State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2014)
S. 51.01(5) Wis. Stats.; s. 111.32(13m) Wis. Stats.

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

EXHIBIT 1

Pro Forma Contract By Authorized Board

Commodity or Service: Administrative Services for the State of Wisconsin Pharmacy Benefit Program

Contract No./Request for Proposal No: ETG0013

Contract Period: January 1, 2018 through December 31, 2020 with two (2), two (2) year renewal options

1. This CONTRACT is entered into by and between the State of Wisconsin Group Insurance Board (BOARD) hereinafter referred to as the "BOARD" and the State of Wisconsin, Department of Employee Trust Funds (ETF) hereinafter referred to as the "DEPARTMENT," and between XXXX hereinafter referred to as the "CONTRACTOR," whose address and principal officer appears on page 2. The DEPARTMENT is the sole point of contact for this CONTRACT.

2. The "AGREEMENT" (Pro Forma State of Wisconsin Pharmacy Benefit Program Agreement), including all exhibits, appendices, and attachments, are hereby incorporated by reference in the Order of Precedence as if set forth below.

3. The CONTRACTOR will observe and comply with all the terms and conditions of the AGREEMENT, CONTRACTOR submittals, terms of the described Uniform Benefits, state employee and local public employee group health insurance plans and in accordance with the CONTRACTOR's proposal dated XXXXX hereby made a part of this CONTRACT and hereby incorporated by reference in the Order of Precedence set forth below.

4. In connection with the performance of work under this CONTRACT, the CONTRATOR agrees not to discriminate against any 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. 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.

5. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. CONTRACTORS with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the CONTRACT, CONTRACTOR shall submit the plan for approval to the DEPARTMENT. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFSMBProcurement@etf.wi.gov.

6. For purposes of administering this CONTRACT, the Order of Precedence is:
   A). This CONTRACT between the DEPARTMENT and XXXX, and;
   B). the RFP including the AGREEMENT dated XXXXX, and;
   C). CONTRACTOR'S proposal dated XXXXX.

Contract Number & Service: **ETG0013** – Administrative Services for the State of Wisconsin Pharmacy Benefit Program

State of Wisconsin **Department of Employee Trust Funds**
By *(Name)*
Signature
Title **Chair** Group Insurance Board
Phone
Date *(MM/DD/CCYY)*

Contractor to Complete
Legal Company Name
Trade Name
Taxpayer Identification Number
Company Address *(City, State, Zip)*
By *(print Name)*
Signature
Title
Phone
Date *(MM/DD/CCYY)*

Exhibit 1

Pro Forma State of Wisconsin Pharmacy Benefit Program Agreement

State of Wisconsin Pharmacy Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (Section 400 of this AGREEMENT), the RFP #ETG0013, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means this State of Wisconsin Pharmacy Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the PHARMACY BENEFIT PROGRAM. This AGREEMENT shall be made a part of the CONTRACT.

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

> **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 twenty (20) years of creditable service.
>
> **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 with twenty (20) years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a). Also means 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, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

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

BOARD means the State of Wisconsin Group Insurance Board.

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

CMS means Centers for Medicare and Medicaid Services.

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

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

CONTRACT means this Pro Forma State of Wisconsin Pharmacy Benefit Program Agreement, which includes all attachments, supplements, endorsements, riders, the Pro Forma Contract By Authorized Board, and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

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

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

DAY means Business DAY unless otherwise indicated.

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

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

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

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

EGWP or "800 SERIES" EGWP means Employer Group Waiver Plan as defined by CMS.

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

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

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

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 health care coverage available to its EMPLOYEES.

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

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

LOCAL EMPLOYER means an employer who has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

GUIDELINES means the "Terms and Conditions for Comprehensive Medical Plan participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits," form ET-1136, specifically Part 4. Uniform Benefits, as in effect for the year in question.

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

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

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

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

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

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

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

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

PBM means Pharmacy Benefit Manager.

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

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

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

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

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP) #ETG0013.

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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

SECURE means the confidentiality, integrity, and availability of the DEPARTMENT'S data is of the highest priority and must be protected at all times. All related hardware, software, firmware, protocols, methods, policies, procedures, standards, and guidelines that govern, store, or transport the data must be implemented in manners consistent with current industry standards, such as, but not limited to the Health Insurance Portability and Accountability Act (HIPAA), Genetic Information Nondiscrimination Act (GINA), National Institute of Standards and

Technology (NIST) 800-53, and Center for Internet Security (CIS) Critical Security Controls to ensure the protection of all DEPARTMENT data.

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

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

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

100 GENERAL

105 Introduction

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

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0013 and in the PROPOSAL.

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

110 Objectives

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

1) Management and delivery of pharmacy benefits per the GUIDELINES as provided by the BOARD.

2) To provide excellent customer service to PARTICIPANTS.

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

4) To provide complete transparency in the contracting, purchasing, and provision of pharmacy benefits through this program as defined in the RFP #ETG0013 for PBM services.

5) Accurate, timely and responsive administration of pharmacy claims.

6) To assist the BOARD in achieving strategic goals that include:

    a) Managing total pharmacy costs.

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

c) Promoting behavior change and accountability.

115 General Requirements

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

1) Share data, claims information and other operational information as necessary for the smooth functioning of the program, for example to the health plans participating in the health insurance program, the BOARD's consulting actuary, DEPARTMENT'S data warehouse and the wellness and disease management vendor, using the most recent file and data specifications provided by the DEPARTMENT.

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

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

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

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

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

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT.

8) Apply effective methods for containing costs for pharmacy BENEFITS with effective utilization review mechanisms for monitoring prescription drug related costs and the administration of Coordination of Benefit (COB) provisions.

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

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

specific Uniform Benefit contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision.

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

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

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

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in services provided by a non-PARTICIPATING PHARMACY.

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

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

14) Provide notification of all significant events:

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

slow-downs or substantial impairment of the CONTRACTOR'S facilities or of other facilities used by the CONTRACTOR in the performance of this AGREEMENT.

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

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

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

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

   ii) The date such action becomes effective.

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

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

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S

data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

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

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

19) 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.

20) The DEPARTMENT must be notified of any changes to the CONTRACTOR'S administrative and/or operative systems

120 Board Authority

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

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

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

4) In cases where data submitted by the CONTRACTOR is deemed to be inadequate by the BOARD, the DEPARTMENT, or the BOARD'S consulting actuary, the BOARD may take any

action up to and including limiting new enrollment into the PHARMACY BENEFIT PROGRAM administered by the CONTRACTOR.

5) In the event a CONTRACTOR becomes, or is at risk for becoming insolvent, experiences a significant event or significant loss of PARTICIPATING PHARMACIES, or if the BOARD so directs due to a significant event as described in Section 115, the BOARD may do any of the following, including any combination of the following:

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

   b) Close the PHARMACY BENEFIT PROGRAM administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.

   c) Take no action.

6) The BOARD may forfeit a SUBSCRIBER'S rights to the PHARMACY BENEFIT PLAN if a PARTICIPANT fraudulently or inappropriately assigns or transfers rights to an ineligible individual(s), or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

7) The BOARD may initiate disenrollment efforts in situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care provider. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. The BOARD may limit re-enrollment options in the PHARMACY BENEFITS PROGRAM.

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

125 Eligibility

125A General

For PHARMACY BENEFIT PLAN purposes, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

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

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

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

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

   c) Certain visiting faculty members in the UW System.

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

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

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

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

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

8) ANNUITANTS and CONTINUANTS:

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

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the PHARMACY BENEFIT PLAN if a timely application is submitted.

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

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

f) Any 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, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

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

125C Change to Family Coverage

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

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

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

125D No Double Coverage

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

125E Local Annuitants

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

125F Medicare Participants

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

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

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

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

125G Premiums

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

a) Projection of incurred claims costs for the renewal benefit period.

b) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

c) Actual and projected weighted cost and utilization trends for the immediate-past, current and renewal benefit period, for both the HEALTH BENEFIT PROGRAM and the CONTRACTOR's book of business.

d) Actual and projected Medicare Part D subsidies, administrative fees and REBATE histories.

e) Updates regarding the pharmacy network contracting and discount negotiation efforts; drug manufacturer REBATE and pricing negotiation efforts; clinical programs; new drug indications and pipeline projections; and brand-to-generic savings.

f) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

g) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

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

1) SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 245 and 250.

2) The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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

4) Medicare Participant Premiums
   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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.
   b) If a Medicare coordinated family PREMIUM category has been established for a family, and one or more family members enrolled in both parts of Medicare dies, the family PREMIUM category in effect shall not change solely as a result of the death.
   c) Except in cases of fraud which shall be subject to Section 150E, coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six (6) months. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.
   d) In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER

130 Administrative Fee and Financial Administration

130A Financial Provisions

1) **Claims Invoicing**:
   a) The BOARD assumes all financial responsibility for claims submitted for PARTICIPANTS to the CONTRACTOR, whether by PARTICIPATING PHARMACIES or PARTICIPANTS. The DEPARTMENT shall initiate Automated Clearinghouse (“ACH”) transfers to the CONTRACTOR within four (4) business days of receipt of the CONTRACTOR’S invoices as authorized below.

   b) Billing and payment cycles for pharmacy claims and administrative fees will occur twice monthly. Billing and payment cycles for claims submitted directly by PARTICIPANTS will occur monthly. Billing and payment cycles may be modified if mutually agreed upon by the CONTRACTOR and the DEPARTMENT. The CONTRACTOR will electronically send invoices, in forms satisfactory to both parties, to the DEPARTMENT as follows:
      (1) Pharmacy Claims Reimbursement. Cycle I: Encompasses prescription claims processed day one (1) through day fifteen (15). The CONTRACTOR will electronically

send an invoice to the DEPARTMENT two DAYS after the end of the cycle. Cycle II: Encompasses prescription claims processed day sixteen (16) through the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.

(2) Member Claims Reimbursements (manual claims received directly from PARTICIPANTS). Each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.

2) **Administrative and Other Fee Invoicing**:

a) As payment in full for the services described in this CONTRACT (except as expressly set forth otherwise herein), the BOARD agrees to pay a per-member-per-month (PMPM) administrative fee that is multiplied by the number of active members in the claims processing system on the fifteenth (15th) of each month.

b) Payments shall be made semi-monthly, based on the number of active members in the claims processing system on the 15th of the month.

(1) Administrative Fees. Cycle I: Encompasses administrative fees for services provided from day one (1) through day fifteen (15). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two business days after the end of the cycle. Cycle II: Encompasses administrative fees for services provided from sixteen (16) through the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.

(2) Other Fees. For any fees other than the administrative fees, each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.

c) The PMPM administrative fee effective January 1, 2018, may be adjusted annually, during the initial term of the contract, as of January 1 of each year. Cost increases for any CONTRACT shall be negotiated in good faith and mutually agreed upon by both parties.

d) Medicare Part D Drug Program. The CONTRACTOR shall administer a Medicare Part D Program for eligible PARTICIPANTS as described in Section 215C. Payment in full by the BOARD for Medicare Part D related services will be a PMPM administrative fee that is multiplied by the number of Medicare Part D active members in the claims processing system on the fifteenth (15th) of each month.

e) In the event the BOARD determines that additional services, not originally contemplated in this CONTRACT, are necessary to realize the purposes or in the best interests of the individuals covered by the pharmacy benefit, the DEPARTMENT may first approach the

CONTRACTOR about providing those services. If the parties both agree, the DEPARTMENT and the CONTRACTOR shall negotiate in good faith in an attempt to establish fair and reasonable additional compensation for the CONTRACTOR to perform the additional services. If unable to reach an agreement, the DEPARTMENT may seek the services elsewhere.

3) <u>Failure to Make Funds Available</u>.

a) In the event that for any reason the DEPARTMENT fails to make funds available to pay claims for COVERED PRODUCTS or has failed to pay fees to the CONTRACTOR and the DEPARTMENT fails to provide the required funds within one (1) business day after notice of the need to provide such funds.

b) In the event that the DEPARTMENT has at any time failed to make funds available to pay claims for COVERED PRODUCTS or has failed to pay fees to the CONTRACTOR, in addition to any other remedies.

4) <u>REBATE Calculation and Payment</u>. The DEPARTMENT will receive 100% of all earned REBATES, including future REBATES on new, REBATE--ELIGIBLE PRODUCTS such as SPECIALTY DRUGS.

a) The DEPARTMENT shall have the right, at its expense, at reasonable times and upon reasonable notice, to review and audit the books and records of the CONTRACTOR pertaining to such REBATES; provided, however, that the CONTRACTOR shall not be obligated to disclose any documents or information that would cause the CONTRACTOR to violate any laws, any contractual obligations of confidentiality, or other legally binding obligations.

b) The DEPARTMENT will receive REBATE payments on a QUARTERLY basis. Within ninety (90) days of the CONTRACTOR's receipt of said quarter's audited REBATE results, the CONTRACTOR will reduce the invoice amount for claims invoicing by the amount of REBATE payments.

5) <u>Pass Through of Drug Manufacturer Revenue</u>. The DEPARTMENT will receive 100% of all drug manufacturer revenue obtained by the CONTRACTOR, including, but not limited to, administrative fees; data fees; clinical programs fees; education and research grants; invoice charge-back fees; and product selection switching incentives.

a) The DEPARTMENT shall have the right, at its expense, at reasonable times and upon reasonable notice, to review and audit the books and records of the CONTRACTOR pertaining to such revenue.

b) The DEPARTMENT will receive drug manufacturer revenue payments on a QUARTERLY basis. Within ninety (90) days of the CONTRACTOR's receipt of said quarter's audited revenue results, the CONTRACTOR will reduce the invoice amount for claims invoicing by the amount of revenue payments.

6) <u>Contractor Maximum Allowable Cost List.</u> The CONTRACTOR maintains a single Maximum Allowable Cost ("MAC") list for generic drug PRODUCTS that is based upon

Wisconsin Medicaid MAC prices multiplied by a factor of 1.20. The CONTRACTOR MAC list may be modified QUARTERLY by the CONTRACTOR to reflect any modification or changes to the Wisconsin Medicaid MAC list. In addition, MAC prices may be increased or decreased as needed to account for sudden fluctuations in pharmacy acquisition costs and MAC prices for new generic entities may be established prior to the QUARTERLY updates. The MAC list will be the same for each distribution channel (i.e. Retail, Retail 90 day, Mail Order, Specialty) and the basis for generic DRUG reimbursement at PARTICIPATING PHARMACIES.

7) Banking

a) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT within four (4) business days following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

b) The CONTRACTOR shall perform a monthly bank reconciliation and provide a reconciliation report to the DEPARTMENT within twenty (20) BUSINESS DAYS following each month's end.

c) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred, and by STATE and LOCAL subgroups.

d) No such amounts that are rightfully transferred to the CONTRACTOR shall be considered PHARMACY BENEFIT PROGRAM assets. Amounts incorrectly transferred to the CONTRACTOR by the DEPARTMENT on behalf of the BOARD remain assets of the Public Employee Trust Fund for which the BOARD is trustee.

130B Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee the cost to handle any claims paid outside of Uniform Benefits unless expressly authorized by the DEPARTMENT.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

3) The payments to the CONTRACTOR under the terms of the CONTRACT do not include compensation for providing the following services:
   a) *On-site personnel*. At the DEPARTMENT's request, the CONTRACTOR shall provide on-site support and administrative services by providing personnel to work at the DEPARTMENT offices to perform tasks associated with the administration of the contract.

b) *Expert services*. At the request of the BOARD, the CONTRACTOR shall make available to the DEPARTMENT qualified medical consultants to assist the DEPARTMENT in its reviews of questionable claims, claims recommended for denial for medical reasons, reconsiderations and appealed claim determinations.
c) *Mailing & Postage*. The CONTRACTOR will pay for all mailing, postage and handling costs for the distribution of materials as required by Section 135 Participant Materials and Marketing, or by other express provisions of this CONTRACT.
d) *Pilot Clinical Services*. Any clinical services entered into as a pilot or limited-term trial shall be paid for by the CONTRACTOR.

130C Recovery of Overpayments

1) Overpayments:

a) If it is determined that any payment has been made under the PHARMACY BENEFIT PLAN and this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

b) If any overpayments made for benefits for ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments.

c) Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments.

d) Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

e) The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS

DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes Over Payments to a PARTICIPATING PHARMACY:

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

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

130D Automated Clearinghouse (ACH)

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

135 Participant Materials and Marketing

135A Informational/Marketing Materials

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

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

The notice in Appendix A of the federal Section 1557 ACA regulations must be published in conspicuously-visible font size in all significant communications and significant publications, both print and web, related to the State of Wisconsin and Wisconsin Public Employers Group Health Insurance Programs. The CONTRACTOR must use the notice as provided below, or a significantly similar version that meets the regulation requirements.

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

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

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

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

The notice is as follows:

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

[*Name of CONTRACTOR*]:

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

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

If you believe that [*Name of CONTRACTOR*] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [*Name and Title of Civil Rights Coordinator*], [*Mailing Address*], [*Telephone number*], [*TTY number—if covered entity has one*], [*Fax*], [*Email*].

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [*Name and Title of Civil Rights Coordinator*] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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

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

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

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

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

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

135B It's Your Choice Open Enrollment Materials

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

1) The CONTRACTOR shall issue written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period, identifying those PARTICIPATING PHARMACIES that will not be IN-NETWORK for the upcoming benefit period and include any specific language directed by the DEPARTMENT summarizing any BENEFIT or other PHARMACY BENEFIT PLAN changes. This notification cannot be combined with informational materials sent to non-PARTICIPANTS. The

CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) this written notice was issued.

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

    a) CONTRACTOR information, including address, toll-free customer service telephone number, and website address.

    b) CONTRACTOR's content for the pharmacy benefit related information page, including available features.

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

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

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

135C Required Member and Prescriber Outreach

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

The CONTRACTOR will also be required to contact PRESCRIBERS and PARTICIPATING PHARMACIES to notify these organizations of formulary change. Notification should be made no less than 90 days prior to the change in formulary.

140 Information Systems

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

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

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

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

   a) A minimum of eight (8) characters,

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

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

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

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

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

      iii) Numeric (0 - 9),

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

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

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

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

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

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

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

145 Data Integration and Technical Requirements

145A General Department Data Requirements

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

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

The CONTRACTOR must follow the DEPARTMENT'S SECURE file transfer protocols (sFTP) using the DEPARTMENT'S sFTP site to submit and retrieve files from the DEPARTMENT or

provide another acceptable means for SECURE electronic exchanging of files with the DEPARTMENT, as approved by the DEPARTMENT.

145B Eligibility/834 File Requirements

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

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

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

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

d) The CONTRACTOR shall maintain an exception report spreadsheet that includes the error details and final resolution, and submit it to the DEPARTMENT, at the frequency directed by the DEPARTMENT.

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

145C Data Warehouse File Requirements

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

a) Pharmacy Claims Data - The CONTRACTOR must submit on a monthly basis, or other frequency agreed upon by the CONTRACTOR and the DEPARMENT, to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Pharmacy Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless

otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) PARTICIPATING PHARMACY Data – The CONTRACTOR must submit on a monthly basis, or other frequency agreed upon by the CONTRACTOR and the DEPARTMENT, to the DEPARTMENT'S data warehouse, in the file format specified by the DEPARTMENT in the most recent Network Pharmacy Data Specifications document, the specified data for all PARTICIPATING PHARMACIES including subcontracted pharmacies, and any non-participating pharmacies for which the CONTRACTOR has processed or expects to process claims. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT

c) Medical Claims Data – The CONTRACTOR must establish a data transfer process to retrieve medical claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data as required later in this section. The medical claims data is based on data provided by the DEPARTMENT's contracted, participating health coverage plans to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a daily file from the participating health coverage plans that will be in a file format compliant with the most recent Claims Data Specifications provided by the DEPARTMENT with consultation with the participating health coverage plans.

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

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

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

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

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

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

Health information provided to the DEPARTMENT will only be aggregate in nature, unless authorized by the PARTICIPANT for the purpose of appeal, issue resolution, or fraud investigation.

145D Data Integration and Use

The CONTRACTOR is expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, Wisconsin Health Information Organization (WHIO) claims data, information requested on the disease management survey and catastrophic claims data, and other data as required by the DEPARTMENT, using the most recent file and data specifications provided by the DEPARTMENT. Where appropriate, such as for the catastrophic claims data report, the CONTRACTOR is expected to separate out pharmacy claims from the DEPARTMENT'S health coverage plans from any pharmacy claims that are paid by the CONTRACTOR.

The CONTRACTOR shall provide and receive all reasonable requests for data and other information as needed in a file format as identified by the DEPARTMENT. The CONTRACTOR will place no restraints on the use of the data.

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

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

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

150 Miscellaneous General Requirements

150A Reporting Requirements and Deliverables:

1) The CONTRACTOR will provide the DEPARTMENT on a monthly basis, with standard management reports that will include at a minimum:
   a) top drugs by cost and prescriptions filled,
   b) monthly trends,
   c) utilization by drug class, disease state, distribution channel and tier/cost-share level,
   d) results of cost savings measures and clinical programs,
   e) REBATE allocation,
   f) complaints, grievances, appeals and independent review decisions,
   g) and telephone/call center and other customer service activity.

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

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

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

   b) Be delivered on or before scheduled due dates,

   c) Be submitted as directed by the DEPARTMENT,

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

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

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

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

5) The CONTRACTOR will present to the DEPARTMENT semi-annually on the overall status of the PHARMACY BENEFIT PLAN to include reviews of drug utilization (SPECIALTY DRUGS and non-specialty drugs); formulary, network and clinical program management; historical and prospective trends; drug pipeline forecasting; and PHARMACY BENEFIT PLAN opportunities. Information and data will be presented for both the commercial and Medicare populations of the PHARMACY BENEFIT PLAN.

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

7) The CONTRACTOR shall promptly respond to all inquiries from the BOARD and the DEPARTMENT concerning any aspect of the PHARMACY BENEFIT PLAN management.

8) The CONTRACTOR shall promptly purge and update files according to BOARD guidelines.

9) The CONTRACTOR shall work cooperatively with BOARD designees on budget and policy implementation.

150B Performance Standards and Penalties

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

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

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

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

150C Nondiscrimination Testing

The CONTRACTOR shall provide annual Internal Revenue Code (IRC) Sec. 105(h) compliant nondiscrimination testing for the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT during the implementation process to determine a schedule and process for the testing. The DEPARTMENT will set a due date for the test results during implementation, and then will provide a due date annually along with other reporting due dates for subsequent years.

150D Audit and Other Services

1) **Records**. The CONTRACTOR shall maintain books, records, documents and other evidence pertaining to the administrative services under this CONTRACT to the extent and in such detail as shall properly reflect all performance of the CONTRACTOR's duties herein and in accordance with full transparency as defined in the RFP #ETG0013.

2) **Cooperation with Auditors**. The CONTRACTOR will, in conjunction with BOARD-designated personnel, participate in and cooperate fully with audits of the CONTRACTOR's services under this CONTRACT as required under Federal or State law, and with other audits or reviews of the CONTRACTOR's services under this CONTRACT determined by the BOARD to be necessary and appropriate. This may include an audit on behalf of the Wisconsin State Legislature by the Legislative Audit Bureau.

3) **Annual Audits.**
   a) The CONTRACTOR is required to submit to annual audits of its services, operations, and compliance under this CONTRACT according to audit guidelines established by the BOARD and in accordance with full transparency as defined in the RFP #ETG0013. The audits will be completed by the firm contracted by the BOARD to complete third party contract audits of the PHARMACY BENEFIT PLAN, and will be paid for by the BOARD. The audits by the third party contractor will be based upon BOARD specifications and will evaluate 100% of the claims processed by the CONTRACTOR. The audit firm will deliver to both the CONTRACTOR and to the BOARD a report of findings and recommendations within the guidelines established by the BOARD.

   b) The report will be prepared in accordance with generally accepted auditing standards, and will include the following matters and other matters as agreed by the BOARD and the CONTRACTOR: comprehensive compliance audit of the program; evaluation of internal control; risk assessment of the administration of the program; analyses of data, billing, etc. to ascertain compliance with CONTRACT provisions and accepted accounting principles, good business practice, etc.; and substantive tests to evaluate the accuracy of recording and processing transactions and the effectiveness, efficiency, and economy of transaction processing.

   c) The audits by the third party contractor of the BOARD will also audit the flow and proper use of the BOARD's funds through the CONTRACTOR's claims processing system; review the content of, and audit cash flows pertaining to all contracts between the CONTRACTOR and pharmaceutical manufacturers, including payments of REBATES from those manufacturers to the CONTRACTOR; and review the content of, and audit cash flows pertaining to all contracts between the CONTRACTOR and PARTICIPATING PHARMACIES.

   d) The CONTRACTOR shall agree to an audit conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the Statement of Standard for Attestation Engagements (SSAE) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.)

4) **Internal Controls Review.** The CONTRACTOR will cooperate with an independent third-party auditor's study and evaluation of and testing of the effectiveness of the internal controls over its contract tasks at least once per year. The study evaluation shall be at the BOARD's expense.

150E Fraud and Abuse

1) **Participant Fraud**

a) Policy on Participant Fraud

No person other than a PARTICIPANT is entitled to BENEFITS under this AGREEMENT. The SUBSCRIBER or any of his or her DEPENDENTS are not authorized by this AGREEMENT to assign or transfer their rights under the AGREEMENT, aid any other person in obtaining BENEFITS to which they are entitled or knowingly present or cause a false or fraudulent claim. The SUBSCRIBER'S rights to coverage under the PHARMACY BENEFITS PLAN are forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise falsely or fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment rights may be limited as determined by the BOARD.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

b) Contractor Responsibility Related to Participant Fraud

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any suspected or identified PARTICIPANT fraud. The CONTRACTOR must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT. Fraud may result in the reprocessing of claims and recovery of overpayments. For information see Section 130 C.

2) **Pharmacy and Prescriber Review Requirements**

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

Examples of potential findings that could be included in QUARTERLY reviews include, but are not limited to:

a) Controlled Substance Prescribing: Identification of PARICIPANTS who have received multiple prescriptions in drug categories with high potential for abuse (e.g. opioids, benzodiazepines, barbiturates, amphetamines, etc.) from more than one provider and filled at more than one pharmacy.

b) Duplicate Therapy: Identification of PARTICI[ANTS who are prescribed multiple drug regimens of related medications for more than one condition, by more than one provider;

c) Multiple attempts to submit a single claim and/or overcharge for cost of drug or PARTICIPANT cost-share amount by a PARTICIPATING PHARMACY.

d) Indications of a PARTICIPANT with multi-prescriber, multi-pharmacy and/or multi–prescription instances.

3) **Appeal Process Support**.

a) The CONTRACTOR shall participate in all administrative hearings under Wis. Admin. Code Ch. ETF 11 to the extent determined to be necessary by the attorney(s) representing the DEPARTMENT.

b) Participation means providing evidence and testimony necessary to explain the claim decisions made by the CONTRACTOR. The CONTRACTOR shall be responsible for any cost required for participation in the administrative hearings by the CONTRACTOR'S staff and any approved subcontractors, including but not limited to time spent at the hearing and travel time to and from the hearing.

150F Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. In addition to (and in accordance with?) the provisions of section 22 of the Department Terms and Conditions, the CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or 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. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. At a minimum, the CONTRACTOR shall report to the DEPARTMENT the following:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

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

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

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

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

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

150G Department May Designate Vendor

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

150H Contract Termination

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

1) If the BOARD terminates this CONTRACT, then all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination.

2) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

3) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

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

150I Transition Plan

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

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

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

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

200 PROGRAM REQUIREMENTS

205 Enrollment

CONTRACTORS must participate in the annual IT'S YOUR CHOICE OPEN ENROLLMENT offering. The IT'S YOUR CHOICE OPEN ENROLLMENT period is scheduled for each fall prior to the covered program year. During the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR will accept any eligible EMPLOYEE or state retiree under Wis. Stat. § 40.51 (16) who enrolls.

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

205A Enrollment Files

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

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

205B Identification (ID) Cards

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

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

1) The CONTRACTOR shall issue ID CARDS within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 2) below.

2) For elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID CARDS by December 15 for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTACTOR must notify the DEPARTMENT Program Manager of any delays with issuing

the ID CARDS. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID CARDS were issued.

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

205C Participant Information

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

1) Information about PARTICIPANT requirements, including PRIOR AUTHORIZATIONS and appeals/grievance procedures.

2) An "Overview of Benefits" brochure that will include a description of how the formulary is developed, information about the web site, and a description of PHARMACY BENEFIT PLAN features.

3) A mail-order brochure.

4) The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, and website address.

205D Termination of Coverage

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

205E Date of Death

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

205F Coordination of Benefits (COB)

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

210 Pharmacy Benefit Management

The CONTRACTOR shall be responsible for ONLINE TRANSACTION PROCESSING of claims for COVERED PRODUCTS submitted by PARTICIPATING PHARMACIES, according to the benefit plan coverage parameters provided under Uniform Benefits. PARTICIPANT file information will be supplied by the BOARD. Such ONLINE TRANSACTION PROCESSING shall include eligibility and coverage determination, calculation of allowable costs and applicable

DEDUCTIBLES, COINSURANCE or COPAYMENTS, and communication of payment disposition to PARTICIPATING PHARMACIES, and shall be subject to the terms and conditions of this CONTRACT, including but not limited to the procedures set forth in Section 230 Claims. In addition to administering pharmacy claims, the CONTRACTOR, with the consent of the BOARD, shall establish the collateral procedures and services necessary to provide PHARMACY BENEFITS under the BOARD's HEALTH BENEFIT PROGRAM in accord with the PROPOSAL and this CONTRACT, including enrollment and eligibility systems, according to Health Insurance PBM ANSI 834 Project Documents.

210A Pharmacy & Therapeutics Committee and Population Health Management

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

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

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

Prior Authorization

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

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

Step Therapy Protocols

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

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

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

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

The current DEPARTMENT programs are:

1) Access to Mail Order Services. The CONTRACTOR shall establish a fair and competitive process to identify, evaluate, and contract with a single vendor of mail order pharmacy services while this CONTRACT is in effect. The process and choice of vendor are subject to approval by the DEPARTMENT, on behalf of the BOARD.
    a) Distribution of Information. The contract with the mail order pharmacy vendor shall provide that a member may begin the mail order process with the chosen vendor by phone, online, or by filling out a mail order brochure. In addition, refills can be ordered online. The vendor will provide to PARTICIPANTS, on request, informational material explaining its services and the forms necessary for PARTICIPANTS to utilize the mail service.

    b) Delivery and Dispensing. Subject to, and in accordance with plan design, the CONTRACTOR's Mail Order pharmacy will dispense new or refill prescription orders upon receipt from a PARTICIPANT of (i) a valid prescription order or a completed refill order form; and (ii) the applicable COPAYMENT, COINSURANCE, or DEDUCTIBLE amount. The CONTRACTOR's Mail Order pharmacy will fill and mail to each PARTICIPANT via common carrier at the address set forth in the eligibility file, or as appearing on the face of the prescription, so long as such addresses are within the United States.

c) The CONTRACTOR'S Mail Order pharmacy shall be subject to all provisions of this CONTRACT that apply to all other PARTICIPATING PHARMACIES.

2) Specialty Drug Management Program. The CONTRACTOR shall make available to the BOARD a SPECIALTY DRUG management program through the vendor or vendors chosen by the CONTRACTOR and in agreement with the BOARD to provide that service. After initial implementation, the BOARD agrees that it will provide incentives based on benefit design for PARTICIPANTS to use the SPECIALTY DRUG management program as the preferred channel for obtaining SPECIALTY DRUGS.

3) Contractor Standard Formulary Management. The BOARD agrees to cooperate and work with the CONTRACTOR to affect the adoption, distribution, and implementation of an evidence based drug formulary designed to achieve the lowest overall net program cost consistent with the highest level of quality outcomes.

4) Generic Alternatives. The CONTRACTOR will implement a Generic Alternatives Program designed to offer generic alternatives to brand PRODUCTS to reduce costs for both the BOARD and the PARTICIPANT.

5) Dose Consolidation. The CONTRACTOR will implement a Dose Consolidation Program designed to identify opportunities for MEMBERS who are on multiple dose medications that can be safely administered in a single dose to reduce costs for both the BOARD and the PARTICIPANT.

6) Pill-Splitting Program. The CONTRACTOR will develop and implement a voluntary half-tablet program designed to encourage the use of half-tablet medications by reducing the COPAYMENT or COINSURANCE for certain PRODUCTS in accord with the provisions of the PHARMACY BENEFIT PLAN. The program will only be available for PRODUCTS that: (i) are COVERED DRUGS on the formulary; (ii) are recognized as an appropriate PRODUCT to split by the CONTRACTOR's P&T Committee; (iii) the various strengths of the PRODUCT are comparably priced; and (iv) the PRODUCT has once-daily dosing. If the Half-Tablet Program is adopted by the BOARD, CONTRACTOR will provide pill splitting devices to PARTICIPANTS. These pill splitting devices may contain the CONTRACTOR logo or may be customized to carry the DEPARTMENT's logo.

7) Web Site. The CONTRACTOR will maintain a publicly accessible website. The site will include but will not be limited to the formulary, benefit design, individual look-up capabilities, claims history, "contact us" option, information on pill splitting, mail order services and other programs offered. There will be direct access to the BOARD's program functions.

8) Pharmacy Auditing Program. Each PARTICIPATING PHARMACY in the CONTRACTOR's network shall be subject to audit. The BOARD may require use of an independent auditor rather than the CONTRACTOR. Auditing will be conducted in four phases starting at a high-level system audit and progressing through further drill-down

and analysis to on-site audits if necessary. Desk-top audits will be conducted on a daily/weekly/monthly basis, depending on the type of audit report. On-site audits will be conducted as needed. Settlements that are the result of reversing or adjusting claims found to be processed in error will be passed back through to the BOARD for inclusion in the funds for the PHARMACY BENEFIT PLAN AND HEALTH BENEFIT PROGRAM.

9) Pharmacy Educational Services. The CONTRACTOR will conduct a program by which PARTICIPATING PHARMACIES are reimbursed for providing clinical and educational services to PARTICIPANTS. The CONTRACTOR shall report on the cost and effectiveness of the program and the BOARD shall have the opportunity to periodically review, suspend or cancel all or part of the program at its discretion.

215 Benefits

215A Overview

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

215B Benefit Plan Specifications

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

1. Because BOARD changes to the PHARMACY BENEFIT PLAN may require programming changes, such changes will be coordinated with the CONTRACTOR to assure timely implementation and minimal disruption of the ongoing PHARMACY BENEFIT PLAN. The time required for new PHARMACY BENEFIT PLAN changes will generally be as follows:

    a) Two weeks for changes within the existing PHARMACY BENEFIT PLAN structure, which require minimal or no changes to the CONTRACTOR's claims and/or eligibility processing systems.

    b) Four to six weeks for changes for which functionality is currently available in the CONTRACTOR's claims and/or eligibility processing systems, but not utilized within the PHARMACY BENEFIT PLAN structure.

    c) Twelve to twenty-four weeks for changes for which functionality needs to be developed in the CONTRACTOR's claims and/or eligibility processing systems.

2. The CONTRACTOR will notify the BOARD as promptly as reasonably possible following receipt of the request as to the feasibility and timing of the requested change. The CONTRACTOR shall not be responsible for implementing any changes to any previously established PHARMACY BENEFIT PLAN information until the CONTRACTOR has confirmed its agreement to and acceptance of implementation of such changes to the BOARD in writing, including a timetable for change implementation.

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

215C Medicare Part D/EGWP Coverage

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

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

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

220 Quality

1) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in encouraging and/or requiring PARTICIPATING PHARMACIES to participate in quality initiatives, including those identified by the DEPARTMENT. The CONTRACTOR must demonstrate their efforts in encouraging prescribers to participate in quality initiatives as well.

2) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, its support for the DEPARTMENT'S initiatives in monitoring and improving quality of care. This may include providing actual contract language that specifies PARTICIPATING PHARMACY agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to pharmacy reimbursement.

3) The CONTRACTOR shall collaborate with, the DEPARTMENT, HEALTH BENEFIT PROGRAM providers and other vendors contracted by the BOARD on quality initiatives to address current population health issues. The CONTRACTOR shall report to the DEPARTMENT semi-annually any initiatives and pilot programs offered by the CONTRACTOR or the PARTICIPATING PHARMACIES, including information on patient engagement and outcomes.

225 Pharmacy Network Administration

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

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

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

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

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

The CONTRACTOR must certify annually that their provider contracts meet the requirements in Section 230. The DEPARTMENT reserves the right to review any contracts with providers that are IN-NETWORK for the PHARMACY BENEFIT PLAN.

225A Pharmacy Network Access

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

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

225B Pharmacy Network Directory

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

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

225C Pharmacy Network Contracts Shall Include Compliance Plans

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

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

1) Effective internal controls to assure compliance with Federal and State laws, rules, regulations and internal policies and procedures.

2) Staff training on identification and prevention of unlawful and unethical conduct.

3) Create a centralized source for distributing information on health care statutes, regulations and other program directives.

4) Establish procedures that allow the prompt, thorough investigation of possible misconduct by employees and independent contractors.

230 Claims

230A Claims Administration

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

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

230B Review of Claims Decisions

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

230C Claims Submitted by Participants

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

235 Grievances

235A Grievance Process Overview

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

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

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

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

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

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

235B Claim Review

The CONTRACTOR shall perform a claim review when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, the CONTRACTOR shall notify the PARTICIPANT of the decision. If the decision is to uphold the denial of BENEFITS, the

PARTICIPANT shall receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a grievance.

235C Participant Notice

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

235D Investigation and Resolution Requirements

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

235E Notification of Department Administrative Review Rights

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

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

The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). However, the DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) 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 guidelines and rules and regulations promulgated by the DEPARTMENT.

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

235F External Review

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

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

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

235G Provision of Complaint Information

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

235H Department Request for Grievance

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

235I Notification of Legal Action

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

235J Compliance with Departmental Determination

If a departmental determination overturns a CONTRACTOR'S decision on a PARTICIPANT'S grievance, the CONTRACTOR shall comply with the determination within ninety (90) calendar DAYS of the date of the determination. As used in this section, "comply" means to take action as

directed in the departmental determination within ninety (90) calendar DAYS. Failure to either comply within ninety (90) calendar DAYS will result in penalties as described in Section 315 Performance Standards.

240 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered DEPENDENTS, see Section 250D Surviving Dependents.

If the ANNUITANT or CONTINUANT contacts the CONTRACTOR directly to cancel coverage, the CONTRACTOR is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

245 Direct Pay Premium Process

The health plans that participate in the HEALTH BENEFIT PROGRAM must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the health plans, and approved by the DEPARTMENT, the health care coverage shall be canceled by the health plans. The health plans 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. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.

Retroactive terminations of coverage for direct pay SUBSCRIBERS may create claims overpayments situations if the PARTICIPANT continues to utilize benefits after losing eligibility and coverage. See Section 130C.

250 Continuation

250A Right to Continue Coverage

A PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue group coverage as required by state and federal law. Application must be postmarked within sixty (60) calendar DAYS of the date the PARTICIPANT is notified of the right to continue or sixty (60) calendar DAYS from the date coverage ceases, whichever is later. The health plans that participate in the HEALTH BENEFIT PROGRAM shall bill the continuing PARTICIPANT directly for the required PREMIUM.

250B Subscriber Nonpayment of Premiums

A PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of thirty-six (36) months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later, except in the following circumstances:

1) When coverage is canceled,

2) PREMIUMS are not paid when due, or

3) Coverage is terminated as permitted by state or federal law.

The health plans that participate in the HEALTH BENEFIT PROGRAM shall bill the CONTINUANT directly for required PREMIUMS.

As required by federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the health plans' requirement for the amount due. However, the health plans may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. A reasonable time period is considered thirty (30) calendar DAYS after the notice is given.

The health plans must notify the DEPARTMENT within one (1) month of the effective date of termination due to non-payment of PREMIUM.

A SUBSCRIBERS retroactive termination of coverage for nonpayment of premiums may create claims overpayments situations if the PARTICIPANT continued to utilize benefits after losing eligibility and coverage. See Section 130C.

250D Surviving Dependents

As required by Wis. Adm. Code ETF 40.01, the surviving covered DEPENDENT of a covered EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously covered under a contract of a deceased EMPLOYEE or ANNUITANT, or a child of the EMPLOYEE or ANNUITANT who is in the process of being adopted by the deceased EMPLOYEE or ANNUITANT, or born within nine (9) months after the death of the EMPLOYEE or ANNUITANT, will be eligible for coverage under the survivor's contract until such time that they are no longer eligible.

Coverage under this section shall be effective on the first DAY of the calendar month following the date of death of the covered EMPLOYEE or ANNUITANT, and shall remain in effect until such time as the DEPENDENT coverage would normally cease had the death not occurred.

PREMIUMS shall be paid:

1) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System, or

2) Directly to the health plans that participate in the HEALTH BENEFIT PROGRAM if the annuity is insufficient to pay PREMIUM.

255 Miscellaneous Program Requirements

255A Implementation

The CONTRACTOR is required to have an Implementation Manager and Implementation Team available to manage the project from the CONTRACT start date until all implementation tasks are

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

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

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

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

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	September 1, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 16, 2017

Activity	Due Dates
Employer Meeting: The CONTRACTOR attends the IYC EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the PHARMACY BENEFIT PLAN are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the PHARMACY BENEFIT PLAN and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	October 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • ACH mechanism for EFT of claims payments and fees.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID CARDS: The CONTRACTOR issues welcome packets that contain ID CARDS for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All claims administrative services for the PHARMACY BENEFIT PLAN are fully operational.	January 1, 2018
Accumulator File Data: The medical and pharmacy data transfer processes for accumulating PARTICIPANT out-of-pocket costs for deductibles and out-of-pocket limits is established, tested and working correctly.	January 1, 2018

Activity	Due Dates
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Medical and Dental Data: The medical and dental data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Pharmacy Claims & Network Data: The pharmacy claims and network data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018

255B Account Management and Staffing

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

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

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

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

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

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

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

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

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

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

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

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

255C Customer Service

The CONTRACTOR shall operate a dedicated customer service department for the PHARMACY BENEFIT PLAN between 7:30 a.m. and 6:00 p.m., CST/CDT Monday through Thursday and 7:30 a.m. to 5:00 p.m. CST/CDT on Friday at a minimum, except for legal holidays. The

CONTRACTOR will also have a sufficient number of customer service representatives available to members, pharmacists and prescribers 24 hours a day, seven days a week, excluding some holidays, via a dedicated, toll-free customer service call center. PARTICIPANTS must also be able to submit questions using e-mail and/or via a website. The call center must be equipped with Telephone Device for the Deaf (TDD) in order to serve the hearing impaired population. Calls and correspondence to customer services representatives shall be tracked, recorded, and retrieved when necessary by name or the DEPARTMENT'S eight (8)-digit member ID.

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

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

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

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

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

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

1) The PARTICIPANTS identifying information;

2) The date and time the inquiry was received;

3) The reason for the inquiry (including a reason code using a coding scheme);

4) The origin of the transaction (e.g., inbound call, the DEPARTMENT, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

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

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

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

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

255D Contractor Web Content and Web-Portal

The CONTRACTOR must provide dedicated web content and a web-portal as part of this AGREEMENT. Web content will provide basic program information. The web-portal will be used to present and track PARTICIPANT level information, such as claim status and out of pocket limit accumulation.

1) The CONTRACTOR must host and maintain customized web pages and a web-portal dedicated to PARTICIPANTS of the PHARMACY BENEFIT PLAN.

    a) The CONTRACTOR must submit the web content and web-portal design for review as directed by the DEPARTMENT.

    b) The DEPARTMENT must approve the content prior to publishing.

    c) The web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market which include Internet Explorer, Mozilla Firefox, Chrome and Safari.

d) The web-portal must be simple, intuitive and easy to use and navigate.

e) The web-portal must be able to render effectively on any form factor for mobile devices which include smartphones and tablets.

f) The website and web-portal must have mobile capabilities. At a minimum the mobile capabilities must allow the PARTICIPANT to access program information.

g) The website must ensure response time averaging two (2) seconds or better, and never more than three (3) second response time, from the time the CONTRACTOR receives the request to the time the response is sent, for all on-line activities. Response time is defined as the amount of time between pressing the ”return” or ”enter” key or depressing a mouse button and receiving a data-driven response on the screen, i.e., not just a message or indicator that a response is forthcoming.

h) The solution must use SSL/TLS for end-to-end encryption for all connections between the user devices and the portal with the use of browsers or smartphone applications (apps).

i) The portal must be SECURED with a minimum of SHA2-256 bit EV certificates to provide the latest in encryption and cryptography.

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

k) The CONTRACTOR must provide the DEPARTMENT reports on the current security safeguards enabled for the website and web-portal, upon the DEPARTMENT’S request.

l) After the initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website and web-portal test environment for the DEPARTMENT’S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website and web-portal. No less than two (2) weeks prior to the annual launch dates for each, the CONTRACTOR must have final content and functionality completed, as determined by the DEPARTMENT.

m) Prior to any launch of the CONTRACTOR website or web-portal, the CONTRACTOR must test the accessibility of the website and web-portal on multiple web browsers and from multiple internet carriers to ensure system capability.

n) The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website content for the upcoming IT’S YOUR CHOICE OPEN ENROLLMENT period. The DEPARTMENT will annually communicate the due date for this submission. Upon DEPARTMENT approval, the updated website content is launched at least two (2) weeks prior to the annual IT’S YOUR CHOICE OPEN ENROLLMENT period.

o) The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links from the website or web-portal to an external (governmental and non-governmental) website/portal or webpage.

p) The CONTRACTOR will notify the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation.

2) Basic information must be available on the CONTRACTOR'S website without requiring log in credentials, including:

a) General information about the PHARMACY BENEFIT PLAN and other programs offered by the BOARD;

b) Directions on how to access the PHARMACY BENEFIT PLAN provider directory.

c) Information about PARTICIPANT requirements, including PRIOR AUTHORIZATIONS and referrals;

d) Ability for PARTICIPANTS to access the PHARMACY BENEFIT PLAN formulary.

e) Ability for PARTICIPANTS to submit questions via the website; and,

f) Contact information including the dedicated toll-free customer service phone number, business hours, 24-hour nurse line, and mailing address.

3) To ensure accessibility among persons with a disability, the CONTRACTOR'S website must comply with Section 508 of the Rehabilitation Act of 1973 (29 USC Section 794d) and implementing regulations at 36 CFR 1194 Subparts A-D. The website must also and conform to W3C's Web Content Accessibility Guidelines (WCAG) 2.0 (see http://www.w3.org/TR/WCAG20/).

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

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

The CONTRACTOR must have a regular patch management process defined for the infrastructure. The CONTRACTOR must have a defined maintenance time window for system

patches, software upgrades. Outages in the system must be communicated through the web-portal or via alerts.

5) The CONTRACTOR must be able to link user profiles and site access permissions to the daily enrollment file provided by the DEPARTMENT and make updates based on current enrollment within three (3) BUSINESS DAYS of data receipt. The CONTRACTOR may utilize another process for validation if the process is pre-approved by the DEPARTMENT.

6) 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:

   a) User name and password creation and recovery;

   b) Enrollment confirmation;

   c) SECURE upload functionality for submitting program required documentation;

   d) Communication functions that allow users to submit SECURE questions to the CONTRACTOR and allow the CONTRACTOR to push general and targeted communications to users via USPS, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT; and,

255E Patient Rights and Responsibilities

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

255F Errors

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

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

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

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

Contractor / Provider / Subcontractor Errors

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

255G Examination of Records

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

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

1) Keep confidential and properly safeguard each “medical record” and all “personal information”, as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

255H Record Retention

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

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

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

255I Subrogation and Other Payers

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

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

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee of thirty (30%) percent of net dollars recovered by the outside legal counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

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

255J Disaster Recovery and Business Continuity

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

255K Other

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

255L Gifts and/or Kickbacks Prohibited

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

255M Conflict of Interest

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

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

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

300 DELIVERABLES

305 Reporting Requirements

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

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

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

Report	Description	Frequency
1) Claims Invoicing **Pharmacy Claims Reimbursement**	The CONTRACTOR notifies the DEPARTMENT twice monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See Section 130A, 1, a. (1) • Cycle I: Encompasses prescription claims processed day one (1) through day fifteen (15). CONTRACTOR will electronically send an invoice to DEPARTMENT two (2) DAYS after the end of the cycle. • Cycle II: Encompasses prescription claims processed day sixteen (16) through the last day of the month. CONTRACTOR will electronically send an invoice to DEPARTMENT two (2) DAYS after the end of the cycle.	Semi-Monthly
2) Claims Invoicing **Member Claims Reimbursement**	The CONTRACTOR notifies the DEPARTMENT monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See Section 130A, 1, a. (2) • Each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle	Monthly
3) Administrative Fee Invoicing	The CONTRACTOR notifies the DEPARTMENT twice monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See Section 130A, 2, b. (1) • Cycle I: Encompasses administrative fees for services provided from day one (1) through day fifteen (15). The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle. • Cycle II: Encompasses administrative fees for services provided from sixteen (16) through the last day of the month.	Semi-Monthly

Report	Description	Frequency
	The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle.	
4) Other Fees Invoicing	The CONTRACTOR notifies the DEPARTMENT monthly during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. See Section 130A, 2, b. (2) • Each cycle consists of one month, always ending on the last day of the month. The CONTRACTOR will electronically send an invoice to the DEPARTMENT two (2) DAYS after the end of the cycle	Monthly
5) Rebate Payments	The DEPARTMENT will receive REBATE payments on a QUARTERLY basis. Within ninety (90) days of the CONTRACTOR's receipt of said quarter's audited REBATE results, the CONTRACTOR will reduce the invoice amount for claims invoicing by the amount of REBATE payments. See Section 130A, 5.	QUARTERLY
6) Drug Manufacturer Revenue Payments	The DEPARTMENT will receive drug manufacturer revenue payments on a QUARTERLY basis. Within ninety (90) days of the CONTRACTOR's receipt of said quarter's audited revenue results, the CONTRACTOR will reduce the invoice amount for claims invoicing by the amount of revenue payments. See Section 130A, 6.	QUATERLY
7) Claims Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. See Section 145C	Monthly
8) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. See Section 130A, 8	Monthly
9) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the semi-monthly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. See Section 130A, 1, d.	Monthly
10) Participating Pharmacy Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent PARTICIPATING PHARMACY Data Specifications document See Section 145C	Monthly
11) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	QUARTERLY
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	QUARTERLY, unless otherwise noted

Report	Description	Frequency
13) Pilot Programs and Initiatives	The CONTRACTOR reports to the DEPARTMENT any initiatives and pilot programs offered by the CONTRACTOR or the PARTICIPATING PHARMACIES, including information on patient engagement and outcomes. See Section 150A, 5.	Semi-Annually
14) Business Recovery Plan and Simulation Report	The CONTRACTOR submits to the DEPARTMENT a business recovery plan that is documented and tested annually, at a minimum. See Section 140, 5.	Annually
15) Coordination of Benefits (COB) Report	The CONTRACTOR collects from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and reports this information to the DEPARTMENT at least annually. *(See Section 205F.)*	Annually
16) Financial and Utilization Data Submission	The CONTRACTOR submits to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. (*See Section 150A, 1*)	Semi-Annually
17) Grievance Summary Report	The CONTRACTOR retains records of grievances and submits an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. See (*Section 115 9. c.*)	Annually
18) Group Experience / Utilization Report	The CONTRACTOR reports annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors, demonstrating support for technology and automation in the format as determined by the DEPARTMENT. The CONTRACTOR also includes details on the HEALTH BENEFIT PROGRAM'S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends in a format as determined by the DEPARTMENT.	Annually
19) Nondiscrimination Testing Results Report	The CONTRACTOR performs annual nondiscrimination testing and submits the results to the DEPARTMENT. (*See Section 150C*)	Annually
20) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. See Section 130.	Annually
21) Statement of Standard for Attestation Engagements (SSAE) 16 Report	The CONTRACTOR agrees to an audit conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the SSAE 16 and provides a copy of the CPA's report to the DEPARTMENT. See Section 150D, 3, d).	Annually

310 Deliverables

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

310A Deliverables to the Department

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

Deliverable	Description	Frequency
1) Implementation Plan	The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID CARDS. *(See Section 205B, 2.)*	Upon identification of issue
5) ID CARD Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID CARDS were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August
7) PARTICIPATING PHARMACY Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June

Deliverable	Description	Frequency
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July

Deliverable	Description	Frequency
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details	As directed by the DEPARTMENT

	and final resolution, and submits it to the DEPARTMENT. *(See Section 150, 4, b.)*	
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred (180) 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 145, 8.)*	As needed
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of Significant Events	The CONTRACTOR provides notification of all significant events as described in Section 115, 14.	As needed
22) External Review Determination	Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the	See description

	external review's determination, the CONTRACTOR notifies the DEPARTMENT of the outcome. *(See Section 245G.)*	
23) Medicare Enrollment Denial	The CONTRACTOR notifies the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare. (*See Section 220G.)*	See description
24) Transition Plan	The CONTRACTOR provides a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID CARDS	The CONTRACTOR provides PARTICIPANTS with ID CARDS indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID CARDS
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including PRIOR AUTHORIZATIONS and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those 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. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) 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 CONTRACTOR sends 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, and • Contact information for questions. *(See Section 230C.)*	See description

Deliverable	Description	Frequency
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides 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 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	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 IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed

10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from 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 shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

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

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Eligibility/Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

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

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 255A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 255A.)*	
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 255A.)*	
4) Web Content Launch: The web content dedicated to the HEATLH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 255A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 255A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 255A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 255A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 255A.)*	
9) ID CARDS: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID CARDS for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 2565A.)*	

10) Claims Administrative Services: All claims administrative services for the PHARMACY BENEFIT PLAN shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	
11) Outbound Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	

315B Account Management

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

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(See Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
2) Approval of Communications: All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

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

Performance Standards	Penalties
1) Financial Accuracy: At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid	Five thousand ($5,000) dollars for

Performance Standards	Penalties
in the correct amount divided by the total claim dollars paid. *(See Section 230.)*	each percentage point for which the standard is not met in each month
2) Processing Accuracy: At least ninety-seven (99.5%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 230.)*	
3) Accumulator File: At least 95% accuracy in health plan file processing, accumulation, and file return to health plans within twenty-four (24) hours.	
4) Direct Member Reimbursement: At least ninety-nine (99%) percent of clean claims adjudicated within 30 days.	

Performance Standards	Penalties
5) Claims Processing Time: At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 230.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
6) Claims Processing System Availability: At least ninety-nine (99%) percent of the time the claims processing system is available for adjudication of online claims submitted by network pharmacies. This includes downtime for system maintenance.	

315D Customer Service

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

Performance Standards	Penalties
1) Call Answer Timeliness: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 255C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 255C.)*	

Performance Standards	Penalties
3) **Open Call Resolution Turn-Around-Time:** At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 255C.)*	
4) **Inquiry Resolution Tracking Document/Log:** Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 255C.)*	
5) **Electronic Written Inquiry Response:** At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 255C.)*	
6) **Key Stakeholder Satisfaction:** At least a ninety-five percent (95%) satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR.	

315E Data Management

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

Performance Standards	Penalties
1) **Claims Data Transfer:** The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 145A)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) **Provider Data Transfer:** The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document, the specified data for all IN-NETWORK providers including subcontracted providers, and any OUT-OF-NETWORK providers for which the CONTRACTOR has processed or expects to process claims. *(See Section 145C)*	

Performance Standards	Penalties
3) Data File Corrections: Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT. *(See Sections 145C)*	
4) Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. *(See Section 150F.)*	

315F Eligibility/Enrollment

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

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 145B)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards	Penalties
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 145B)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) ID CARDS: The CONTRACTOR shall issue ID CARDS within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID CARDS for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID CARDS by December 15 for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the IT'S YOUR	

CHOICE OPEN ENROLLMENT period through December 10. *(See Section 205B, 2.)*	
5) 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 255.)*	

315G Other

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

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155D.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	

Performance Standards	Penalties
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met
7) Mail Order Dispensing Accuracy: At least ninety-nine (99%) percent of the time, prescriptions are dispensed accurately with no errors.	Twenty-five hundred ($2,500) dollars per day for which standard is not met.
8) Mail Order Shipping Time: At least ninety (90%) percent of clean prescriptions are shipped within two (2) business days. At least ninety-nine (99%) percent of prescriptions requiring intervention are shipped within five (5) business days.	

400 UNIFORM BENEFITS

NOTE: Uniform Benefits will be updated when the Group Insurance Board approves the benefits for 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the AGREEMENT is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

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

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the third party administrator(s) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a 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 Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-NETWORK Limit.

Except as specifically stated for EMERGENCY and URGENT CARE (see Sections III, A, 1 and III, A, 2), YOU do not have coverage for services from OUT-OF-NETWORK PROVIDERS unless YOU receive a PRIOR AUTHORIZATION from YOUR TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefit: State of Wisconsin	Eligible PARTICIPANTS who are not eligible for nor enrolled in MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	High DEDUCTIBLE Health Plan for eligible PARTICIPANTS [3]
Annual Medical DEDUCTIBLE	$250 Individual/$500 Family When an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS or prescription drugs.	None	The DEDUCTIBLE must be met before coverage begins. The DEDUCTIBLEs are:$1,500 per individual plan $3,000 per family plan DEDUCTIBLE includes prescription drugs and applies to Out-of-Pocket-Limit (OOPL).
Annual Medical COINSURANCE	After DEDUCTIBLE: 90%/10% applies to medical services except for office visits, and as described below. COINSURANCE applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to OOPL.	After DEDUCTIBLE: 90%/10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
Annual Medical OOPL	$1,250 PARTICIPANT/$2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to OOPL. [1]	After DEDUCTIBLE: $2,500 per individual plan $5,000 per family plan except as described below.
Routine, preventive services as required by federal law	100%	100%	100%

Benefit: State of Wisconsin	Eligible PARTICIPANTS who are not eligible for nor enrolled in MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	High DEDUCTIBLE Health Plan for eligible PARTICIPANTS [3]
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	$15, DEDUCTIBLE need not be met first COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE	No medical COPAYMENTs	After DEDUCTIBLE: $15 Primary Care Office Visit COPAYMENT applies towards meeting the annual OOPL
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	$25 per visit, DEDUCTIBLE need not be met first COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE	No medical COPAYMENTs	After DEDUCTIBLE: $25 per visit COPAYMENT applies towards meeting the annual OOPL
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	After DEDUCTIBLE: 90% (10% member cost to OOPL)	100%	After DEDUCTIBLE: 90% (10% member cost to OOPL)
EMERGENCY Room COPAYMENT (Waived if admitted as an inpatient directly from the EMERGENCY room or for observation for 24 hours or longer.)	$75 COPAYMENT to OOPL. After COPAYMENT, DEDUCTIBLE and 90% COINSURANCE (10% member cost to OOPL)	$60	After DEDUCTIBLE, $75 COPAYMENT to OOPL. After DEDUCTIBLE and copay 90% (10% member cost to OOPL)

Benefit: State of Wisconsin	Eligible PARTICIPANTS who are not eligible for nor enrolled in MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	High DEDUCTIBLE Health Plan for eligible PARTICIPANTS [3]
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	After DEDUCTIBLE: 80% (20% member cost to OOPL) [2]	80% to an annual OOPL of $500 per PARTICIPANT; no aggregate family limit (20% member cost to OOPL) [2]	After DEDUCTIBLE: 80% (20% member cost to OOPL) [2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: 90% HOSPITAL charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	100% HOSPITAL charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	After DEDUCTIBLE: 90% HOSPITAL charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost to OOPL).
Cochlear Implants PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90% for HOSPITAL charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90% for HOSPITAL charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)
Hearing Aids for PARTICIPANTS age 18 and older. One aid per ear no more than once every 3 years.	After DEDUCTIBLE: 80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After DEDUCTIBLE: 80% (20% member cost to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. §632.895 (16), 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)

Benefit: State of Wisconsin	Eligible PARTICIPANTS who are not eligible for nor enrolled in MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	High DEDUCTIBLE Health Plan for eligible PARTICIPANTS [3]
Temporo-mandibular Joint Disorders:	After DEDUCTIBLE: 80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: 80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants:	After DEDUCTIBLE: 90% (10% member cost to OOPL) following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.	100% following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.	After DEDUCTIBLE: 90% (10% member cost to OOPL) following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.
Prescription Drugs:	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible PARTICIPANTS in (Program Option PO 2 and MEDICARE eligible and enrolled in PO 6 and PO 7)**	**WPE eligible PARTICIPANTS in PO 6 who are not eligible for nor enrolled in MEDICARE as the primary payor**[3]	**WPE eligible PARTICIPANTS in PO 4 including MEDICARE eligible and enrolled**	**High DEDUCTIBLE Health Plan WPE eligible (PO 7) PARTICIPANTS** [3]
Annual Medical DEDUCTIBLE applies to Out-of-Pocket-Limit (OOPL).	None	$250 Individual/$500 Family When an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS or prescription drugs.	$500 Individual/ $1,000 Family When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to prescription drugs.	The DEDUCTIBLE must be met before coverage begins. The DEDUCTIBLES are: $1,500 per individual plan $3,000 per family plan. DEDUCTIBLE includes prescription drugs.
Annual Medical COINSURANCE	100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to Out-of-Pocket-Limit (OOPL).	After DEDUCTIBLE: 90%/10% applies to medical services except for office visits, and as described below. COINSURANCE applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to OOPL.	After DEDUCTIBLE: 90%/10% applies to medical services except for office visits, and as described below. COINSURANCE applies to Out-of-Pocket-Limit (OOPL) except as described below.

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible PARTICIPANTS in (Program Option PO 2 and MEDICARE eligible and enrolled in PO 6 and PO 7)**	**WPE eligible PARTICIPANTS in PO 6 who are not eligible for nor enrolled in MEDICARE as the primary payor**[3]	**WPE eligible PARTICIPANTS in PO 4 including MEDICARE eligible and enrolled**	**High DEDUCTIBLE Health Plan WPE eligible (PO 7) PARTICIPANTS** [3]
Annual Medical OOPL (OOPL)	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to OOPL. [1]	$1,250 PARTICIPANT/$2,500 aggregate family limit except as described below.[1]	After $500 per individual $1,000 aggregate per family DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, 80% to OOPL. [1]	After DEDUCTIBLE: $2,500 per individual plan $5,000 per family plan except as described below.
Routine, preventive services as required by federal law	100%	100%	100%	100%
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	No medical COPAYMENTs	$15, DEDUCTIBLE need not be met first COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE	No medical COPAYMENTs	After DEDUCTIBLE: $15 Primary Care Office Visit COPAYMENT applies towards meeting the annual OOPL

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible PARTICIPANTS in (Program Option PO 2 and MEDICARE eligible and enrolled in PO 6 and PO 7)**	**WPE eligible PARTICIPANTS in PO 6 who are not eligible for nor enrolled in MEDICARE as the primary payor**[3]	**WPE eligible PARTICIPANTS in PO 4 including MEDICARE eligible and enrolled**	**High DEDUCTIBLE Health Plan WPE eligible (PO 7) PARTICIPANTS** [3]
Specialist COPAYMENT Applies to: • Specialists URGENT CARE	No medical COPAYMENTs	$25 per visit, DEDUCTIBLE need not be met first COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE	No medical COPAYMENTs	After DEDUCTIBLE: $25 per visit COPAYMENT applies towards meeting the annual OOPL
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	100%	After DEDUCTIBLE: 90% (10% member cost to OOPL)	100%	After DEDUCTIBLE: 90% (10% member cost to OOPL)
EMERGENCY Room Copay (Waived if admitted as an inpatient directly from the EMERGENCY room or for observation for 24 hours or longer.)	$60	$75 COPAYMENT to OOPL. After COPAYMENT, DEDUCTIBLE and 90%COINSURANCE (10% member cost to OOPL)	$60	After DEDUCTIBLE, $75 to OOPL. After DEDUCTIBLE and copay 90% (10% member cost to OOPL)
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	80% to an annual OOPL of $500 per PARTICIPANT; no aggregate family limit (20% member cost to OOPL)[2]	After DEDUCTIBLE: 80% (20% member cost to OOPL) [2]	80% to an annual OOPL of $500 per PARTICIPANT; no aggregate family limit (20%member cost to OOPL) [2]	After DEDUCTIBLE: 80% (20% member cost to OOPL) [2]

Benefit: Participating Wisconsin Public Employer's (WPE)	WPE eligible PARTICIPANTS in (Program Option PO 2 and MEDICARE eligible and enrolled in PO 6 and PO 7)	WPE eligible PARTICIPANTS in PO 6 who are not eligible for nor enrolled in MEDICARE as the primary payor[3]	WPE eligible PARTICIPANTS in PO 4 including MEDICARE eligible and enrolled	High DEDUCTIBLE Health Plan WPE eligible (PO 7) PARTICIPANTS [3]
Cochlear Implants for PARTICIPANTS age 18 and older	100% HOSPITAL charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL)	After DEDUCTIBLE: 90% HOSPITAL charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	100% HOSPITAL charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	After DEDUCTIBLE: 90% HOSPITAL charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost to OOPL).
Cochlear Implants PARTICIPANTS under age 18	100% HOSPITAL charges HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90% for HOSPITAL charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 90% for HOSPITAL charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)
Hearing Aids for PARTICIPANTS age 18 and older. One aid per ear no more than once every 3 years.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After DEDUCTIBLE: 80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After DEDUCTIBLE: 80% (20% member cost to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for PARTICIPANTS under age 18	As required by Wis. Stat. § 632.895 (16), 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. § 632.895 (16), 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), 90%. (10% member cost to OOPL)

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible PARTICIPANTS in (Program Option PO 2 and MEDICARE eligible and enrolled in PO 6 and PO 7)**	**WPE eligible PARTICIPANTS in PO 6 who are not eligible for nor enrolled in MEDICARE as the primary payor**[3]	**WPE eligible PARTICIPANTS in PO 4 including MEDICARE eligible and enrolled**	**High DEDUCTIBLE Health Plan WPE eligible (PO 7) PARTICIPANTS** [3]
Temporo-mandibular Joint Disorders:	80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: 80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: 80% (20% member cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants:	100% following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.	After DEDUCTIBLE: 90% (10% member cost to OOPL) following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.	100% following accident or INJURY up to a maximum of $1,000 per tooth.	After DEDUCTIBLE: 90% (10% member cost to OOPL) following accident or INJURY up to a maximum health plan payment of $1,000 per tooth.
Prescription Drugs:	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL charges. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except Specialty Medications):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 Copayment: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 Coinsurance: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 Coinsurance: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL (OOPL)
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS, except:

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage.

c) When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 Copayment: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Coinsurance: 40% ($200 max)
The Level 4 COINSURANCE applies when any Specialty Medication is obtained from a Participating Pharmacy other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred Specialty Medications. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $7,150 individual / $14,300 family.

The maximum annual amount YOU pay for YOUR Level 4 Preferred Specialty Medications.
Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all Usual and Customary HOSPITAL charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. Charges for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR 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.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the charges that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: 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: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK 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 IN-NETWORK PROVIDER, 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: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have 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.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild. [1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy. [2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child. [3, 4, 5, 6]

[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] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, whichever occurs first, except that:

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 CONTRACTOR will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR 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.

[4] 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 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

    a) Only one of the individuals has legal ownership of the residence.

    b) One or both of the individuals have one or more additional residences not shared with the other individual.

    c) One of the individuals leaves the common residence with the intent to return.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees. Includes 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, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

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

1) Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

2) Serious impairment to the PARTICIPANT'S bodily functions.

3) Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

Examples of EMERGENCIES are listed in Section III, A, 1, e. EMERGENCY services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

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 TPA 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. The criteria that the TPA 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: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) 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; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) 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.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

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

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

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.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

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 in order 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 TPA.

HOSPITAL: Means an institution that:

1) 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

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

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

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) 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.

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 or DOMESTIC PARTNERS.

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

IN-NETWORK PROVIDER: 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 PARTICIPANTS. 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. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. Level M Drugs are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with Level M Drugs, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

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. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

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 TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

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.

MISCELLANEOUS HOSPITAL EXPENSE: Means Usual and Customary HOSPITAL ancillary charges, other than Bed And Board, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

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.

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 TPA's professional directory of IN-NETWORK PROVIDERS. Care from an OUT-OF-NETWORK PROVIDER requires Prior-Authorization from the TPA unless it is an EMERGENCY or URGENT CARE.

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 of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK provider may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: charges for COPAYMENTS such as EMERGENCY room and Level 3 prescription drugs, payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of Participating Pharmacies.

PBM: The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It 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.

PCP: Means an IN-NETWORK PRIMARY CARE PROVIDER who is named as a PARTICIPANT'S primary health care contact. He/She provides entry into the health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one

or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

YOU must name YOUR PCP on YOUR enrollment application. Each family PARTICIPANT may have a different PCP.

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 this program.

PREFERRED SPECIALTY PHARMACY: Means a PARTICIPATING PHARMACY which meets criteria established by the PBM to specifically administer Specialty Medication services, with which the PBM has executed a written contract to provide services to PARTICIPANTS, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one PARTICIPATING PHARMACY as a PREFERRED SPECIALTY PHARMACY.

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.

PRIOR AUTHORIZATION: Means obtaining approval from YOUR TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, 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 TPA and are described in the It’s Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

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.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It’s Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED 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 TPA before services are rendered.

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. These services may include physical and occupational therapy, speech-language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED INJECTIBLE: 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: Specific zip codes in those counties in which the affiliated physicians are approved by the TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA 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 TPA 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 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, DOMESTIC PARTNERS, 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.

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.

SUBSCRIBER: An ELIGIBLE EMPLOYEE who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

TPA: The third party administrator who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Group Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. 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. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, 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. In some cases the amount the TPA 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), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she 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. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA 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 item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) Emergency Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that you call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-URGENT CARE follow-up must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined service area.

d) EMERGENCY services include reasonable accommodations for repair of durable medical equipment as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) Urgent Care

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY CARE. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that you contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-URGENT CARE follow-up must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) Preoperative and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SDM program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay 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 in consultation with the mother.

b) Elective sterilization.

c) Contraceptives 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.

   ii) IUDs and diaphragms, as described under the DURABLE MEDICAL EQUIPMENT provision.

   iii) Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the PARTICIPANT is in her second or third trimester of pregnancy when the PROVIDER'S participation in the BENEFIT PLAN offered by the TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was pre-approved by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or Urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to

orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care 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.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) 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. The attending physician must ask for or approve this service.

Home care 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 PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, 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.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR 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.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. 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 includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient charges are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient DEPARTMENT of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of Natural Teeth and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected 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, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

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 Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered 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.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED 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 the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants, Section III, A, 18), donor-related services, and related physician charges.

20) Chiropractic Services
When performed by an IN-NETWORK PROVIDER. Benefits are not available for MAINTENANCE CARE.

21) 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 includes:

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 DME in Section C, 3) and physical complications of all stages of mastectomy, including lymphedemas,

d) Breast implants.

22) Smoking Cessation
Coverage includes pharmacological products that by law require a written prescription and are described under the prescription drug benefits in Section D, 29. Coverage also includes 1 office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require PRIOR AUTHORIZATION by the TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and SPECIALTY HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. 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.

   c) HOSPITAL and ambulatory surgery center charges and related anesthetics for dental care: Covered 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.

2) Outpatient Care
EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an EMERGENCY room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

a) Outpatient Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. The outpatient services means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37.

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.

b) Transitional Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional care is 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 the federal Mental Health Parity and Addiction Equity Act.

c) Inpatient Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by an OUT-OF-NETWORK PROVIDER, if provided as required by an EMERGENCY detention or on an EMERGENCY basis and the PROVIDER notifies the TPA within 72 hours after the initial provision of service.

d) Other
Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D, 1.

2) Durable Diabetic Equipment and Related Supplies
When prescribed by an IN-NETWORK PROVIDER for treatment of diabetes and purchased from an IN-NETWORK PROVIDER, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject**

to cost sharing as outlined in the SCHEDULE OF BENEFITS. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL. Durable diabetic equipment includes:

a) Automated injection devices.

b) Continuing glucose monitoring devices.

c) Insulin infusion pumps, limited to one pump in a calendar year and YOU must use the pump for 30 days before purchase.

All DURABLE MEDICAL EQUIPMENT purchases or monthly rentals must be PRIOR AUTHORIZED as determined by the TPA.

(Glucometers are available through the PBM. Refer to Section D, 2 for benefit information.)

3) Medical Supplies and Durable Medical Equipment
When prescribed by an IN-NETWORK PROVIDER for treatment of a diagnosed ILLNESS or INJURY and purchased from an IN-NETWORK PROVIDER, MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**.

The following MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered only when PRIOR AUTHORIZED as determined by the TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, 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 when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the DURABLE MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage For Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with Congenital Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or 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: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for non-intensive level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.

D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

If YOU do not show YOUR PBM IDENTIFICATION CARD at the pharmacy at the time YOU are obtaining benefits, YOU may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTIBLE).

MEDICARE eligible PARTICIPANTS will be covered by a MEDICARE Part D prescription drug plan (PDP) provided by the PBM. PARTICIPANTS who choose to be enrolled in another MEDICARE Part D PDP other than this PDP will not have benefits duplicated.

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

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

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

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTIBLES and narcotics are among those for which a 90-day supply is not available.

i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.

j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.

k) SPECIALTY MEDICATIONS and SELF-ADMINISTERED INJECTIBLES when obtained by prescription and which can safely be administered by the PARTICIPANT, must be obtained from a PBM PARTICIPATING PHARMACY OR PREFERRED SPECIALTY PHARMACY. In some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

2) Insulin, Disposable Diabetic Supplies, Glucometers
The PBM will list approved products on the FORMULARY. PRIOR AUTHORIZATION is required for anything not listed on the FORMULARY.

a) Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug COPAYMENT, as described on the SCHEDULE OF BENEFITS.

b) Disposable Diabetic Supplies and Glucometers will be covered after a 20% COINSURANCE as outlined in the SCHEDULE OF BENEFITS when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL for prescription drugs.

3) Other Devices and Supplies
Other devices and supplies administered by the PBM that are subject to a 20% COINSURANCE and applied to the annual OOPL for prescription drugs are as follows:

a) Diaphragms

b) Syringes/Needles

c) Spacers/Peak Flow Meters

IV. Exclusions and Limitations

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Uniform Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by TPAs 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 11 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be MEDICALLY NECESSARY, but still are not covered under this program, while others may be examples of services which are not MEDICALLY NECESSARY or not medical in nature, as determined by the TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2) Medical Services

   a) Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, 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 the Benefits and Services Section.

   b) Expenses for medical reports, including preparation and presentation.

   c) Services rendered (a) in 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) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by an IN-NETWORK PROVIDER to treat a metabolic or peripheral disease or a skin or tissue infection.

   d) Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include NUTRITIONAL COUNSELING as provided in the Benefits and Services Section.

   e) Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

   f) Services of a blood donor. MEDICALLY NECESSARY autologous blood donations are not considered to be services of a blood donor.

g) Genetic testing and/or genetic counseling services, unless MEDICALLY NECESSARY to diagnose or treat an existing ILLNESS.

3) Ambulance Services

a) Ambulance service, except as outlined in the Benefits and Services Section, unless authorized by the TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, therapies, as determined by the TPA, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

i) These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) limit this exclusion.)

c) Physical fitness or exercise programs.

d) Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

e) Massage therapy.

5) 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 the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits and Services Section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

b) All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services Section.

c) All oral surgical procedures not specifically listed in the Benefits and Services Section.

6) Transplants

a) Transplants and all related services, except those listed as covered procedures.

b) Services in connection with covered transplants unless PRIOR AUTHORIZED by the TPA.

c) Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per PARTICIPANT per TPA is covered during the lifetime of the policy, except as required for treatment of kidney disease.

d) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

e) All separately billed donor-related services, except for kidney transplants.

f) Non-human organ transplants or artificial organs.

7) 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 semen (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) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) 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, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

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.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless authorized by the TPA.

c) MEDICAL SUPPLIES and DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and 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.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. 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 the PARTICIPANT’S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED INJECTIBLE medications.

j) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

k) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l) Infertility and fertility medications.

m) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.

n) Charges to replace expired, spilled, stolen or lost prescription drugs.

11) General

a) Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b) 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.

c) Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d) INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e) 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.

f) Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) MAINTENACE CARE.

k) Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

l) 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.

m) Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the BENEFIT PLAN.

n) Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o) Expenses incurred prior to the coverage EFFECTIVE DATE of coverage by the TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, 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).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

v) On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

w) EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.

x) EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the TPA.

y) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

z) Coma stimulation programs.

aa) Orthoptics (Eye exercise training) except for two sessions as MEDICALLY NECESSARY per lifetime. The first session for training, the second for follow-up.

ab) Any diet control program, treatment, or supply for weight reduction.

ac) Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.

ad) 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 YOU are actually insured under Worker's Compensation.

ae) Services related to an INJURY that was self-inflicted for the purpose of receiving TPA and/or PBM Benefits.

af) Charges directly related to a non-covered service, such as hospitalization charges, 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 PRIOR AUTHORIZED by the TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

ag) 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.

ah) Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services Section.

ai) Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is EMERGENCY ambulance transportation.

aj) Sexual counseling services related to infertility.

ak) Services that a child's school is legally obligated to provide, whether or not the school actually provides the services and whether or not YOU choose to use those services.

al) Hypnotherapy.

am) Marriage counseling.

an) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 or as required by the federal Mental Health Parity and Addiction Equity Act.

ao) Biofeedback.

B. Limitations

1) COPAYMENTS or COINSURANCE are required for:

   a) State of Wisconsin program PARTICIPANTS, except for retirees for whom MEDICARE is the primary payor, for all services unless otherwise required under federal and state law.

   b) State of Wisconsin PARTICIPANTS for whom MEDICARE is the primary payor, and for all PARTICIPANTS of the Wisconsin Public Employers program, and/or limitations apply to, the following services: DURABLE MEDICAL EQUIPMENT, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an EMERGENCY room.

2) Benefits are limited for the following services: Replacement of NATURAL TEETH because of accidental INJURY, Oral Surgery, HOSPITAL Inpatient, licensed SKILLED NURSING FACILITY, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.

3) Use of OUT-OF-NETWORK PROVIDERS and HOSPITALS requires prior written approval by the PARTICIPANT'S PRIMARY CARE PROVIDER and the TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic 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. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or Non- Participating Pharmacies.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or 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.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this section, the following words are defined as follows:

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 PLAN. When a 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, notwithstanding the above, 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.

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 THIS PLAN or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN: means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2) Coverage under a governmental plan or coverage that is required or provided by 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). It also does

not include any PLAN whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate PLAN. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate PLAN.

PRIMARY PLAN / SECONDARY PLAN: The order of benefit determination rules state whether This PLAN is a PRIMARY PLAN or SECONDARY PLAN as to another PLAN covering the person.

When This PLAN is a SECONDARY PLAN, its benefits are determined after those of the other PLAN and may be reduced because of the other PLAN'S benefits.

When This PLAN is a PRIMARY PLAN, its benefits are determined before those of the other PLAN and without considering the other PLAN'S benefits.

When there are more than two PLANS covering the person, This PLAN 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.

THIS PLAN: means the part of YOUR Summary Plan Description (group contract) that provides benefits for health care and pharmaceutical expenses.

C. Order of Benefit Determination Rules

1) General
When there is a basis for a claim under THIS PLAN and another PLAN, THIS PLAN is a Secondary Plan that has its benefits determined after those of the other PLAN, unless:

a) The other PLAN has rules coordinating its benefits with those of THIS PLAN, and

b) Both those rules and THIS PLAN’S rules described in subparagraph 2 require that THIS PLAN’S benefits be determined before those of the other PLAN.

2) Rules
THIS PLAN determines its order of benefits using the first of the following rules which applies:

a) Non-Dependent/Dependent
The benefits of the PLAN which covers the person as an employee or PARTICIPANT are determined before those of the PLAN which covers the person as a DEPENDENT of an employee or PARTICIPANT.

b) DEPENDENT Child/Parents Not Separated or Divorced
Except as stated in subparagraph 2, c below, when THIS PLAN and another PLAN cover the same child as a DEPENDENT of different persons, called "parents":

i) 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

ii) 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.

However, if the other PLAN does not have the rule described in 1. 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.

c) 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:

i) First, the PLAN of the parent with custody of the child,

ii) Then, the PLAN of the spouse of the parent with the custody of the child, and

iii) 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 C., 2., b.

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.

d) 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 rule d. is ignored.

e) Continuation Coverage

i) If a person has continuation coverage under federal or state law and is also covered under another PLAN, the following shall determine the order of benefits:

(1) First, the benefits of a PLAN covering the person as an employee, member, or SUBSCRIBER or as a DEPENDENT of an employee, member, or SUBSCRIBER.

(2) Second, the benefits under the continuation coverage.

ii) If the other PLAN does not have the rule described in subparagraph 1), and if, as a result, the PLANS do not agree on the order of benefits, this paragraph e. is ignored.

f) 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.

D. Effect on the Benefits of This Plan

1) When This Section Applies
This section applies when, in accordance with Section C, Order of Benefit Determination Rules, THIS PLAN is a SECONDARY PLAN as to one or more other PLANS. In that event, the benefits of THIS PLAN may be reduced under this section. Such other PLAN or PLANS are referred to as "the other PLANS" in subparagraph 2 below.

2) Reduction in This Plan's Benefits
The benefits of THIS PLAN will be reduced when the sum of the following exceeds the ALLOWABLE EXPENSES in a CLAIM DETERMINATION PERIOD:

a) The benefits that would be payable for the ALLOWABLE EXPENSES under THIS PLAN in the absence of this COB provision, and

b) The benefits that would be payable for the ALLOWABLE EXPENSES under the other PLANS, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of THIS PLAN 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 THIS PLAN are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of THIS PLAN.

E. Right to Receive and Release Needed Information

The TPA 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 THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PROGRAM. If it does, the TPA 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 THIS PLAN. The TPA 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.

G. Right of Recovery

If the amount of the payments made by the TPA 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.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA 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 TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA 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 TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an independent review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, 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 his/her eligibility for claimed services or benefits under the HEALTH BENEFIT PROGRAM (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA 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:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA'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 TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. 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 It's Your Choice open enrollment period.

Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

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 TPA 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 TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA 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 TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA 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 TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future charges may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

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

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA 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 TPA'S or DEPARTMENT'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.

4) 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 TPA or DEPARTMENT to such extent.

The TPA'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 TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA 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 TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA 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 INJURY or ILLNESS for which the TPA 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 TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA 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 this contract, 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 TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA 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 this contract. The PARTICIPANT shall advise the TPA 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

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. 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 YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA 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 TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, 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 HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, 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 HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.