842	$16,956,462
Aug-2024	17,684	$16,251,207	$167,942	1.03%	$16,083,265	$15,730,569	0.8590	$1,336,749	$17,067,318
Sep-2024	17,729	$15,962,033	$142,580	0.89%	$15,819,453	$15,573,044	0.8545	$1,340,333	$16,913,377
Oct-2024	17,773	$18,347,777	$163,928	0.89%	$18,183,849	$15,529,915	0.8493	$1,343,344	$16,873,259
Nov-2024	17,792	$15,866,794	$138,102	0.87%	$15,728,692	$15,448,846	0.8455	$1,345,045	$16,793,891
Dec-2024	17,820	$15,884,100	$146,318	0.92%	$15,737,782	$15,428,008	0.8431	$1,346,976	$16,774,984
Total Base Period 2022	40,332	$35,688,989	$246,676	0.69%	$35,442,313	$30,374,601	0.7843	$2,120,500	$32,495,101
Base Period PMPM		$884.88	$6.12		$878.76	$753.11		$52.58	$805.69
Total Base Period 2023	197,380	$168,729,246	$1,624,929	0.96%	$167,104,317	$168,123,156	0.8445	$11,975,289	$180,098,446
Base Period PMPM		$854.84	$8.23		$846.61	$851.77		$60.67	$912.45
Total Base Period 2024	211,184	$192,368,644	$1,858,612	0.97%	$190,510,033	$187,760,028	0.8644	$15,963,930	$203,723,958
Base Period PMPM		$910.91	$8.80		$902.10	$889.08		$75.59	$964.68

MA PPO

2026 Renewal - Preliminary Rates

MA Component of Premium PMPM

	State Regular	Local Regular	Local Deductible
	2026 Projected	2026 Projected	2026 Projected
Actuarial Value	0.955	0.955	0.955
MA Star Rating	4	4	4
Aggregate Benchmark (based on Star Rating)	$1,119.78	$1,119.78	$1,119.78
MA Risk Score	0.864	0.864	0.864
Claims Component	**$45.95**	**$45.95**	**$45.95**
Projected **Total Medical Claims Cost**	$1,023.48	$1,023.48	$1,023.48
Member Cost Sharing	$10.04	$10.04	$10.04
Direct Capitation (Risk Adjusted)	**$967.49**	**$967.49**	**$967.49**
Non-Claims Component	**$93.57**	**$93.57**	**$93.57**
Administration	$57.91	$57.91	$57.91
Fees and Taxes			
Risk Charges	$11.07	$11.07	$11.07
Profit	$18.34	$18.34	$18.34
Other (describe below)	$6.25	$6.25	$6.25
TOTAL	**$139.52**	**$139.52**	**$139.52**

Description of Other (Gym Memberships, etc.):

*Other: Customizations to our standard administration process that will allow us to deliver State of WI's unique requests.

Medicare Plus Medical Detail - State & Local

	Medical	
	Total Members	**Plan Paid**
Jan-2023	4,603	1,322,523
Feb-2023	4,622	916,504
Mar-2023	4,576	1,000,835
Apr-2023	4,567	846,395
May-2023	4,557	980,223
Jun-2023	4,547	1,334,410
Jul-2023	4,570	900,451
Aug-2023	4,544	895,929
Sep-2023	4,546	853,954
Oct-2023	4,535	899,624
Nov-2023	4,534	908,936
Dec-2023	4,517	859,851
Jan-2024	4,448	1,407,425
Feb-2024	4,468	1,009,688
Mar-2024	4,442	994,590
Apr-2024	4,426	1,362,149
May-2024	4,411	947,704
Jun-2024	4,422	866,443
Jul-2024	4,414	899,950
Aug-2024	4,411	859,198
Sep-2024	4,399	870,194
Oct-2024	4,411	879,922
Nov-2024	4,400	753,444
Dec-2024	4,378	705,935
Total Base Period 2023	54,718	$11,719,636
Base Period PMPM		$214.18
Total Base Period 2024	53,030	$11,556,641
Base Period PMPM		$217.93

Medicare Plus				
2026 Rates				
	State		Local	
Actuarial Value				
Rate Tier	Single	Family	Single	Family
2025 Premium Rate	$ 250.68	$ 501.36	$ 266.34	$ 532.68
2026 Premium Rate	$295.68	$591.36	$314.16	$628.32
State/Local Relationship Logic			1.06	
Family Relationship Logic		2.00		2.00

VALID

Medicare Plus Non-Claims Component				
2026 Projected				
	State		Local	
Rate Tier	Single	Family	Single	Family
Administration	NA	NA	NA	NA
Fees and Taxes	NA	NA	NA	NA
Risk Charges	NA	NA	NA	NA
Profit	NA	NA	NA	NA
Other (describe below)	NA	NA	NA	NA
Non-Claims Component Total	$0.00	$0.00	$0.00	$0.00

Description of Other (Gym Memberships, etc.):