TERMS AND CONDITIONS FOR COMPREHENSIVE

MEDICAL PLAN PARTICIPATION IN THE STATE OF WISCONSIN

GROUP HEALTH BENEFIT PROGRAM AND UNIFORM BENEFITS

FOR THE 2014 BENEFIT YEAR

Department of Employee Trust Funds

GROUP INSURANCE BOARD

P.O. Box 7931
Madison, Wisconsin 53707

September 2013

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

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

Contract By Authorized Board

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

Request for Bid/Proposal No:
ET-1136-14 (Project #ETD0001)

Contract Period:
01/01/2014 thru 12/31/2014 with annual renewal unless otherwise earlier modified or terminated as

Authorized Board:
Group Insurance Board

CONTRACT TO PARTICIPATE UNDER GROUP HEALTH BENEFIT PROGRAM

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

1. This contract is entered into by and between the State of Wisconsin Group Insurance Board (BOARD) and the contractor (known as “the HEALTH PLAN”) whose name, address, and principal officer appears on page ii. The State of Wisconsin Department of Employee Trust Funds (DEPARTMENT) is the sole point of contact for BOARD contracting.
2. The “TERMS AND CONDITIONS FOR COMPREHENSIVE MEDICAL PLAN PARTICIPATION IN THE STATE OF WISCONSIN GROUP HEALTH BENEFIT PROGRAM AND UNIFORM BENEFITS FOR THE 2014 BENEFIT YEAR” (form ET-1136-14), including all attachments and addenda (known as "the GUIDELINES"), are hereby incorporated by reference as if set forth in full.
3. The HEALTH PLAN agrees that in consideration of participating in the State of Wisconsin group health insurance program, it shall observe and comply with all the GUIDELINES' stated terms and conditions, including without limitation the General Requirements, HEALTH PLAN utilization addenda, terms of the described Uniform Benefits, state employee and local public employee group health insurance plans. The HEALTH PLAN affirmatively represents that it meets and shall continue to meet all requirements described in the General Requirements of the GUIDELINES.
4. The HEALTH PLAN further agrees that the BENEFITS and obligations under this agreement are not assignable or transferable except by written agreement of the BOARD and that this agreement is executed with the HEALTH PLAN as presently constituted. Any change in the ownership or controlling interest of the HEALTH PLAN, any acquisition by the HEALTH PLAN of another comprehensive medical plan with which the BOARD has contracted to participate in the state group health program, and any merger between the HEALTH PLAN and any other entity is a significant event requiring notification of the BOARD.
5. In connection with the performance of work under this contract, the HEALTH PLAN agrees not to discriminate against any employees or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the HEALTH PLAN further agrees to take affirmative action to ensure equal employment opportunities. The HEALTH PLAN agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.
6. For purposes of administering this contract, or in the event of any conflict, ambiguity, or inconsistency among the terms of this Contract and the documents incorporated within, the Order of Precedence to resolve any inconsistencies is:
   1) This contract;
   2) The GUIDELINES, including all attachments;
   3) Certification to Health Insurance Issuer for Disclosure of PHI to ETF; and
   4) Any applicable federal or State statute and rule or regulation.

Contract Number & Service: *ETD0001, Medical Plan Participation in the State of Wisconsin Group Health Benefit Program*

State of Wisconsin Department of Employee Trust Funds
By Authorized Board (Name) Group Insurance Board
By *(Name)* Jon Litscher
Signature
Title Chair, Group Insurance Board
Phone 608-266-9854 (Robert Marchant, Deputy Secretary)
Date *(MM/DD/CCYY)*

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

Certification to Health Insurance Issuer for Disclosure of PHI to ETF

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

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

WHEREAS, the employee health insurance plan is administered by the Department of Employee Trust Funds ("ETF") on behalf of the Plan Sponsor and is a "group health plan" and Covered Entity within the meaning of the Health Insurance Portability and Accountability Act of 1998 ("HIPAA"); and

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

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

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

THEREFORE, ETF, on behalf of itself and the GIB, hereby certifies that the documents and materials for the group health plan (hereinafter "Plan Documents") will comply with the requirements of 45 C.F.R. § 164.504 (f)(2) and that ETF will safeguard and limit the use and disclosure of protected health information that GIB may receive from ETF to perform the plan administration functions.

Further, ETF certifies that:

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

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

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

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

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

Substitute **W-9**

Division of Executive Budget and Finance
State Controller's Office

DO NOT send to IRS

Taxpayer Identification Number (TIN) Verification

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

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

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

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

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

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

Entity Designation (check only one)
Required

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

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

___ ___ ___ ___ ___ ___ ___ ___ ___

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

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

Certification
Under penalties of perjury, I certify that:

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

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

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

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

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

STATE OF WISCONSIN
DOA-3477 (R05/98)

Bid / Proposal # _____

Commodity / Service _____

VENDOR INFORMATION

1. BIDDING / PROPOSING COMPANY NAME _____
   FEIN _____

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

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

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

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

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

   City _____ State _____ Zip + 4 _____

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

   Phone ( ) _____ Toll Free Phone ( ) _____

   FAX ( ) _____ E-Mail Address _____

   Address _____

City _____ State _____ Zip + 4 _____

5. CEO / President Name _____

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

INTRODUCTION

OBJECTIVES

The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objective stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board agree that these terms shall always be interpreted consistent with the objectives stated herein.

The Board's objective with alternate health care programming is: to encourage the growth of alternate health benefit plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board (Board) has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

The Board is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the Board has developed these Guidelines by which alternate health delivery plans may be evaluated for possible inclusion under the State of Wisconsin's group health benefit program on a "dual-choice" basis.

"Dual-choice" refers to a program where eligible employees, ANNUITANTS under Wis. Stat. § 40.51 (16), and currently insured other retirees and continuants have the opportunity to choose between at least two competing health benefit plans, the standard plan and one or more alternate plans. The mechanics of "dual-choice" are relatively simple. Once an alternate plan receives approval from the Board on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the Board. The Board reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health care plans to submit their premium rate quotations for the following calendar year. The Board reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

The Board determines the premium rate for its self-insured Standard, fee-for-service, group health benefit plan. This premium is established after review of claims experience, secular trends, etc., and after consultation with the Board's actuary. The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure. Under the tiered structure, the Office of State Employment Relations has determined the Standard Plan to be placed in Tier 2 for purpose of

determining premium contribution share for those subscribers who are active employees assigned to work out of state.

The tiered premium structure is based on recommendations from the Board's appointed actuary whereby each alternate plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the Board's actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest employee premium contribution level. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total premium. Plans are determined to be qualified on a county by county basis. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or a Tier 2 plan available in any county. The Department may take such action as necessary to implement this intent.

Effective January 1, 2009, local governments seeking to participate in the health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the health plan and prescription drug plan. Administration of the underwriting process is done by the Standard Plan administrator and actual assessment of the surcharge is determined by the Board's actuary.

Local governments must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. The Board also may offer an optional deductible benefit and/or coinsurance benefit structure that mirrors the State program for local governments.

Local employers must pay at least 50% but not more than 105% of the lowest cost / 88% of the average cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest / average cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

In the event that the contribution is based on a percentage of the lowest / average cost qualified plan, if an alternate plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total alternate plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The Board is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health-care delivery system. A health care plan with efficient, highly qualified providers, who effectively practice peer-review

and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health care plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the Board to participate under the State of Wisconsin's Group Health Benefit program. They have been developed to explain and clarify the general requirements set forth under Wis. Stats. Subchapter IV of Chapter 40, and Chapters ETF 10 and 40, Wisconsin Administrative Code, Rules of the Department of Employee Trust Funds. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stats. Chapters 150, 185 (185.981-.985), 600-646, and Public Laws 93-222 (the HMO Assistance Act of 1973) and 94-460 (Health Maintenance Organization Amendments of 1976) and other applicable state/federal health benefit law provisions.

Participation in the program is not limited exclusively to organizations, which are considered "qualified" by the federal government as a health maintenance organization (HMO). The Board is interested in providing public employees with the opportunity to enroll in any comprehensive health benefit program, which is able to demonstrate financial responsibility, a successful operating experience, and meets the requirements outlined in these Guidelines.

GENERAL REQUIREMENTS

Statutory Authority to Contract

Wis. Stats. Subsection 40.03 (6) (a), provides:

> "(6) GROUP INSURANCE BOARD. The group insurance board:
>
> (a) 1. Shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter; or
>
> 2. May, wholly or partially in lieu of sub. 1, on behalf of the state, provide any group insurance plan on a self-insured basis in which case the group insurance 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 insured employees with the benefits provided under this chapter."

To be harmonious with the rest of the Guidelines and the requirement under section II below, that plans have broad-based community support, the Board will contract with only those plans which have received Insurance Commissioner approval. Contracts once approved, must be renegotiated annually if the plan is to be offered in succeeding years.

An organization interested in participating under the state's group health benefit plan must meet the requirements of Wis. Stat. § 40.03 (6) (a) and these Guidelines before the Board will consider the plan.

Operating Experience

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

To document the community support requirement, the plan must submit to the Board information on current enrollments, projected growth and historical data that would support the fact that the plan has experienced steady growth since its inception. The plan must provide a current listing of employer/employee groups participating under the program or actively sponsoring participation in the plan. If the plan is so large that providing a listing of each and every participating employer/employee group would be an inconvenience, the Board will accept a representative listing of 20 such organizations.

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

Financial Requirements

Any organization determined to be eligible to contract with the Group Insurance Board must be able to demonstrate that the plan has the financial resources necessary to carry out its obligations to public employees and dependents who choose to be covered under the program.

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

In determining financial stability, the Board will consider:

1. Financial soundness of arrangements for health care services.

2. Adequate working capital (both current and projected).

3. Insolvency protection for subscribers. Consisting of, for example: financial bonds, third party guarantees, reinsurance, deposits, automatic conversion rights, or other arrangements which are adequate to the satisfaction of the Board to provide for continuation of benefits until the end of the month in which insolvency is declared; for those persons hospitalized on or before the date of insolvency, benefits must continue until 12 months from the date of insolvency, the attending physician determines confinement is no longer medically necessary, discharge, or the contract maximum has been reached, whichever occurs first.

Such documentation of financial stability may include one or more of the following:

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

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

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

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

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

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

Each plan must submit to the Board on an annual basis, information on its current financial condition including a balance sheet, statement of operations, financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles), and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin Law.) Failure to file annual financial statements (prior to July 1 following the end of the preceding contract period) shall constitute sufficient grounds for the Board to deny future renewals, or consider the plan to be non-qualifying.

Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

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

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

   b. Prepaid group practice HMO.

   c. Staff model HMO.

   Plans that will be considered under these guidelines to be offered in any county also include:

   a. Point of service HMOs (POS-HMO).

   b. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

3. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4.

4. The Board strongly encourages HEALTH PLANS to adopt a system by which upon enrollment in the GROUP HEALTH INSURANCE PROGRAM, SUBSCRIBERS and DEPENDENTS shall be required to select a PRIMARY CARE PHYSICIAN (PCP). Under such a system, the PCP furnishes primary care-related services, arranges for and

coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week. Primary care includes ongoing responsibility for preventive health care, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services. The PCP shall either furnish or arrange for most of the PARTICIPANT'S health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services. The Board will reward Health Plans that establish a well-documented and efficient PCP process that effectively leads to better care and lower cost by providing credit to a plan's composite score during annual negation at a level determined by the Board.

5. Plans must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult members including members whose biometric results are obtained through the State's biometric screening vendor. Plans must provide incentives of $150.00 in value to members who complete an HRA and biometric screening to encourage participation. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. Members may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The Board will reward health plans that administer HRAs and biometric tests to more than 50% of the Participants described above by crediting the plan's composite score during annual negotiation. Plans must demonstrate, upon request by the Department, their efforts in utilizing the results to improve the health of members of the group health insurance program.

6. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network hospitals, providers, large multi-specialty groups, small group practices and systems of care to participate in quality standards and initiatives, including those as identified by the Department.

7. Plans must demonstrate, upon request by the Department, their support for the Department's initiatives in monitoring and improving quality of care, such as collecting HEDIS measures and submitting quality improvement plans as directed by the Department. This may include providing actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to provider reimbursement.

8. Plans must provide the results of their annual CAHPS survey to the Department as follows:

   a. Results must be based on responses from commercially insured adult Plan members in Wisconsin;

   b. Survey must be conducted by a certified CAHPS survey vendor;

   c. Results must utilize the current version of the CAHPS Health Plan survey as specified by the National Committee for Quality Assurance (NCQA) guidelines at the time the survey is administered;

d. Results must be for each standard NCQA composite;

e. Plans must submit timely results in a file format as specified by the Department;

f. Plans must submit separate results for each of its service areas, if available.

9. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, information requested on the disease management survey and catastrophic claims data, and information received from health risk assessments. Where appropriate, such as for the catastrophic claims data report, plans are expected to separate out pharmacy claims from the Department's pharmacy benefit manager from any pharmacy claims that are paid by the plan.

10. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians, such as Utilization Review (UR), chronic care/disease management, prior authorizations for high-tech radiology and low back surgery, and wellness/prevention. Each plan shall report annually to the Board its utilization and disease management capabilities and effectiveness in improving the health of members and encouraging healthy behaviors, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the Department. Plans shall also include a report detailing the State of Wisconsin group experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the plan 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 each plan.

    Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

    - Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.

    - Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.

    - Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.

    - Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.

    - Procedure to monitor emergency admissions to non-plan hospitals.

    - Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.

- If members are required to select a primary care provider or primary care clinic, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.

- If members are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the plan, have a process to enroll the participants into the appropriate wellness and/or disease management programs.

- Prior authorization procedures for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the plan for members 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 authorization procedures for high-tech radiology tests, including MRI, CT scan, and PET scans.

In its report, plans must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

11. Plans must provide a credible Shared Decision Making (SDM) program for Low Back Pain surgery consistent with the Prior Authorization requirement to all participants and may collaborate with providers to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). Upon request by the Department, plans must report annual patient utilization rates and program impacts in accordance with Department guidance.

12. With the intent of reducing hospital admissions, plans must demonstrate, upon request by the Department, their efforts at contacting members who have been discharged from an in-patient hospital stay greater than twenty-four (24) hours and who have been diagnosed with heart failure, myocardial infarction, pneumonia, or any other high-risk health condition as specified by current Disease Management Guidance as issued by the Department, within 3-5 business days after the member is initially discharged from the hospital. Plans may coordinate with a hospital or provider group in order to contact these members.

13. Plans must cover emergency and urgent care and related catastrophic medical care received from plan or non-plan providers at the in-plan level of benefits. The emergency room copayment is applicable if the participant is not admitted to the hospital. This out-of-service area care may be subject to usual and customary charges while holding the participant harmless as described in Section II., E., 5. unless the participant accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. Plans shall make every effort to settle claim disputes in a reasonable time frame. Plans affiliated with larger nationwide networks may offer coverage through affiliated plan networks as long as there is no additional cost to the plan or participants for doing so.

14. Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the state group health benefit program as a result of such termination of employment. (See Wis. Stat. § 632.897)

15. Plans must agree to participate in the regular "dual-choice" enrollment offering. A regular dual-choice enrollment offering is scheduled approximately 90 days prior to the end of each contract period. During such dual-choice enrollments the plan will accept any individual (active employee, continuant or retiree) who transfers from one health benefit plan to another without requiring evidence of insurability, or waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3) and any eligible employee or state retiree under Wis. Stat. § 40.51 (16) who enrolls. In certain situations, for example, when the Centers for Medicare and Medicaid Services does not allow an enrollment due to an individual's residence in a given area, a plan is not required to accept the individual. Any individual who is confined as an inpatient at the time of such transfer shall become the liability of the succeeding plan unless the facility in which the participant is confined is not part of the succeeding plan's network. In this instance, the liability will remain with the previous insurer. The new plan shall assume liability for any subsequent services as provided for in 3.18 (3) of the Contract.

    However, if a plan becomes insolvent, experiences a significant loss of primary physicians and/or hospitals or no longer meets the minimum criteria for qualification in that county, or if the Board so directs due to an unapproved change of ownership, merger or acquisition, the department may close the plan to new enrollments, authorize a special enrollment period so that subscribers in that service area may change to another plan without waiting periods for pre-existing conditions, or both. The special enrollment period authorized by the Board may either require all employees insured by the plan to elect coverage under another plan or allow all employees insured by the plan the option to continue to be insured by the plan or to elect coverage under another plan.

16. Each plan will offer the uniform benefit level provided public employees under the standard health benefit coverage. Each plan must meet any and all applicable state or federal requirements concerning benefits and cost-sharing which may be imposed on the State of Wisconsin as an employer, the plan as an insurer, or a federally qualified health benefit program. Rate adjustments, if any, required for such mandated benefit payments will occur on January 1 after the next contract period begins unless otherwise mutually agreed to in writing.

    Each plan will offer the uniform benefit level to annuitants. With respect to annuitants eligible for Medicare, each plan will offer the uniform benefit and carve-out the benefits paid by Medicare so that annuitants on Medicare receive the same uniform benefit level as provided active employees except that premium for annuitants on Medicare is reduced.

17. Contracting organizations must participate in both the state group and the local public employer group.

18. The Board may allow plans that have substantially but not completely met the requirements of these Guidelines to participate as a health care plan provider, but not be considered "qualifying" for purposes of establishing the employer contribution toward premium when the contribution is based on a percentage of the lowest / average cost qualified plan. The reasons a plan may be considered "non-qualifying" shall include, but not be limited to:

    1. Failure to submit required information in the format specified by the department,

    2. Insufficient provider coverage in a service area (determined by the Board),

    3. Failure to provide the benefit level as described in Section II. D., 3,

    4. Failure to substantiate premium rate proposals, or

    5. Failure to comply with the contract.

19. Non-qualifying plans. This section applies only to those for whom contributions are based on a percentage of the lowest / average cost qualified plan. Local government employers must pay at least 50% but not more than 105% of the lowest cost / 88% of the average cost qualified plan in the employer's area (except for eligible employees who work less than half-time for whom the minimum contribution shall be at least 25% of premium). Local government employers who determine the employee premium contribution based on the tiered structure established for state employees must do so in accordance with Wis. Adm. Code § ETF 40.10. The county of the employer is considered the service area for local employers. At the request of a participating employer, the Department will review the service area used to determine the least / average cost qualified plan used for determining the employer’s maximum premium contribution. If the Department reviews the service area, it will be based on the zip code locations that includes at least 80% of the covered employees of the participating employer. Once the Department has made such an assessment, that service area will determine the least / average cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria. A non-qualifying plan approved by the Board for participation in the state Group Health Insurance Program may market its plan in any area. However, only the lowest / average cost qualified plan's premium rate would be used in the above calculations. No plan may qualify for determining employer contributions in its first year of operation under the Board's program. PPPs are not qualified in areas served by SMP. The service area for PPPs will be considered the subscriber's county of residence.

    The Standard Plan premium rates for state employees will be the same statewide. However, premium rates for the Standard Plan for the local government program will depend upon the geographic location of the municipality. The state has been divided into the following premium areas:

Geographic Area	Cost Factor
Balance of State	1.0
Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix Counties	1.03
Kenosha, Ozaukee, Racine, Washington, Waukesha Counties	1.07
Milwaukee County, Out of State	1.1

20. 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 plan and plans must notify the Department of subscribers terminating or reinstating coverage as described in Section II., J.

21. Plans will provide and receive all reasonable requests for data and other information as needed in a file format as identified by the Department after seeking input from plans. This includes requests for the pharmacy benefit manager to administer the pharmacy benefit program. Data file requests containing personal health identifiers must be submitted via the Department's secure FTP site, unless otherwise directed by the Department.

22. Plans shall not recoup any payments it has made for prescriptions filled by participants on and after January 1, 2004.

23. Optional Dental Coverage. Plans may offer optional dental coverage if the Department receives a description of benefit level prior to the annual premium bid on a date specified by the Department. The eligibility and enrollment provisions will be the same as the medical coverage provisions as specified by the Guidelines. If a plan offers dental coverage, it will be offered to all participants who enroll for medical coverage with the plan. However, a plan may offer dental coverage under the state employee's plan only, the local employer's plan only or both plans. If a plan offers dental coverage, the plan must independently review all adverse grievance decisions issued by a third-party dental administrator and provide to affected members notification of such a review and appeal rights to the Department in accordance with the contract.

    A participant's level of benefit, after commencing a treatment for orthodontia, will not be adversely impacted by a subsequent change in benefit level made by the plan. If a participant is in a course of orthodontic treatment and changes plans while covered under this program, and both the prior and succeeding plans provide orthodontic coverage, the succeeding plan must continue to cover the course of orthodontic treatment. The participant must use plan providers of the succeeding plan. Benefit accumulations from the prior plan will carry over and will be applied to the new benefit level.

24. PPPs and POSs may have different co-pay and deductible schedules for out-of-plan providers, except in the case of emergency, urgent care or when the service is not reasonably available from a plan provider. If the participant resides in a plan's qualified county, the PPP and POS must consider the participant's physical capability to travel the necessary distance to see a specialty plan provider when determining if that plan provider is reasonably available.

25. If the participant receives anesthesiology, radiology or pathology (includes all lab tests) services at a plan clinic or hospital, it will be covered at the in-plan level of benefits even if that care is not provided by a plan provider. The only exception is when the participant knowingly elects to receive such care through a non-plan provider.

26. The plans shall comply with Wis. Stat. § 628.46 with regard to any interest due for late payment of claims submitted by a non-plan provider.

27. The plans shall comply with and abide by the Patient's Rights and Responsibilities as printed in the annual Dual-Choice brochure. Plans that have their own Patient's Rights and Responsibilities may also use them unless there is a conflict. In that case the Patient's Rights and Responsibilities which is more favorable to the participant will apply.

28. The plans shall comply with all state and federal laws regarding patient privacy and shall assist the Board in complying with all requirements of the Early Retiree Reinsurance Program as specified in 45 C.F.R. 149.35.

Provider Agreements

Any organization seeking approval under these Guidelines must provide the following information:

1. If professional services are provided through contractual arrangements, such as an Independent Practice Association (IPA), a sample copy of the actual contractual agreement established between the organization and the participating physicians who will be providing professional services. If more than one type of contract is used then include a sample of each.

2. Detailed explanation of any relationship between the plan and hospitals which would be involved under the group health benefit program. Each applicant must specify whether there is a contractual relationship between the plan and the hospital(s) involved or if the relationship is limited only to the extent that physicians providing services under the program have staff privileges with the hospital(s).

3. Detailed explanation of how physicians and hospitals are compensated under the program including a description of any and all incentives involved. If physicians are salaried, a detailed explanation of how salaries are established, reviewed and changed, and who is the authorizing party for such action. The intent is to secure information on how a plan reimburses its providers; the Board is not interested in specific fees or salary information.

4. Detailed explanation of medical specialties associated directly or indirectly with the plan. For those plans where medical specialists are used as referral physicians rather than primary care, the plans must submit documentation to demonstrate that the referral physician(s) has, in fact, agreed to accept such referrals. If there is a contractual arrangement where an organization has contracted with a clinic/individual practitioner to provide either primary or referral care, such contractual agreements must be identified and included with the proposal.

5. Except for those benefits which require the enrollee to satisfy a deductible or be subject to co-payment, the contract for professional or hospital services must contain a provision whereby the physician and/or hospital and/or health care provider (as defined under Wis. Stat. § 655.001 (8)) agrees to accept the payments provided by the plan as full payment for covered services. Each plan must certify that it will "hold harmless" the enrollee from any effort(s) by third parties to collect payments for medical/hospital services.

   This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee from being held liable for hospital or professional charges except for

those benefits which require the enrollee to satisfy a deductible; be paid on a co-payment basis; or in those instances where the individual failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of published plan requirements shall not be subject to the "hold-harmless" provision.

6. Provider agreements for transplants are expected to specify that retransplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered and is not subject to the Uniform Benefits exclusion on retransplantation.

7. Plans are expected to incorporate into hospital and provider agreements the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

8. Plans are expected to incorporate into hospital and provider agreements the hospital readmissions reduction program and the community-based care transitions program as described by Medicare and that are conducted under the authority of Sections 3025 and 3026.

Capital Equipment and Expenditures

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

> "Item F. of the Guidelines is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

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

Enrollment and Reporting

If an organization submits a proposal to participate under the State of Wisconsin's group health benefit program and the proposal receives approval by the Board, the plan will be offered to active and retired public employees at a time established by the Board (dual-choice enrollment) subject to the following:

1. Any plan, which receives approval from the Group Insurance Board, must:

    a. Secure a minimum of 100 subscriber contracts (state/local employees enrolled; this number does not include any dependents covered under the plan) or;

    b. Demonstrate that 10% of the eligible employees within the area to be serviced by the plan have opted to participate in the program.

2. The Board may waive the minimum participation requirement set forth under Section II., G., 1., provided the organization submits a marketing plan which demonstrates that this minimum number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a

similar extent by employees of other groups and the location is convenient to potential subscribers. This marketing plan will be considered confidential by the Board insofar as permitted by Wisconsin Law.

As stated previously, each plan so approved will be required to offer annually, a "dual-choice enrollment" opportunity. The Board establishes when such dual-choice enrollment periods will be held. Each plan will be required to prepare informational materials in a form and content acceptable to the Board and clearly indicate any changes from the previous year's materials when submitting draft materials to the Department.

3. Each organization must demonstrate to the Board's satisfaction its ability to provide the following:

   a. The specified level of services to enrollees.

   b. An adequate mechanism for maintaining records on each enrolled employee and covered dependents, including but not limited to, initial determination of eligibility for dependents for disabled and full-time student status.

   c. Effective methods for containing costs for medical services, hospital confinements or any other benefit to be provided. Particular emphasis should be placed on the presence of an effective peer review mechanism and utilization review mechanism for monitoring health care costs. The Board is also particularly interested in COB (Coordination of Benefit) provisions such as third party requests, dual-coverage under different plans, etc.

   d. An effective mechanism for handling complaints and grievances made by enrollees.

      1) This includes a formal grievance procedure, which at a minimum complies with Wis. Adm. Code § INS 18.03, whereby the individual is provided the opportunity to present a complaint to the organization and the organization will consider the complaint and advise the enrollee of its final decision. Enrollees must be advised of the grievance process when a claim or referral is denied or if the enrollee expresses, in writing, dissatisfaction with the administration or claims practices or provision of services by the plan. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefit contractual provision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision.

      2) When necessary, the Board intends to take a proactive approach in resolving complaints. The plan will be expected to cooperate fully with the efforts of the Department in resolving complaints. Adverse decisions are subject to review by the Board for contractual compliance if the employee is not satisfied with the plan's action on the matter.

      3) The plan must retain records of grievances and file an annual summary (see schedule in Section II., J.) with the Board 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 of Employee Trust Funds.

e. Statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically the state/local employees and dependents covered thereunder if experience rated. If the plan premium is community-rated then the plan should give some indication of the percentage the state and local employee groups represent of the total covered community. The Board will require each plan to provide an explanation of rate methodology and the rate calculation developed by the Plan's actuary or consultant. Along with supporting documentation deemed necessary by the Board's actuary. The Board will also require enrollment information on state enrollees by age, sex, single or family coverage of members. Such information will be required once each year (per Section II., C.) and shall be treated as confidential by the Board in accordance with Wisconsin and federal law.

f. An adequate mechanism for handling medical costs and services provided to an enrolled individual in the event of an emergency, which occurs out of the service area.

g. Compliance with state and federal regulations pertaining to mandated or minimum benefits which may be applicable to the plan (under insurance statutes or otherwise).

h. Unless a benefit is being changed or added to the plan to comply with state or federal law, no benefit changes shall occur during the contract period unless the Board initiates the proposed changes.

i. A written description which will provide state and local employees with a clear explanation of pre-authorization and referral requirements. Such brochure shall be prepared and set forth in lay language for ease of understanding, and in a form and content acceptable to the Board and will be provided to the employee within 30 days of the effective date of coverage or the date the plan receives the employee's application, whichever is later.

j. Provide at least annually the names of individuals in the organization who are considered "key contacts." Key contacts are the names and telephone numbers of the chief executive officer and the liaison person with the Department of Employee Trust Funds. Also those persons who should be contacted by the various state agencies and local employers regarding claims problems, complaints and grievances and ordering supplies. Further, each plan must identify one person who will be designated as a "key contact" for the Employee Assistance Program Coordinators to ensure proper assessment, coordination and treatment for members who request referral to a facility for alcohol, drug and/or mental health problems.

k. Notification of significant event:

   1) Each plan shall notify the Board in writing of any "Significant Event" within ten (10) calendar days after the plan 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 plan's ability to meet its obligations under the public employee health plans, including, but not limited to, any of the following: disposal of major assets; loss of 15% or more of the plan's membership; termination or modification of any contract or subcontract if such termination or modification will have a material effect on the plan's

obligations under the state/local employees health program; 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, state licensing or certification, 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 plan's facilities or of other facilities used by the plan in the performance of this contract.

2) In addition, any change in the ownership of or controlling interest in the plan, any merger with another entity or the plan's acquisition of another plan which participates in the state group health insurance program is a "significant event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (51%) interest in the plan or any transfer of 10% or more of the indicia of ownership, including but not limited to shares of stock. The plan agrees to provide to the Board at least 60 days advance notice of any such event. The Board may accept a shorter period of notice when it determines the circumstances so justify. If the Board determines that the change of ownership or control, merger or acquisition is not in the best interests of the group health insurance program and insured employees, the Board may do any of the following, including any combination of the following:

   a) Terminate the plan's participation upon any notice it deems appropriate, including no notice.

   b) Authorize a special enrollment period and require that each subscriber enrolled in that plan change to another plan. No plan may impose a waiting period for pre-existing conditions with respect to such special enrollment periods.

   c) Authorize a special enrollment period so that a subscriber enrolled in that plan may voluntarily change to another plan. No plan may impose a waiting period for pre-existing conditions with respect to such special enrollment periods.

   d) Close the plan to any new enrollments for the remainder of the contract period.

   e) Require that prior to making a selection between plans, prospective subscribers be given a written notice describing the Board's concerns.

   f) Take no action.

3) The Board requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another participating plan in order to fulfill the Board's responsibility to assess the effects of the pending action upon the best interests of the group health insurance program and insured employees. The Board pledges to keep the information disclosed as required under par. (b) temporarily confidential unless the plan waives confidentiality or a court orders the Department or Board to disclose the information or the Department or Board determines that under the particular circumstances, any harm to the public interest that would result from permitting inspection is

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

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

b) The date such action becomes effective.

c) 60 days after the Board receives the information.

4) The Board shall reserve the right to institute action as it deems necessary to protect the interests of its employees and dependents, as the result of a "significant event."

l. Agree to utilize identification numbers (group and subscriber) according to the system established by the Department of Employee Trust Funds. 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. Plans must always keep record of social security numbers for providing data and other reports to the Department and track the 8-digit unique member identification number that is assigned by the Department.

m. The plan's provider network must comply with the access standards set forth in WI Adm. Code § INS 9.32.

n. Provide coverage for eligible children as required under the National Medical Support Notice, a State and Federal law providing for a special enrollment opportunity for eligible children in certain cases when ordered by a court.

Rate-Making Process

Each plan must include in its proposal to the Board a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the Board insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans are encouraged to separate higher cost providers within geographic areas under the tiered structure into separate plans. The state and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. Plans shall provide rates for

both the regular and deductible options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The Department reserves the right to audit, at the expense of the plan, the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. **The Board reserves the right to reject any plan's bid when the Board believes it is not in the best interests of the group health insurance program.** The Board reserves the right to reopen the bid process after final bids are submitted when the Board determines that it is in the best interests of the group health insurance program. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)

- Family (Employee Plus Eligible Dependents)

- Medicare Coordinated
  - Individual
  - Family (all insureds under Medicare)
  - Family (at least 1 under Medicare, at least 1 other not under Medicare)

- Graduate Assistants[1]:
  - Individual
  - Family

- Deductible Option for Local Program

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

2. Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in Table 7 of Addendum 1 without written justification. It may not exceed 50% of the single rate for regular coverage, unless determined by the Board's actuary to be lower; 2 eligible rate shall be 2 times the individual Medicare coordinated rate; family rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate. It may not exceed the calculated rate in Table 7 of Addendum 1 without written justification.

[1] Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

4. Deductible Option for Local Program: The ratio is to be determined annually by the Board's actuary based on the relative value of the deductible plan to the traditional plan.

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

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

7. The Board will assess administration fees to cover expenses of the Department of Employee Trust Funds. This charge is added by the Board to the rates quoted by each alternate plan and is collected prior to transmittal of the premiums to the alternate plans.

8. Include completed Table contained in Addendum 1.

9. Plans shall not include in their rate any claims that they decide to pay outside the Uniform Benefits contract.

Submission of Proposals

Proposals to participate in the state group health insurance program must be submitted to the Board and address each of the requirements in Section II of the Guidelines. In addition to requirements previously cited, each plan proposal must be received by April 15 and include:

1. Fifteen (15) copies.

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

3. A description of case management and disease management activities.

4. A list and count of providers under contract arranged by county of practice for state employees, and by zip code for local employees. An electronic version of the listing must also be made available. The Board will expect an updated listing by July 23 in order to determine what areas will constitute your service area.

5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must be in writing and address the method used for providing services and processing claims under such circumstances.

6. An organizational chart.

7. Statement of agreement to abide by all the terms and conditions set forth in the "Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits" document.

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

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

Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds

(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by the Department the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by the Department the following Monday.)

Due Date (Receipt by Dept)	Information Due	Date Submitted
April 15, 2013	• New plans only. Proposal to participate in the program addressing each of the requirements in Section II of the Guidelines (Section II., I, page 1-18).	
April 29, 2013	• Estimated premium rate proposal for next calendar year.	
May 14, 2013	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June 1, 2013	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • Plan Utilization and Rate Review Information (Addendum 1). This information is to be mailed directly to: Nichole Ramsey Deloitte Consulting 50 South Sixth Street Suite 2800 Minneapolis, MN 55402-1538 • Addendum 1Tables 8A and 8B describing catastrophic data. • Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year. • Report detailing the State of Wisconsin group experience with comparisons to aggregate benchmarks. [Section II., D., 8.]	
June 15, 2013	• HEDIS information is required for the prior calendar year in the format as determined by the Department.	
July 1, 2013	• Preliminary premium rate quotations for next calendar year. (Annually, each plan will be provided with a rate quotation form about one week in advance of the due date.)	
July 6, 2013	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit. • Information of the plan's features, including objective documentation as requested, for use in the health plan features comparison summary in the Dual-Choice brochure.	
July 12, 2013	• 1st Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	
July 13, 2013	• The plan's address and telephone number as it should appear in the Dual-Choice brochure.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
July 23, 2013	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1 data submission was unacceptable.)	
July 30, 2013	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August 2, 2013	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 13, 2013	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period.	
August 20, 2013	• Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
August 27, 2013	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals.	
August 31, 2013	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period.	
September 14, 2013	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September 21, is required. • For plans not participating in the group health insurance program in 2014, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 2014. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24.** • Draft of letter the plan will mail to current subscribers summarizing dental benefit, accessing the plan's health risk assessment tool, and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September 21, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24, WITH FORWARDING REQUESTED.**	
September 17, 2013	• Put a PDF copy of your plan's provider directory for the upcoming benefit year on your plan's web site and provide ETF with the location. The PDF must remain on your plan's web site through the benefit year.	
September 26, 2013	• Dual-Choice kick off meeting in Madison.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
September 30, 2013	• Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page. • Provide four (4) copies of all informational materials in final form to the Department. • Final dental benefit description that will be provided to members if the plan offers dental coverage.	
October 7 – November 1, 2013	• Dual-Choice Enrollment Period.	
October 11, 2013	• Report on disease management capabilities and effectiveness. [Section II., D., 8.] • 2nd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
January 1, 2014	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of accessing the plan's health risk assessment tool and referral and grievance procedures must be included.	
January 10, 2014	• 3rd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	
January 14, 2014	• Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March 1, 2014	• Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights.	
April 1, 2014	• A Quality Improvement plan in the format set forth by the Department.	
April 11, 2014	• 4th Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.	
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • Report direct pay terminations and reinstatements in the format as determined by the Department.	
Monthly	• Generate and process the reports identifying the Full File Compare discrepancies, contacting the Department regarding proposed resolutions for those discrepancies that you are unable to resolve.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
Annually	• Verify eligibility of adult disabled children age 26 or older, which includes checking that the: ○ Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year, and ○ Support and maintenance requirement is met, and ○ Child is not married.	
Quarterly	• Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. Dates are specified above.	

ADDENDUMS

ADDENDUM 1

PLAN UTILIZATION AND RATE REVIEW INFORMATION

NAME OF PLAN: _____

SERVICE AREA COVERED: _____

PREMIUM RATES BASED ON: COMMUNITY RATED EXPERIENCE
STATE EMPLOYEE EXPERIENCE*
LOCAL EMPLOYEE EXPERIENCE*
OTHER (PLEASE SPECIFY BASIS)
* USE SEPARATE ADDENDUM 1 PAGES

This Rate Review information shall be provided June 1,2013. It must be submitted directly to the Board's Actuary in the prescribed Excel format via e-mail.

The Department will provide written guidelines to the plan concerning the definitions, group numbers or subgroups, report period, and other information required to prepare this report. Additional data may be required on different subgroups (COBRA participants, for example) throughout the contract year.

STATE OF WISCONSIN
ACTUARIAL DATA REPORT
GENERAL TABLE DESCRIPTION

Based upon the membership, experience data, trend assumptions, and assumed administrative costs provided, the data and calculations provided in TABLEs 1-9 of the Addendum1 utilization and experience data request calculate prospective premium rates for calendar year 2014. Any plan for which proposed calendar year 2014 premium rates differ from those developed in Addendum 1 TABLES 1-9 will be required to submit its actual renewal calculation for calendar year 2014.

TABLE 1 -- CONTRACT MIX AND CONTRACT SIZE

TABLE 1 will calculate average contract size and contract mix figures based upon data provided. The number of member months in the period 4/1/2012-3/31/2013 for single and family coverage should be input into Columns C and D, line 31. The number of contract months in the period of 4/1/2012-3/31/2013 for single and family coverage should be input into Columns C and D, line 32. Column E automatically calculates the member month and contract month totals, while lines 34-35 automatically calculate average contract size and mix for single and family coverage. In addition, the health plan name should be entered on line 3.

TABLE 2 -- ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

The first section of TABLE 2 requests the member counts for the period of 4/1/2012-3/31/2013 by age group and sex. These counts should reconcile to TABLE 1.

The second section of TABLE 2 requests the member counts for December 2012 by age group and sex (regardless of whether the member is an employee or a dependent).

The third section of TABLE 2 requests the member counts for March 2013 by age group and sex (regardless of whether the member is an employee or a dependent).

A box at the bottom of TABLE 2 will show the automatically calculated average age and average age/sex factor.

The age calculation should be based on the employee or dependent's age on the first day of the month.

TABLE 3 -- ACTUARIAL DATA REPORTS
TABLE 3A AND 3B: APRIL 1, 2012 THROUGH MARCH 31, 2013 CLAIMS EXPERIENCE
TABLE 3C: JANUARY 1, 2012 THROUGH DECEMBER 31, 2012 AND JANUARY 1, 2013 THROUGH MARCH 31, 2013 CLAIMS EXPERIENCE

GENERAL DESCRIPTION

TABLE 3 requests claims experience information for all health plans, whether they are experience rated or fully or partially capitated. There are separate sections for medical and dental plan data (TABLES 3A and 3B, respectively). Please complete those portions of the data request that are applicable to your type of plan.

1. **Category: One report is requested for each of the following eight categories:**
   i. State of Wisconsin Employee Plan, Non-Medicare
   ii. State of Wisconsin Employee Plan, Medicare
   iii. State of Wisconsin Employee Plan, Graduate Assistant
   iv. State of Wisconsin Local Plan, Non-Medicare
   v. State of Wisconsin Local Plan, Medicare
   vi. State of Wisconsin High Deductible Plan
   vii. Total Organization, Non-Medicare/Commercial
   viii. Total Organization, Medicare

   For the Medicare lines of business (State & Local), the experience and membership provided should include only those members who are Medicare-eligible (no non-Medicare eligible spouses or other dependents). Please respond to the questions in TABLE 9A and indicate if this is not the case.

   Please note that the Total Organization refers to all commercial group business for your organization, including the State of Wisconsin but excluding Medicaid participants. If you offer more than one plan option to either Non-Medicare or Medicare State of Wisconsin Employee or Local Plan participants, please include a separate report for each option.

2. **Report Period**

   The report should include all services rendered from April 1, 2012 through March 31,2013.

3. **Benefit Description**

   Refer to the section immediately following for a detailed description of services to be included in each benefit category. If you are unable to follow these definitions, indicate the reason why and the actual definition used.

4. **Total Number of Admissions**

   For hospital inpatient services, the total number of admissions rendered for all members during the Report Period.

5. **Total Number of Days**

   For hospital inpatient services, the total number of hospital days rendered for all members during the Report Period.

6. **Total Paid Charges**

   For all services, the total paid claims. Paid claims are defined as discounted charges net of employee cost-sharing during the requested Report Period. In other words, the experience should not include any participant/member liabilities such as copayments, coinsurance or deductibles. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

7. **Total Number of Member Months**

   The total number of member months is the number of months each member and dependent is eligible for benefits during the Report Period. Please note that this cell is linked to the total 4/1/2012-3/31/2013 member months from TABLE 2. The number of member months should be consistent with the Monthly Membership Report.

8. **Annual Admissions Per 1,000**

   For hospital inpatient services, calculated as the total Number of Admissions divided by the total Number of Member Months, times 12,000.

9. **Annual Days Per 1,000**

   For hospital inpatient services, calculated as the Total Number of Days divided by the Total Number of Member Months, times 12,000.

10. **Average Length of Stay**

    For hospital inpatient services, calculated as the Total Number of Days divided by Total Number of Admissions.

11. **Average Paid Charges Per Day**

    For hospital inpatient services, calculated as Total Paid Charges divided by the Total Number of Days.

12. **Average Paid Charges Per Member Per Month**

    Calculated as Total Paid Charges divided by the total Number of Member Months.

13. **Total Number of Services**

    For non-hospital inpatient services, the total number of services rendered for all members during the Report Period. Please note the services are defined in the Benefit Description section.

14. Annual Services Per 1,000

For non-hospital inpatient services, calculated as Total Number of Services divided by the total Number of Member Months, times 12,000.

15. Average Paid Charges Per Service

For non-hospital inpatient services, calculated as the Total Paid Charges divided by the Total Number of Services.

16. Incurred Claim Factor

This factor is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges.

17. Runout Months

This is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of4/1/2012-3/31/2013. For example, if a plan includes experience for claims that were incurred from 4/1/2012-3/31/2013 and paid through 5/31/2013, the Runout Months would equal two and the Incurred Claim Factor should be reflective of the Runout Months.

18. Incurred Claims

Incurred claims will be calculated as (1 + Completion Factor) multiplied by the Paid Charges. This represents the total amount of claims that have been incurred in the Reporting Period.

19. Capitation Charges

The total capitation payments paid during the Report Period for each requested category of service. Please note that any amount entered into the "Other" category of service will need to be described in detail using the space provided.

STATE OF WISCONSIN
ACTUARIAL DATA REPORT - ALL HEALTH PLANS
BENEFIT DESCRIPTION FOR TABLES 3A, 3B, and 3C

TABLE 3A – MEDICAL PLAN EXPERIENCE

TABLE 3A requests medical utilization and claims experience for the period4/1/2012-3/31/2013.

The following benefit descriptions should be used in developing the Actuarial Data Report. Where possible, Current Procedural Terminology Codes–CPT 2012 Professional Edition, (CPT-4 codes) has been included to aid in the summarization of information. The appropriate HCFA Common Procedure Coding System (HCPCS) Level II codes are also included. For services affected by the Medicare Resource Based Relative Value System (RBRVS), both the CPT code ranges used prior to RBRVS and the evaluation and management CPT code ranges introduced by RBRVS have been included.

Capitation charges are requested throughout the section. Where requested, capitation payments paid for various service categories during the Report Period must be entered.

A. HOSPITAL INPATIENT

This benefit includes daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Services are counted as the number of admissions and the number of days confined. Ancillary charges should not include professional charges for hospital-based physicians.

1. Non-Maternity
   a. Medical: A medical admission includes a confinement without a major surgery and without a diagnosis indicating a substance abuse or psychiatric condition.

   b. Surgical: A surgical admission includes a confinement primarily resulting from a surgery or multiple surgeries.

   c. Mental Health: A psychiatric admission includes a confinement with a primary diagnosis involving a psychiatric condition.

   d. Substance Abuse: A substance abuse admission includes a confinement with a primary diagnosis involving an alcohol and/or drug abuse condition.

2. Maternity
   a. Maternity Deliveries: This benefit includes hospital inpatient room and board and ancillary services for normal and cesarean deliveries for the mother. Charges for the well newborn baby should be included but newborn admissions and days should be excluded.

   b. Maternity - Non-Deliveries: This benefit includes hospital inpatient room and board and ancillary services for complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.

   c. Neonatal ICU: This benefit includes hospital inpatient room and board and ancillary services for premature infants or other neonatal care.

3. Extended Care Facility

   This benefit includes daily room and board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

Total paid charges related to Total Hospital Inpatient Capitation must be entered in this section.

B. HOSPITAL OUTPATIENT

Emergency Room

This benefit includes services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Services are counted as the number of visits to the emergency room. Charges should include facility charges only and not professional charges.

Outpatient Surgery

This benefit includes hospital outpatient services for surgery, including surgery performed in a hospital outpatient facility or a freestanding surgical facility. Services are counted as the number of surgical procedures and not the number of outpatient surgical encounters. Charges should include facility charges only and do not include professional charges.

Radiology

This benefit includes the technical component of radiology services performed by a hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

Pathology

This benefit includes the technical component of pathology services performed by the hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

Outpatient Mental Health

This benefit includes mental health outpatient services. Services are counted as the number of visits to the outpatient mental health facility. Charges should include facility charges only and not professional charges.

Outpatient Substance Abuse

This benefit includes substance abuse outpatient services. Services are counted as the number of visits to the outpatient substance abuse facility. Charges should include facility charges only and not professional charges.

Other

This benefit includes hospital outpatient services other than emergency room, surgery, radiology and pathology, such as physical therapy, maternity non-delivery, and supplies. Services are counted as the number of procedures. Charges should include facility charges only and not professional charges.

Total paid charges related to Total Hospital Outpatient Capitation must be entered in this section.

Other Facility

a. Hospice -This benefit includes all facility charges and services provided in a hospice for a terminally ill patient and family. Charges incurred in the hospice ward of a hospital are included as well as in a stand-alone hospice facility.

b. Transitional Care -This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be provided in a hospital outpatient or day care setting and charges would include professional and facility charges.

Total paid charges related to Total Facility Capitation must be entered in this section.

PHYSICIAN

Surgical Services

a. Inpatient Surgery:

(1) Professional Surgeon (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgeries performed by a surgeon on an inpatient basis. Services are counted as the number of inpatient surgical procedures and not the number of surgical admissions. Charges should include normal pre-surgical and post-surgical encounters with the surgeon and would include both primary and assistant surgeon charges.

b. Anesthesia:

(1) Inpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140 or 10040-69990 with anesthesia modifier)

This benefit includes services by an anesthesiologist or anesthetist for non-maternity and maternity surgeries performed in an inpatient setting. Services are counted as the number of inpatient surgical procedures requiring anesthesia. Charges should include inpatient pre-surgical and post-surgical encounters, and the usual monitoring procedures.

(2) Outpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140, or 10040-69990 with anesthesia modifier)

Same as above except in an outpatient setting, including a hospital outpatient department, freestanding surgical facility or physician's office.

c. Maternity:

(1) Normal Deliveries (CPT-4 Codes 59400-59430, 59610-59614)

This benefit includes physician obstetrical care for normal deliveries and complications of pregnancy that result in a normal delivery. Services are counted as the number of maternity cases that result in a normal delivery. Charges should include delivery care and standard pre- and post-natal visits.

(2) Cesarean Deliveries (CPT-4 Codes 59510-59515, 59618-59622)

This benefit includes physician obstetrical care for cesarean deliveries and complications of pregnancy that result in a cesarean delivery. Services are counted as the number of maternity cases that result in a cesarean delivery. Charges should include delivery care and standard pre-natal and post-natal visits.

(3) Other OB Services (CPT-4 Codes 59000-59350, 59812-59899)

This benefit includes physician obstetrical care for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion as well as other obstetrical services that are not related to a delivery (e.g. amniocentesis, fetal monitoring, etc.). Services are counted as the number of procedures. Charges should include surgical care and standard pre-natal visits.

d. Outpatient Surgery:

(1) Outpatient Surgical Center (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit provides for surgery by a physician in a hospital outpatient department or a freestanding surgical facility. Services are counted as the number of outpatient procedures and not the number of outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with a surgeon.

(2) Office (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgery by a physician in the physician's office. Services are counted as the number of office outpatient surgical procedures and not the number of office outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with the physician.

Physician — Inpatient Visits

a. Hospital Visits (CPT-4 Codes 99217-99239, 99289-99300, 99460, 99462-99465, HCPCS Codes M0064-M0100)

This benefit includes visits to hospitals by a physician. Services are counted as the number of visits. Physician visits by the surgeon in the case of a surgery should be included in the surgery benefit.

b. Critical Care Visits (CPT-4 Codes 99170-99199, 99289-99292, 99466-99480)

This benefit includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician (e.g. cardiac arrest, shock, bleeding, respiratory failure, etc.). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Services are counted as the number of procedures.

c. Mental Health Visits (CPT-4 Codes 90791-90899; HCPCS Codes G0176-G0177, H0001-H2999, M0064-M0100)

This benefit includes visits to hospitals for a psychiatric patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

d. Substance Abuse Visits (CPT-4 Codes 90791-90792, 90832-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes visits to hospitals for a substance abuse patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

e. Extended Care Visits (CPT-4 Codes 99304-99318, HCPCS Codes M0064-M0100)

This benefit includes physician visits to approved extended care facilities. Services are counted as the number of procedures.

f. Home Health Visits (CPT-4 Codes 99324-99350, 99500-99602, HCPCS Codes M0064-M0100)

This benefit includes physician visits in the insured's home or a custodial facility. It does not include visits by a nurse. Services are counted as the number of visits.

Office Services

a. Office Visits (CPT-4 Codes 99143-99150, 99201-99215, HCPCS Codes M0064-M0100)

This benefit includes visits to a physician's office. Physical exams, well baby exams and any pre-surgical or post-surgical visits are included elsewhere. Services are counted as the number of visits. Charges should include professional fees of the primary physician or the referral physician. Charge levels should include only the physician's time; the charges for lab or x-ray procedures performed in the physician's office and medications are included elsewhere.

b. Therapeutic Injections (J Codes) (CPT-4 Codes 96360-96379; HCPCS Codes J0120-J8999)

This benefit includes professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included. Services are counted as the number of procedures.

c. Allergy Testing/Allergy Immunotherapy (CPT-4 Codes 95004-95079, 95115-95199, HCPCS Codes G0008-G0010, J0171-J8999)

This benefit includes professional services and materials associated with allergy tests when administered by the staff of the attending physician. This benefit also includes professional services and materials associated with allergy immunotherapy (serum, syringes, etc.) when administered by the staff of the attending physician. Services are counted as the number of procedures.

d. Chemotherapy Drugs (HCPCS Codes J9000-J9999)

This benefit includes professional services and materials associated with chemotherapy drugs when administered by the staff of the attending physician. Services are counted as the number of procedures.

e. Diagnostic Testing

This benefit provides for the following professional services:

Service	CPT-4 or HCPCS Codes
Biofeedback	90901-90911
Gastroenterology	91000-91299
Otorhinolaryngology Services	92502-92505, 92511-92526, 92700
Vestibular Function Tests	92531-92548
Non-Invasive Peripheral Vascular Diagnostic Studies	93875-93990
Pulmonary	94002-94799
Neurology	95800-96020
Chemotherapy	96401-96549, HCPCS Codes Q0083-Q0085
Dermatology	96900-96999
Miscellaneous	96101-96125, 96150-96155, 99000-99091, 99175-99199, 99354-99360, 99477-99499, HCPCS Code G9143

Not all of the above procedures are necessarily diagnostic testing. They were included in this benefit because they are related to diagnostic testing. Services are counted as the number of procedures.

f. Urgent Care

This benefit includes services for medical care performed in an urgent care facility. Services are counted as the number of visits to the urgent care center. Charges should include both facility and professional charges.

g. Other (HCPCS Codes A4206-A4608, A4641-A4652, A5051-A9999, B4000-B5200, M0075-M0100)

This benefit includes physician office services not included elsewhere. Services are counted as the number of procedures.

Other Physician Services

a. Emergency Room Visits (CPT-4 Codes 99281-99288)

This benefit includes visits to the emergency area of a hospital outpatient facility by either a primary care physician or a hospital staff physician. Services are counted as the number of visits.

b. Consults (CPT-4 Codes 99241-99255, 97802-97804, HCPCS G0270-G0271)

This benefit includes a consulting specialist and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate source for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. Consultations can be provided for both inpatient and outpatient care. Services are counted as the number of consultations.

c. Cardiovascular (CPT-4 Codes 92950-93799; HCPCS Codes M0300-M0301, Q0035)

This benefit includes therapeutic services (e.g. CPR), cardiography (e.g. EKGs), cardiac catheterization and other cardiovascular services performed by a physician. Services are counted as the number of procedures.

d. Dialysis (CPT-4 Codes 90935-90999; HCPCS Codes A4650-A4932, E1500-E1699, M0064-M0100)

This benefit includes services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures. Services are counted as the number of procedures.

e. Other Physician Services (CPT-4 Codes 96567-96571, 99143-99150, 99363-99380; Miscellaneous HCPCS Codes)

This benefit includes physician services not allocated to other line items. Services are counted as the number of procedures.

f. Radiology:

(1) Inpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by a physician when the x-ray is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of radiology services should be included in the hospital inpatient benefit.

(2) Outpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by the physician when the x-ray is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of radiology services should be included in the Hospital Outpatient - Radiology benefit or in the Physician - Radiology - Office (Combined Professional and Technical) benefit.

(3) Office - (Combined Professional and Technical) (CPT-4 Codes 70010-77032, 77071-79999; HCPCS Codes Q0092, R0000-R5999)

This benefit includes both the professional and technical component of radiology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the x-ray is performed in an office or clinic setting.

g. Surgical Pathology:

(1) Inpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional services by a physician when the surgical pathology procedure is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of pathology services should be included in the hospital inpatient benefit.

(2) Outpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional service by the physician when the surgical pathology procedure is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of pathology services should be included in the Hospital Outpatient - Pathology benefit or in the Physician - Pathology - Office (Combined Professional and Technical) benefit.

(3) Office (Combined Professional and Technical) (CPT-4 Codes 88300-88399; HCPCS Code Q0091)

This benefit includes both the professional and technical component of surgical pathology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the lab work is performed in an office or clinic setting.

OTHER SERVICES

Physical Therapy

(CPT-4 Codes 97001-97002, 97005-97799)

This benefit includes physical therapy when ordered by the attending physician. Services are counted as the number of procedures.

Occupational/Speech Therapy

(CPT-4 Codes 92506-92508, 97003-97004, HCPCS Codes V5362-V5364)

This benefit includes occupational therapy when ordered by the attending physician. Services are counted as the number of procedures.

Chiropractic

(CPT-4 Codes 98940-98943)

This benefit includes visits to a licensed chiropractor's office including those visits involving manipulations. This benefit includes x-rays taken in the chiropractor's office. Services are counted as the number of procedures.

Private Duty Nursing/Home Health

(CPT-4 Codes 99500-99602)

This benefit includes private nursing and home health visits if required by the attending physician and not representing custodial care. Services are counted as the number of procedures.

Ambulance

(HCPCS Codes A0000-A0999)

This benefit includes professional ambulance service. Services are counted as the number of procedures.

Durable Medical Equipment/Prosthetics

(HCPCS Codes A4611-A4640, B9000-B9999, E0100-E1406, E1700-E8002, K0001-K0899, L0100-L9999, Q0081, V5030-V5299, V5336)

This benefit includes appliances, equipment, and prosthetic devices. Appliances and equipment include braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. Prosthetics includes artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, and medically necessary reconstruction). Services are counted as the number of items.

Laboratory

(CPT Codes 36415, 80047-88299, 89049-89240; HCPCS Codes G0027, P0000-P9999)

This benefit includes both the professional and technical component of non-physician laboratory services when these services are billed together. Services are counted as the number of procedures.

ADDITIONAL BENEFITS

Immunizations

(CPT-4 Codes 90281-90749)

This benefit includes the professional services and materials associated with administering immunizations. Services are counted as the number of procedures.

Well Baby Exams

(CPT-4 Codes 99381, 99391, 99460-99465)

This benefit includes normal periodic examinations of well children under age one. Services are counted as the number of exams.

Well Child Exams

(CPT Codes 99382-99384, 99392-99394, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of children ages 1 through 17. Services are counted as the number of exams.

Physical Exams

(CPT-4 Codes 99385-99387, 99395-99397, 99401-99429, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of adults and children over the age of 17. Services are counted as the number of exams.

Vision Services

(CPT-4 Codes 92002-92287, 92499)

This benefit includes eye exams and other ophthalmology services conducted by a licensed ophthalmologist or optometrist. Services are counted as the number of procedures.

Vision Supplies

(CPT-4 Codes 92310-92371; HCPCS Codes V2020-V2799)

This benefit includes lenses and frames and contact lenses. Services are counted as the number of services.

Speech Exams

(CPT-4 Codes 92506-92508; HCPCS Codes V5301-V5364 (except V5336))

This benefit includes speech exams. Services are counted as the number of procedures.

Hearing Exams

(CPT-4 Codes 92550-92597; HCPCS Codes V5000-V5020)

This benefit includes hearing exams. Services are counted as the number of procedures.

Podiatrist

This benefit includes services performed by a licensed podiatrist. There are no specifically identified CPT codes for this treatment. Services are counted as the number of visits.

Mammography Exams

(CPT Codes 77051-77059)

This benefit includes routine mammography examinations of female adults. Charges should include the x-ray associated with the exam. Services are counted as the number of procedures.

Outpatient Mental Health

(CPT-4 Codes 90801-90815, 90845-90899; HCPCS Codes G0176-G0177, H0001-H2999)

This benefit includes psychiatric treatment by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

Outpatient Substance Abuse

(CPT-4 Codes 90801-90815, 90845-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes treatment of alcohol and/or drug abuse by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

Other Services

This line item would include all services that have not been allocated to any of the above line items.

Total paid charges related to Total Inpatient Physician Capitation must be entered in this section.

Total paid charges related to Total Outpatient Physician Capitation must be entered in this section.

Total paid charges related to Total Other Capitation must be entered in this section and will need to be described in detail using the space provided at the bottom of TABLE 3A.

NOTE: **The "% of Total" column is the "Sub-total" cost of the major service category divided by the "Grand Total" of the PMPM cost.**

TABLE 3B -- DENTAL PLAN EXPERIENCE

TABLE 3B requests utilization and claims experience for 4/1/2012-3/31/2013. HCPCS codes and CDT-2 codes have been included to aid in the summarization of dental actuarial data. If possible it is requested that plans provide capitation expenses broken down by similar categories as non-capitation expenses.

1. Diagnostic Services

   (HCPCS Codes D0100-D0999; CDT-2 Codes 00100-00999)

2. Preventive Dental

   (HCPCS Codes D1000-D1999; CDT-2 Codes 01000-01999)

   This benefit includes routine dental examinations, prophylaxis, x-rays, and fluoride treatment for children. Services are counted as the number of procedures.

3. Restorative/Crowns

   (HCPCS Codes D2000-D2999; CDT-2 Codes 02000-02999)

4. Endodontics

   (HCPCS Codes D3000-D3999; CDT-2 Codes 03000-03999)

5. Periodontics

   (HCPCS Codes D4000-D4999; CDT-2 Codes 04000-04999)

6. Prosthdontics

   (HCPCS Codes D5000-D5899, D6200-D6999; CDT-2 Codes 05000-05899, 06200-06999)

7. Oral Surgery

   (HCPCS Codes D6000-D6199, D7000-D7999; CDT-2 Codes 06000-06199, 07000-07999)

This benefit includes dental treatment for oral surgery, such as extractions and alveoloplasty.

Orthodontia

(HCPCS Codes D8000-D8999; CDT-2 Codes 08000-08999)

Other

(HCPCS Codes D5900-D5999, D9110-D9999; CDT-2 Codes 05900-05999, 09110-09999) This benefit includes maxillofacial prosthetics and adjunctive general services.

TABLE 3C – MENTAL HEALTH AND SUBSTANCE ABUSE EXPERIENCE

TABLE 3C requests utilization and claims experience for calendar year 2012 (1/1/2012-12/31/2012) as well as the period 1/1/2013-3/31/2013. This data will be used to assist the Department in determining the impact of the mental health parity rules on the program. The benefit descriptions and instructions included above (TABLE 3A section) should be used in developing the requested table.

TABLE 3D – MEDICAL PLAN EXPERIENCE BY MONTH

TABLE 3D requests medical utilization and claims experience by month for the period 1/1/2012-3/31/2013.

A. MEMBERS AND CONTRACTS

The total number of members is the total number of employees and dependents eligible for benefits during each month. The total number of contracts is the total number of employees eligible for benefits during each month.

Capitation charges should be included in the totals by month for this section.

Plans are asked to provide all utilization and paid charges for the time period of 1/1/2012 – 3/31/2013. Plans can use their own algorithm for deriving table 3D, but table 3A instructions can be used as guidance for the medical sections and table 3B instructions can be used as guidance for the dental section. The sum of the totals from sections B, C, D and E below should be the total medical utilization and paid charges provided during these time periods. The total from sections F below should be the total dental utilization and paid charges provided during these time periods.

B. HOSPITAL INPATIENT

This benefit includes daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Services are counted as the number of admissions and the number of days confined. Ancillary charges should not include professional charges for hospital-based physicians.

C. HOSPITAL OUTPATIENT

D. PHYSICIAN

E. OTHER SERVICES

F. DENTAL SERVICES

TABLE 4A -- MEDICAL TREND ASSUMPTIONS AND
TABLE 4B -- DENTAL TREND ASSUMPTIONS

TABLES 4A & 4B request information regarding the trends used in the rate development for medical and dental, respectively. **NOTE: The trend periods used in the calculations are listed at the top of the table.**

Step I shows the calculation of the weighted trend for fee-for-service costs. The weighted trend is the trend assumed by the carrier from the midpoint of the experience period to the midpoint of the rating period. Prepare separate tables for each period. Prepare one table for 2012-2013 and another table for 2013-2014 annual trends.

The first column of both TABLES 4A and 4B lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second and third columns represent trend factors for cost and utilization. Estimates of these factors need to be input for both trending periods.

The fourth, fifth, and sixth columns are automatically calculated fields which develop an overall trend factor for both rating periods.

Step 2 calculates the two year weighted trend for fee-for-service costs. The aggregate trend is calculated by multiplying the sum of one (1) plus the weighted trend for the first period (for only 9 months) times the sum of one (1) plus the weighted trend for the second period.

Step 3 requests the aggregate trend for capitated services.

The first column indicates the major service categories for capitated services. These categories correspond to those in the applicable experience tables (TABLE 3A or 3B) for capitated services.

The second column requests the projected annual trend for 2012-2013.

The third and fourth columns automatically calculate an overall weighted annual trend for 2012-2013 based on the trend input and the distribution of capitated service categories.

The fifth, sixth and seventh columns are similar to columns one, two and three and four as described above. However, plans should enter projected annual trend for 2013-2014 in the fifth column.

The two year weighted trend for capitated services is then calculated. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period times the sum of one plus the weighted trend for the second period.

Step 4 is where the carrier should explain any special circumstances which may have caused the trends to be unusually high or low.

TABLE 5 -- MEDICAL AND DENTAL ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS

TABLE 5 requests a breakdown of the administrative expenses and any other miscellaneous costs included in the rate development.

Medical Administrative Expenses:

The first column requests a detailed description of the different expense categories.

The second column is the 2012 PMPM cost for the expense category.

The third column is the PMPM cost that was included in the 2013 rate calculation.

The fourth column is the estimated PMPM cost included in the 2014 rate calculation.

Every plan is required to provide a detailed description of the components that make up the expense category(ies), for example, margin, profit and general administrative expense. If necessary, please attach additional sheets.

Medical Other PMPM Costs:

The first column requests a detailed description of the different cost categories.

The second column is the 2012 PMPM cost for the cost category.

The third column is the PMPM cost that was included in the 2013 rate calculation.

The fourth column is the estimated PMPM cost included in the 2014 rate calculation.

Every plan is required to provide a detailed description of the components that make up the expense category(ies). If necessary, please attach additional sheets.

Dental Administrative Expenses and other PMPM Costs:

Please follow the guidelines outlined above for the medical administrative expenses and other PMPM costs in completing the dental administrative expenses and PMPM costs.

TABLE 6 -- REQUIRED PREMIUM PMPM

TABLE 6 uses the information provided on TABLES 3 - 5 to arrive at the required premium per member per month for calendar year 2014. Please note that these automatically calculate and plans are not required to input data.

MEDICAL

Line 1 - is the grand total amount of fee-for-service PMPM claims costs for the experience period as shown in TABLE 3A. This amount includes the incurred claim factor supplied to bring the claims to an incurred level.

Line 2 - is the aggregate fee-for-service trend factor as shown in TABLE 4A.

Line 3 - is the claim costs trended to the rating period, which is calculated by multiplying Line 1 by Line 2.

Line 4 - is the total capitation costs from TABLE 3A.

Line 5 - is the aggregate capitated services trend factor from TABLE 4A.

Line 6 - is the total capitation cost trended to the rating period.

Line 7 - are the total estimated 2014 PMPM administrative costs as shown on TABLE 5.

Line 8 - is the total estimated 2014 PMPM other costs as shown on TABLE 5.

Line 9 - is the required medical premium PMPM and is calculated by adding lines 3, 6, 7 and 8.

DENTAL

Line 10 - is the grand total amount of fee-for-service PMPM claims costs for the experience period as shown on TABLE 3B, Line 3.

Line 11 - is the aggregate fee-for-service trend factor as shown in TABLE 4B.

Line 12 - is the claim costs trended to the rating period, which is calculated by multiplying Line 10 by Line 11.

Line 13 – is the total capitation costs from TABLE 3B, Line 2.

Line 14 - is the aggregate capitated services trend factor from TABLE 4B.

Line 15 – is the total capitation cost trended to the rating period.

Line 16 – are the total estimated 2014 administrative costs as shown in TABLE 5.

Line 17 – is the required dental premium PMPM and is calculated by adding lines 12, 15 and 16.

TABLE 7 – 2013 CALCULATED RATES

TABLE 7 includes information from TABLES 1 through 6 to automatically calculate the employee and dependent rates.

Step 1 details the calculation of the conversion factor used to convert the required premium per member per month to employee and dependent rates.

Line 1, Column B - is the contract mix from TABLE 1, line 12.

Line 2, Column B - is the contract mix from TABLE 1, line 13.

Line 3, Column B - is the sum of the contract mix for employee and family, which must equal 100%.

Line 1, Column C - is the average contract size for employee of 1.0.

Line 2, Column C - is the average contract size for family from TABLE 1, line 10.

Line 3, Column C - is the average contract size in total from TABLE 1, line 11.

Line 1, Column D - is the rate ratio for employee of 1.0.

Line 2, Column D - is the rate ratio for family of 2.0 for Medicare, 2.5 for non-Medicare.

Line 3, Column D - is the weighted average rate ratio in total for employee and family.

Line 1, Column E - is the conversion factor for employee and is derived by dividing the total average contract size by the total rate ratio.

Line 2, Column E - is the conversion factor for family and is derived by multiplying the conversion factor for employee by the rate ratio for family.

Step 2 details the calculation of the 2014 medical and dental rates using the required premium PMPM and the conversion factor.

MEDICAL

Line 4, Column C - is the required premium PMPM from TABLE 6, line 9.

Line 5, Column C - is conversion factor for employee.

Line 6, Column C - is the calculated 2014 rate for employee and is derived by multiplying the required premium PMPM by the conversion factor.

Line 4, Column D - is the required premium PMPM from TABLE 6, line 9.

Line 5, Column D - is the conversion factor for family.

Line 6, Column D - is the calculated 2014 rate for family and is derived by multiplying the required premium PMPM by the conversion factor.

Line 7 - The last line requests the 2013 in force medical only rates for single and family coverage.

DENTAL

Line 8, Column C - is the required premium PMPM from TABLE 6, line 17.

Line 9, Column C - is conversion factor for employee.

Line 10, Column C - is the calculated 2014 rate for employee and is derived by multiplying the required premium PMPM by the conversion factor.

Line 8, Column D - is the required premium PMPM from TABLE 6, line 17.

Line 9, Column D - is the conversion factor for family.

Line 10, Column D - is the calculated 2014 rate for family and is derived by multiplying the required premium PMPM by the conversion factor.

Line 11 - The last line requests the 2013 in force dental rates for single and family coverage.

Step 3 is the calculated 2014 rate for medical and dental combined.

Line 12, Column C - is the calculated 2014 employee rate for medical and dental combined.

Line 12, Column D - is the calculated 2014 family rate for medical and dental combined.

Line 13, Column C – calculates the total 2013 single in force rate for medical and dental combined.

Line 13, Column D – calculates the total 2013 family in force rate for medical and dental combined.

TABLE 8A – CLAIMS IN EXCESS OF $100,000
Incurred Period: April 1, 2012 through March 31, 2013

Line 1 - is the total amount of paid claims for individuals with paid claims of $100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of $150,000 each, you would enter the value of $150,000 X 5 = $750,000.

Line 2 - is the number of individuals with paid claims of $100,000 or greater.

Line 3 – is the total amount of claims of $100,000 or greater on an individual basis. For example, if you had five cases with paid claims of $150,000 each, this cell would calculate as follows: $150,000*5 - $100,000*5 = $250,000.

Line 4 - is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of 4/1/2012-3/31/2013. For example, if a plan includes experience for claims that were incurred from 4/1/2012-3/31/2013 and paid through 5/31/2013, the Runout Months would equal two.

Line 6 - will be calculated as (1 + Completion Factor) multiplied by the Paid Charges. This represents the total amount of claims of $100,000 or greater that have been incurred in the Reporting Period.

TABLE 8B – CLAIMS IN EXCESS OF $100,000 DETAIL

TABLE 8B requests member level claims data by major cost category of large paid claims of $100,000 or greater during the defined report period. TABLE 8B is a separate data submission that is submitted to the Department only. Additional data may be requested on different subgroups throughout the year.

TABLE 9A – QUESTIONS REGARDING SUBMITTED DATA

TABLE 9A requests responses to questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 9A. TABLE 9A is considered a part of the required data and must be provided at the same time as all other information.

TABLE 9B – SCHEDULE OF DENTAL BENEFITS

TABLE 9B requests plans submit their 2013 and 2014 schedule of dental benefits in the prescribed format. TABLE 9B is considered a part of the required data and must be provided at the same time as all other information.

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TABLE 9C – TOP PROVIDER REPORT

TABLE 9C requests plans submit a list of top facility and top professional providers based on Plan Paid dollars for the Addendum population and the time period April 1, 2012 through March 31, 2013. The provider information requested includes name, location, National Provider Identifier number and utilization counts.

Table 9C is only included in three of the eight categories:

i. State of Wisconsin Employee Plan, Non-Medicare
ii. State of Wisconsin Employee Plan, Medicare
iii. State of Wisconsin Local Plan, Non-Medicare

State of Wisconsin STATE NON-MEDICARE, NON-GRAD ASSISTANTS -

Plan Name:

TABLE 1

CONTRACT MIX AND CONTRACT SIZE

Show your calculation of contract mix and average contract size in the space provided below. The following is an example of a calculation averaging the total member months and contract months for the rating period. You may choose to use this method or another method that may be more appropriate.

EXAMPLE FORMAT OF CALCULATION

	Single	Family	Total
Member Months	A.	B.	C. (A+B)
Contract Months	D.	E.	F. (D+E)
Contract Size	G. (A/D) = 1.0	H. (B/E)	I. (C/F)
Contract Mix	J. (D/F)	K. (E/F)	L. 100%

CALCULATION OF CONTRACT MIX AND AVERAGE CONTRACT SIZE (show calculation):

Please enter in the member months and contract months for 4/1/12 - 3/31/13 for both single and family coverages. The contract sizes and contract mixes will be calculated automatically.

	Single	Family	Total
Member Months	0	0	0
Contract Months	0	0	0
Contract Size	0.0	0.0	0.0
Contract Mix	0.0%	0.0%	0.0%

TABLE 2
ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

	Member Months 4/1/12 - 3/31/13		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	December 2012 Member Counts		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	March 2013 Member Counts		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	Age/Sex Factors (using member months)		
Age Category	Male	Female	Total
Under 1	3.66	3.05	N/A
1-4	0.59	0.50	N/A
5-14	0.37	0.33	N/A
15-17	0.52	0.57	N/A
18-24	0.46	0.74	N/A
25-34	0.54	1.25	N/A
35-44	0.78	1.26	N/A
45-54	1.34	1.61	N/A
55-64	2.36	2.26	N/A
65-74	3.07	2.79	N/A
75+	3.07	2.79	N/A
TOTAL	N/A	N/A	N/A

Average age (from 4/12-3/13 member months):	N/A
Average age/sex factor (using 4/12-3/13 member months):	N/A

TABLE 3A - Medical
Claims Experience - Actuarial Data

Type of Service	April 1, 2012 Through March 31, 2013									
	Total # of Admissions	Total # of Days	Total Paid Charges	Total # of Member Months	Annual Admissions/ 1,000	Annual Days/1,000	Average Length of Stay	Average Paid Charges per Day	Average Paid Charges PMPM	Percent of Total
Hospital Inpatient										
Medical	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Surgical	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Mental Health (MH)	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Substance Abuse (SA)	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Subtotal Non-Maternity	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Maternity Deliveries	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Maternity Non-Deliveries	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Neonatal ICU	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Subtotal Maternity	0	0	$0	0	0	0	0.00	$0.00	$0.00	
Extended Care Facility	0	0	$0	0	0	0	0.00	$0.00	$0.00	
1. Total Hospital Inpatient	0	0	$0	0	0	0	0.00	$0.00	$0.00	0.0%
2. Total Hospital Inpatient Capitation			$0	0					$0.00	0.0%

Type of Service	Total # of Services	Total Paid Charges	Total # of Member Months	Annual Services/ 1,000	Average Paid Charges	Average Paid Charges PMPM	Percent of Total
Hospital Outpatient							
Emergency Room	0	$0	0	0	$0.00	$0.00	
Surgery	0	$0	0	0	$0.00	$0.00	
Radiology	0	$0	0	0	$0.00	$0.00	
Pathology	0	$0	0	0	$0.00	$0.00	
Mental Health (MH)	0	$0	0	0	$0.00	$0.00	
Substance Abuse (SA)	0	$0	0	0	$0.00	$0.00	
Other (Specify)	0	$0	0	0	$0.00	$0.00	
3. Total Hospital Outpatient	0	$0	0	0	$0.00	$0.00	0.0%
4. Total Hospital Outpatient Capitation		$0	0			$0.00	0.0%
5. TOTAL HOSPITAL		$0	0			$0.00	
Other Facility							
Hospice	0	$0	0	0	$0.00	$0.00	
Transitional Care	0	$0	0	0	$0.00	$0.00	
6. Total Facility	0	0	0	0	$0.00	$0.00	0.0%
7. Total Facility Capitation		$0	0			$0.00	0.0%
Physician Services							
Inpatient Surgery	0	$0	0	0	$0.00	$0.00	
Inpatient Anesthesia	0	$0	0	0	$0.00	$0.00	
Outpatient Anesthesia	0	$0	0	0	$0.00	$0.00	
IP Maternity - Normal Deliveries	0	$0	0	0	$0.00	$0.00	
IP Maternity-Cesarean Deliveries	0	$0	0	0	$0.00	$0.00	
IP Other OB Services	0	$0	0	0	$0.00	$0.00	
Outpatient Hosp/Surgical Center	0	$0	0	0	$0.00	$0.00	
Office Surgery	0	$0	0	0	$0.00	$0.00	
Inpatient Hospital Visits	0	$0	0	0	$0.00	$0.00	
Inpatient Critical Care Visits	0	$0	0	0	$0.00	$0.00	
Inpatient Mental Health Visits	0	$0	0	0	$0.00	$0.00	
Inpatient Substance Abuse Visits	0	$0	0	0	$0.00	$0.00	
Extended Care Facility Visits	0	$0	0	0	$0.00	$0.00	
Home Health Visits	0	$0	0	0	$0.00	$0.00	
Office Visits	0	$0	0	0	$0.00	$0.00	
Therapeutic Injections (J Codes)	0	$0	0	0	$0.00	$0.00	
Allergy Testing/Immunotherapy	0	$0	0	0	$0.00	$0.00	
Chemotherapy Drugs	0	$0	0	0	$0.00	$0.00	
Diagnostic Testing	0	$0	0	0	$0.00	$0.00	
Urgent Care	0	$0	0	0	$0.00	$0.00	
Emergency Room	0	$0	0	0	$0.00	$0.00	
Consults	0	$0	0	0	$0.00	$0.00	
Cardiovascular	0	$0	0	0	$0.00	$0.00	
Dialysis	0	$0	0	0	$0.00	$0.00	
Inpatient Radiology	0	$0	0	0	$0.00	$0.00	
Outpatient Radiology	0	$0	0	0	$0.00	$0.00	
Office Radiology	0	$0	0	0	$0.00	$0.00	
Inpatient Pathology	0	$0	0	0	$0.00	$0.00	
Outpatient Pathology	0	$0	0	0	$0.00	$0.00	
Office Pathology	0	$0	0	0	$0.00	$0.00	
Other (Specify)	0	$0	0	0	$0.00	$0.00	
8. Subtotal Physician Services	0	$0	0	0	$0.00	$0.00	0.0%
Other Services							
Physical Therapy	0	$0	0	0	$0.00	$0.00	
Occupational/Speech Therapy	0	$0	0	0	$0.00	$0.00	
Chiropractic Services	0	$0	0	0	$0.00	$0.00	
Private Duty Nursing/Home Health Care Services	0	$0	0	0	$0.00	$0.00	
Ambulance	0	$0	0	0	$0.00	$0.00	
DME/Prosthetics	0	$0	0	0	$0.00	$0.00	
Laboratory	0	$0	0	0	$0.00	$0.00	
9. Subtotal Other Services	0	$0	0	0	$0.00	$0.00	0.0%
Additional Services							
Immunizations	0	$0	0	0	$0.00	$0.00	
Well Baby Exams	0	$0	0	0	$0.00	$0.00	
Well Child Exams	0	$0	0	0	$0.00	$0.00	
Physical Exams	0	$0	0	0	$0.00	$0.00	
Vision Services	0	$0	0	0	$0.00	$0.00	
Vision Supplies	0	$0	0	0	$0.00	$0.00	
Speech Exams	0	$0	0	0	$0.00	$0.00	
Hearing Exams	0	$0	0	0	$0.00	$0.00	
Podiatry Services	0	$0	0	0	$0.00	$0.00	
Mammography	0	$0	0	0	$0.00	$0.00	
Outpatient Mental Health	0	$0	0	0	$0.00	$0.00	
Outpatient Substance Abuse	0	$0	0	0	$0.00	$0.00	
Other	0	$0	0	0	$0.00	$0.00	
10. Subtotal Additional Services	0	$0	0	0	$0.00	$0.00	0.0%
11. Total Inpatient Physician Capitation		$0	0			$0.00	0.0%
12. Total Outpatient Physician Capitation		$0	0			$0.00	0.0%
13. Other Capitated Services*		$0	0			$0.00	0.0%
14. Total Non-Capitation		$0	0			$0.00	0.0%
15. Total Non-Cap Incurred Claim Factor	0.000%						
16. Number of Runout Months	0						
17. Incurred Non-Capitation Total		$0	0			$0.00	0.0%
18. Total Capitation		$0	0			$0.00	0.0%
19. Incurred Claim Grand Total		$0	0			$0.00	0.0%

* Please list and describe in detail all other capitated services

TABLE 3B - Dental
Claims Experience - Actuarial Data

Type of Service	April 1, 2012 Through March 31, 2013						
	Total # of Services	Total Paid Charges	Total # of Member Months	Annual Services/ 1,000	Average Paid Charges	Average Paid Charges PMPM	Percent of Total
Non-Capitated Dental Expenses							
Diagnostic	0	$0	0	0	$0.00	$0.00	0.0%
Preventive	0	$0	0	0	$0.00	$0.00	0.0%
Restorative	0	$0	0	0	$0.00	$0.00	0.0%
Crowns	0	$0	0	0	$0.00	$0.00	0.0%
Endodontics	0	$0	0	0	$0.00	$0.00	0.0%
Periodontics	0	$0	0	0	$0.00	$0.00	0.0%
Prosthodontics	0	$0	0	0	$0.00	$0.00	0.0%
Oral Surgery	0	$0	0	0	$0.00	$0.00	0.0%
Orthodontia	0	$0	0	0	$0.00	$0.00	0.0%
Other	0	$0	0	0	$0.00	$0.00	0.0%
1. Total Non-Cap	0	$0	0	0	$0.00	$0.00	0.0%
2. Total Non-Cap Incurred Claim Factor	0.000%						
3. Number of Runout Months	0						
4. Total Incurred Non-Cap	0	$0	0	0	$0.00	$0.00	0.0%
Capitated Dental Expenses							
Diagnostic		$0	0			$0.00	0.0%
Preventive		$0	0			$0.00	0.0%
Restorative		$0	0			$0.00	0.0%
Crowns		$0	0			$0.00	0.0%
Endodontics		$0	0			$0.00	0.0%
Periodontics		$0	0			$0.00	0.0%
Prosthodontics		$0	0			$0.00	0.0%
Oral Surgery		$0	0			$0.00	0.0%
Orthodontia		$0	0			$0.00	0.0%
Other		$0	0			$0.00	0.0%
5. Total Capitated		$0	0			$0.00	0.0%
6. Incurred Claim Grand Total		$0	0			$0.00	0.0%

List capitated expenses by service category if available, otherwise please explain below.

TABLE 3C - Mental Health and Substance Abuse
Claims Experience - Actuarial Data

	2012			2013		
	January 1, 2012 Through December 31, 2012			January 1, 2013 Through March 31, 2013		
1. Total # of Member Months	0			0		
Type of Service	**Total # of Admissions**	**Total # of Days**	**Total Paid Charges**	**Total # of Admissions**	**Total # of Days**	**Total Paid Charges**
Hospital Inpatient						
Mental Health (MH)	0	0	$0	0	0	$0
Substance Abuse (SA)	0	0	$0	0	0	$0
2. Total Hospital Inpatient	0	0	$0	0	0	$0
3. Total Hospital Inpatient Capitation			$0			$0

Type of Service	**Total # of Services**	**Total Paid Charges**	**Total # of Services**	**Total Paid Charges**
Hospital Outpatient				
Mental Health (MH)	0	$0	0	$0
Substance Abuse (SA)	0	$0	0	$0
4. Total Hospital Outpatient	0	$0	0	$0
5. Total Hospital Outpatient Capitation		$0		$0
6. TOTAL HOSPITAL		$0		$0
Other Facility				
Transitional Care	0	$0	0	$0
7. Total Facility	0	0	0	0
8. Total Facility Capitation		$0		$0
Physician Services				
Inpatient Mental Health Visits	0	$0	0	$0
Inpatient Substance Abuse Visits	0	$0	0	$0
9. Subtotal Physician Services	0	$0	0	$0
Additional Services				
Outpatient Mental Health	0	$0	0	$0
Outpatient Substance Abuse	0	$0	0	$0
10. Subtotal Additional Services	0	$0	0	$0
11. Total Inpatient Physician Capitation		$0		$0
12. Total Outpatient Physician Capitation		$0		$0
13. Other Capitated Services*		$0		$0
14. Total Non-Capitation		$0		$0
15. Total Non-Cap Incurred Claim Factor	0.000%		0.000%	
16. Number of Runout Months	0		0	
17. Incurred Non-Capitation Total		$0		$0
18. Total Capitation		$0		$0
19. Incurred Claim Grand Total		$0		$0

* Please list and describe in detail all other capitated services

TABLE 3D - Medical
Claims Experience - Actuarial Data
January 1, 2012 Through March 31, 2013

	MEMBERS	CONTRACTS
Jan-12	0	0
Feb-12	0	0
Mar-12	0	0
Apr-12	0	0
May-12	0	0
Jun-12	0	0
Jul-12	0	0
Aug-12	0	0
Sep-12	0	0
Oct-12	0	0
Nov-12	0	0
Dec-12	0	0
Total 2012	0	0
Jan-12	0	0
Feb-12	0	0
Mar-12	0	0
Total 2013 Q1	0	0

	HOSPITAL INPATIENT			HOSPITAL OUTPATIENT		PHYSICIAN	
	Total # of Admissions	Total # of Days	Total Paid Charges	Total # of Services	Total Paid Charges	Total # of Services	Total Paid Charges
Jan-12	0	0	$0	0	$0	0	$0
Feb-12	0	0	$0	0	$0	0	$0
Mar-12	0	0	$0	0	$0	0	$0
Apr-12	0	0	$0	0	$0	0	$0
May-12	0	0	$0	0	$0	0	$0
Jun-12	0	0	$0	0	$0	0	$0
Jul-12	0	0	$0	0	$0	0	$0
Aug-12	0	0	$0	0	$0	0	$0
Sep-12	0	0	$0	0	$0	0	$0
Oct-12	0	0	$0	0	$0	0	$0
Nov-12	0	0	$0	0	$0	0	$0
Dec-12	0	0	$0	0	$0	0	$0
Total 2012	0	0	$0	0	0	0	0
Jan-12	0	0	$0	0	0	0	0
Feb-12	0	0	$0	0	0	0	0
Mar-12	0	0	$0	0	0	0	0
Total 2013 Q1	0	0	$0	0	0	0	0

	OTHER		DENTAL	
	Total # of Services	Total Paid Charges	Total # of Services	Total Paid Charges
Jan-12	0	$0	0	$0
Feb-12	0	$0	0	$0
Mar-12	0	$0	0	$0
Apr-12	0	$0	0	$0
May-12	0	$0	0	$0
Jun-12	0	$0	0	$0
Jul-12	0	$0	0	$0
Aug-12	0	$0	0	$0
Sep-12	0	$0	0	$0
Oct-12	0	$0	0	$0
Nov-12	0	$0	0	$0
Dec-12	0	$0	0	$0
Total 2012	0	$0	0	$0
Jan-12	0	$0	0	$0
Feb-12	0	$0	0	$0
Mar-12	0	$0	0	$0
Total 2013 Q1	0	$0	0	$0

State of Wisconsin STATE NON-MEDICARE, NON-GRAD ASSISTANTS -

TABLE 4A
MEDICAL TREND ASSUMPTIONS

	Trend Periods To Be Used In Calculations
Experience Period:	April 1, 2012 Through March 31, 2013
Rating Period:	January 1, 2014 Through December 31, 2014
Midpoint of Experience Period:	October 1, 2012
Midpoint of Rating Period:	July 1, 2014

Step 1. Calculate Weighted Trend for Experience Claims Data

2012-2013 Annual Trend

	Trends				
Category	**Cost**	**Utilization**	**Combined**	**% of Total See Table 3A**	**Weighted Trend**
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	0.0%	0.0%

2013-2014 Annual Trend

	Trends				
Category	**Cost**	**Utilization**	**Combined**	**% of Total See Table 3A**	**Weighted Trend**
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	0.0%	0.0%

Step 2. Calculate Aggregate Trend Factor for Experience Claims Data

2012-2013 Annual Trend	1.000
2013-2014 Annual Trend	1.000
1) Aggregate Trend Factor	1.000

Step 3. Calculate Weighted Trend for Capitated Services

	2012-2013 Annual Trend			2013-2014 Annual Trend		
	Trends			Trends		
Category	**Trends**	**% of Total See Table 3**	**Weighted Trend**	**Trends**	**% of Total See Table 3**	**Weighted Trend**
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Inpatient Physician	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient Physician	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Capitated Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		0.0%	0.0%	**Total**	0.0%	0.0%

2012-2013 Annual Trend	1.000
2013-2014 Annual Trend	1.000
2) Aggregate Trend Factor	1.000

Step 4. Describe any special circumstances which may have caused aggregate trends to be unusually high or low.

State of Wisconsin STATE NON-MEDICARE, NON-GRAD ASSISTANTS -

TABLE 4B
DENTAL TREND ASSUMPTIONS

	Trend Periods To Be Used In Calculations
Experience Period:	April 1, 2012 Through March 31, 2013
Rating Period:	January 1, 2014 Through December 31, 2014
Midpoint of Experience Period:	October 1, 2012
Midpoint of Rating Period:	July 1, 2014

Step 1. Calculate Weighted Trend for Experience Claims Data

2012-2013 Annual Trend

	Trends				
Category	**Cost**	**Utilization**	**Combined**	**% of Total See Table 3B**	**Weighted Trend**
Diagnostic	0.0%	0.0%	0.0%	0.0%	0.0%
Preventive	0.0%	0.0%	0.0%	0.0%	0.0%
Restorative	0.0%	0.0%	0.0%	0.0%	0.0%
Crowns	0.0%	0.0%	0.0%	0.0%	0.0%
Endodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Periodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Prosthodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Oral Surgery	0.0%	0.0%	0.0%	0.0%	0.0%
Orthodontia	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	**0.0%**	**0.0%**

2013-2014 Annual Trend

	Trends				
Category	**Cost**	**Utilization**	**Combined**	**% of Total See Table 3B**	**Weighted Trend**
Diagnostic	0.0%	0.0%	0.0%	0.0%	0.0%
Preventive	0.0%	0.0%	0.0%	0.0%	0.0%
Restorative	0.0%	0.0%	0.0%	0.0%	0.0%
Crowns	0.0%	0.0%	0.0%	0.0%	0.0%
Endodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Periodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Prosthodontics	0.0%	0.0%	0.0%	0.0%	0.0%
Oral Surgery	0.0%	0.0%	0.0%	0.0%	0.0%
Orthodontia	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	**0.0%**	**0.0%**

Step 2. Calculate Aggregate Trend Factor for Experience Claims Data

2012-2013 Annual Trend	1.000
2013-2014 Annual Trend	1.000
1) Aggregate Trend Factor	1.000

Step 3. Provide aggregate trend for capitated services.

	2012-2013 Annual Trend			2013-2014 Annual Trend		
	Trends			Trends		
Category	**Trends**	**% of Total See Table 3**	**Weighted Trend**	**Trends**	**% of Total See Table 3**	**Weighted Trend**
Diagnostic	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Preventive	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Restorative	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Crowns	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Endodontics	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Periodontics	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prosthodontics	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Oral Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Orthodontia	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		0.0%	0.0%	**Total**	0.0%	0.0%

2012-2013 Annual Trend	1.000
2013-2014 Annual Trend	1.000
2) Aggregate Trend Factor	1.000

Step 4. Describe any special circumstances which may have caused trends to be unusually high or low.

TABLE 5
MEDICAL AND DENTAL
ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS

MEDICAL - ADMINISTRATIVE EXPENSES BY MAJOR CATEGORY

Detailed Description of Administrative Expense Category	2012 PMPM Actual	2013 PMPM Per Rate Renewal	2014 PMPM Estimated
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
1) TOTAL	$0.00	$0.00	$0.00

MEDICAL - OTHER PMPM COSTS

Detailed Description of PMPM Costs	2012 PMPM Actual	2013 PMPM Per Rate Renewal	2014 PMPM Estimated
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
2) TOTAL	$0.00	$0.00	$0.00

DENTAL - ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS

Detailed Description of Administrative Expense Category and PMPM Costs	2012 PMPM Actual	2013 PMPM Per Rate Renewal	2014 PMPM Estimated
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
	$0.00	$0.00	$0.00
3) TOTAL	$0.00	$0.00	$0.00

TABLE 6
REQUIRED PMPM

A. DESCRIPTION - MEDICAL	COST PMPM
1. PMPM incurred claims cost for experience period (Table 3A Line 17)	$0.00
2. Aggregate trend factor (Table 4A Line 1)	1.000
3. Claims cost trended to rating period (1. x 2.)	$0.00
4. Total capitation (Table 3A Line 18)	$0.00
5. Aggregate capitated services trend factor (Table 4A Line 2)	1.000
6. Capitation costs trended to rating period (Line 4 x Line5)	$0.00
7. 2014 Administrative costs PMPM (Table 5 Line 1)	$0.00
8. 2014 Other PMPM cost (Table 5 Line 2)	$0.00
9. **REQUIRED MEDICAL PREMIUM PMPM (3.+ 6.+ 7.+8.)**	$0.00

B. DESCRIPTION - DENTAL	COST PMPM
10. PMPM incurred claims cost for experience period (Table 3B Line 4)	$0.00
11. Aggregate trend factor (Table 4B Line 1)	1.000
12. Claims cost trended to rating period (Line 10 x Line 11)	$0.00
13. Total Capitation (Table 3B Line 5)	$0.00
14. Aggregate capitated services trend factor (Table 4B Line 2)	1.000
15. Capitation costs trended to rating period (Line 13 x Line 14)	$0.00
16. 2014 Administrative and other PMPM costs (Table 5 Line 3)	$0.00
17. **REQUIRED DENTAL PREMIUM PMPM (12.+ 15.+16.)**	$0.00

TABLE 7
2014 CALCULATED RATES

Step 1

Conversion Factor Calculation				
	Contract Mix	**Average Contract Size**	**Rate Ratio**	**Conversion Factor**
1. Employee	0.0%	0.0	1.0	0.000
2. Family	0.0%	0.0	2.5	0.000
3. Total	0.0%	0.0	0.0	

Step 2

2014 Medical Rate Calculation		
	Employe	**Family**
4. Required Premium PMPM	$0.00	$0.00
5. Conversion Factor	0.000	0.000
6. 2014 Calculated Rates	$0.00	$0.00
7. 2013 Inforce Rates	$0.00	$0.00

2014 Dental Rate Calculation		
	Employe	**Family**
8. Required Premium PMPM	$0.00	$0.00
9. Conversion Factor	0.000	0.000
10. 2014 Calculated Rates	$0.00	$0.00
11. 2013 Inforce Rates	$0.00	$0.00

TOTAL - Medical and Dental Combined		
	Employe	**Family**
12. 2014 Calculated Rates	$0.00	$0.00
13. 2013 Inforce Rates	$0.00	$0.00
		Single Rate Increase

TABLE 8A

LARGE CLAIMANTS > $100,000

4/1/12 - 3/31/13 Service Dates	
1. Total Paid Claims for Individuals with Paid Claims of $100,000 or Greater	$ -
2. Number of Individuals with Paid Claims of $100,000 or Greater	0
3. Total Paid Claims Greater than $100,000 on an Individual Basis	$ -
4. Total Incurred Claim Factor	0.000%
5. Number of Runout Months	0
6. Incurred Claims Total	$ -

TABLE 9A - General Data Questions

please enter in the space provided below each question

1) Are the paid claims provided in the experience data net or gross of copays, coinsurance, and deductibles? If claims include member cost sharing amounts, please provide an estimate of an adjustment factor (if possible) to convert paid amounts to a level net of any member cost sharing.

2) When providing information for Medicare lines of business (State & Local), who is being included in the membership.

a) If a Medicare-eligible member with family coverage has a spouse (no other dependents) who is not eligible for Medicare, where are the spouse's membership and claims experience being reflected? In other words, are the spouse and his/her experience reflected in the Medicare (State or Local) experience or the regular employee (State or Local) experience?

b) In a situation similar to that above in (a) where there are also dependent children, how are the children's membership and claims experience being reflected? Are their membership and claims experience included in the Medicare (State or Local) or regular employee (State or Local) experience?

c) What happens when an employee not eligible for Medicare has a Medicare-eligible spouse? In other words, where are the employee and his/her experience reflected (Medicare or regular employee coverage) and where are the spouse and his/her experience reflected (Medicare or regular employee coverage)? If there are any dependent children, where are their membership and claims experience reflected?

3) Please describe the basis for the renewal (experience, community rated etc.)

TABLE 9B
Dental Benefit Schedule

		Plan Year 2013	Plan Year 2014	
	Dental Coverage			Yes or No
Type of Service		**Benefit Schedule Plan Year 2013**	**Benefit Schedule Plan Year 2014**	**Additional Comments**
1. General				
Individual Annual Deductible				
Family Annual Deductible				
Annual Benefit Maximum				
2. Diagnostic & Preventative Procedures				
Oral Exams And Cleanings	Plan Coinsurance			
	Maximum Annual Procedures			
Tests And Laboratory Examinations	Plan Coinsurance			
	Maximum Annual Procedures			
Other Preventative Procedures	Plan Coinsurance			
	Maximum Annual Procedures			
3. X-Rays	Plan Coinsurance			
	Maximum Annual Number Of Full Mouth			
	Maximum Annual Number Of Bitewings			
4. Fluoride Treatments	Plan Coinsurance			
	Maximum Annual Procedures For Children			
	Maximum Annual Procedures For Adults			
	Age Limit For Children			
5. Space maintainers (not orthodontic)	Plan Coinsurance			
	Age Limit			
6. Sealants	Plan Coinsurance			
	Maximum Annual Procedures For Adults			
	Age Limit			
7. Restorative Procedures				
Basic (fillings, extractions,..)	Plan Coinsurance			
Endodontic	Plan Coinsurance			
Periodontic	Plan Coinsurance			
Prosthodontic	Plan Coinsurance			
Prosthodontic (fixed)	Plan Coinsurance			
Prosthetics	Plan Coinsurance			
Implant Services	Plan Coinsurance			
8. Orthodontic Procedures	Plan Coinsurance			
	Age Limit			
	Lifetime Benefit Maximum			
9. Emergency Services				
Pain Treatment	Plan Coinsurance			
Minor Procedures	Plan Coinsurance			

TABLE 9C
TOP PROVIDER REPORT
Based on 4/1/2011 - 3/31/2012 Incurrals

FACILITY

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.						$0	0
2.						$0	0
3.						$0	0
4.						$0	0
5.						$0	0
6.						$0	0
7.						$0	0
8.						$0	0
9.						$0	0
10.						$0	0

PROFESSIONAL

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.						$0	0
2.						$0	0
3.						$0	0
4.						$0	0
5.						$0	0
6.						$0	0
7.						$0	0
8.						$0	0
9.						$0	0
10.						$0	0
11.						$0	0
12.						$0	0
13.						$0	0
14.						$0	0
15.						$0	0
16.						$0	0
17.						$0	0
18.						$0	0
19.						$0	0
20.						$0	0

ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE

Providers Under Contract Physically Located in Each Major City/County/Zip Code
State and Local Employees

Using the format provided by ETF, record the number of providers under contract sorted by zip-code who are physically located within each county and major city in the service area. Major cities are those that have over 33% of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior.

Provider Guarantee:
In addition to the continuity of care provisions under Wis. Stat. §609.24, the following provider guarantee provision applies. Providers listed here and/or on any of the plan's publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department’s request.

If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant’s options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.

This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 1; the final copy is due on July 23. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Upon request, the Department may review the qualification status of a plan on a county by county basis and make recommendations to the Board. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a county or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.

2. There must be at least one general hospital under contract and/or routinely utilized by plan providers per county or major city. If a hospital is not present in the county, plans must sufficiently describe how they provide access to providers per standards set forth under Wis. Adm. Code § INS 9.34 (2).
3. If optional dental coverage is offered, a dentist must be available in each county (or major city if applicable).
4. A chiropractor must be available in each county (or major city if applicable).
5. The plan must have a minimum of one year of operation.
6. After being offered to state employees for one year, the plan must have achieved an enrollment of 100 subscribers or 10% of the employees in the service area. Service area means the entire geographic area in which the plan is qualified.

Health plans are responsible for submitting two types of reports to ETF

(1) A listing that includes all providers of any type. All providers should be listed by name and National Provider Identifier (NPI), as specified by the Department. Under no circumstances, should a clinic be listed in lieu of provider names.

(2) Health plans must also submit counts of providers and institutions used by ETF to determine plan qualification by county. Summary counts must be provided for every County and Major City in which a health plan has at least one PCP. ETF not only determines qualification status from the provider counts, but also determines whether or not a health plan will be listed in the "It's Your Choice" booklet as a non-qualified plan. Generally, if a health plan has at least one PCP in a county, the health plan will be listed in the "It's Your Choice" booklet although ETF may choose not to list a plan if it is not practical to do so. For example, ETF would not list a health plan that has a low number of providers in a high population county.

Plans that remove providers from their network for the following calendar year for the group health insurance program are prevented from adding those providers back to the network without approval from the Department until the next benefit year for which they submit a final bid based on inclusion of those providers. This provision does not apply to normal attrition.

Please note that all providers that health plans make available to participants or publish in the provider listings sent to members must be reflected in both the provider listing and the provider counts. Specific instructions on how to submit the information detailed above will be provided to the health plans in advance of the due date. ETF reserves the right to modify instructions and data requests as needed and may also request updated reports from health plans as needed.

SAMPLE FORMAT

Date: _____

Plan: We-Care (Name of Plan) La Crosse (Location/Service Area)

Counties and Major Cities in Service Area	No. Dentists	No. Chiropractors	No. General Hospital Routinely Utilized	No. FTE Primary Care Providers*	Total Members
Crawford	17	3	0	4	560
Juneau	10	3	0	3	90

La Crosse (City)	7	2	2	29	340
La Crosse (County)	18	4	3	102	680

* Primary care provider as defined in Uniform Benefits and utilized by the plan in the manner described in the definition.

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This CONTRACT sets forth the terms and conditions for the HEALTH PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered by the Group Insurance Board as required by Wis. Stat. § 40.51.

ARTICLE 1 DEFINITIONS

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

1.1 "ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a currently insured recipient of a disability benefit under Wis. Stat. § 40.65; or a terminated EMPLOYEE with 20 years of creditable service.

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTINUANT" means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

1.5 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.6 "DEPARTMENT" means the Department of Employee Trust Funds.

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

- Spouse.
- DOMESTIC PARTNER, if elected.
- Child.
- Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Child of the DOMESTIC PARTNER insured on the policy.
- Grandchild if the parent is a DEPENDENT child.

(1) A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.

(2) 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. 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, 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. The HEALTH PLAN 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 HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(b) After attaining age 26,as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

(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 acknowledgment 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) Any DEPENDENT eligible for BENEFITS who is not listed on an application for coverage will be provided BENEFITS based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

1.8 "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:

- Each individual is at least 18 years old and otherwise competent to enter into a contract.
- Neither individual is married to, or in a domestic partnership with, another individual.
- The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
- The two individuals consider themselves to be members of each other's immediate family.
- The two individuals agree to be responsible for each other's basic living expenses.
- The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

- Only one of the individuals has legal ownership of the residence.

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

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

1.9 “DUAL-CHOICE” means the enrollment period referred to in DEPARTMENT materials as the It’s Your Choice enrollment period that is available at least annually to eligible EMPLOYEES and ANNUITANTS under Wis. Stat. § 40.51 (16) to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51.

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

1.11 "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., 2m., or 8.

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

1.13 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.14 “HEALTH PLAN” means the alternate health care plan signatory to this agreement.

1.15 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.16 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.17 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

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

1.19 "PREMIUM" means the rates shown on ATTACHMENT C plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

1.20 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

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

ARTICLE 2 ADMINISTRATION

2.1 AMENDMENTS

This CONTRACT may be amended by written agreement between the HEALTH PLAN and the BOARD at any time.

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this CONTRACT, the contractor agrees not to discriminate against EMPLOYEES or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The HEALTH PLAN agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

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

(4) In cases where PREMIUM rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by the data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

(5) The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLANS shall notify the DEPARTMENT within two business days of discovering that the protected health information (PHI) or personal information of one or more PARTICIPANTS has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. This notification requirement shall apply only to PHI or personal information received or maintained by the HEALTH PLANS pursuant to this agreement. The HEALTH PLANS shall make good faith efforts to communicate with the DEPARMENT about breaches by major provider groups if the HEALTH PLANS know those breaches affect DEPARTMENT PARTICIPANTS.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in certain events including, but not limited to, strike and disaster, and shall submit it to the DEPARTMENT upon request.

(7) The DEPARTMENT reserves the right to require HEALTH PLANS to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to members in a manner similar to the annual informational mailing process.

2.3 CLERICAL AND ADMINISTRATIVE ERROR

(1) Except for the constructive waiver provision of section 3.6, no clerical error made by the EMPLOYER, the DEPARTMENT or the HEALTH PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of section 3.6, if an EMPLOYEE or ANNUITANT has made application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the EMPLOYER or the DEPARTMENT, due to clerical error, to give proper notice to the HEALTH PLAN of such EMPLOYEE'S application.

(3) In the event that an EMPLOYER erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid.

(4) Except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid. 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 months and in accordance with § 3.16 (3). No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (2) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper effective date of EMPLOYER contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled, except as required by law.

2.4 REPORTING

(1) EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish electronic eligibility files to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish electronic eligibility files while the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number and unique DEPARTMENT identifier) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

(4) Unless individually waived by the BOARD, each HEALTH PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire HEALTH PLAN membership and the state group membership where applicable. The HEALTH PLAN will include the state group membership prescription drug data from the pharmacy benefit manager in their reported prescription drug measures consistent with NCQA requirements. The data will be supplied in a format specified by the DEPARTMENT.

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than $100 per day per occurrence, to begin on the 2nd day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed $5,000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(1) The HEALTH PLAN shall provide the SUBSCRIBER with identification cards indicating the EFFECTIVE DATE of coverage, a listing of all available providers and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization and referral requirements. If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Four (4) copies of all informational materials in final form must be provided to the DEPARTMENT. 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.

(3) Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement:

> "[NAME OF HEALTH PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a HEALTH PLAN mailing to correctly inform PARTICIPANTS.

2.6 FINANCIAL ADMINISTRATION

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.

2.7 INSOLVENCY (OR SOLVENCY)

(1) ATTACHMENT B provides documentation that, in the event the HEALTH PLAN becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the confinement ceases, the attending physician determines confinement is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer to another HEALTH PLAN.

(2) The HEALTH PLAN shall submit to the DEPARTMENT on an annual basis, information on its financial condition including a balance sheet, statement of operations, financial audit reports, and utilization statistics.

2.8 DUE DATES

(1) Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the following month's coverage.

(2) The EMPLOYER shall immediately validate and enter into the DEPARTMENT'S myETF Benefits system the completed applications filed by newly eligible EMPLOYEES or require EMPLOYEES to submit their request directly through myETF Benefits. For any requests submitted by a newly eligible EMPLOYEE through myETF Benefits, the EMPLOYER shall immediately validate and approve the completed application.

2.9 CONTINUATION OR CONVERSION OF INSURANCE

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must be received by the DEPARTMENT postmarked within 60 days of the date the PARTICIPANT is notified by the EMPLOYER of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for required PREMIUMS. The HEALTH PLAN may not apply a surcharge to the PREMIUM, even if otherwise permitted under State or federal law.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S HEALTH PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the county where the PARTICIPANT resides.

(2) Such PARTICIPANT may also elect to convert to individual coverage, without underwriting if application is made directly to the HEALTH PLAN within 30 days after termination of group coverage as provided under Wis. Stat. §632.897. The PARTICIPANT shall be eligible, to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The HEALTH PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options, including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of PREMIUM. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may also be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The HEALTH PLAN will automatically treat the child as a qualified DEPENDENT as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S and/or PBM's internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with an Ombudsperson at the DEPARTMENT. The PARTICIPANT may also request a departmental determination. 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). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12). However, the Department will not issue a determination regarding denials of coverage by a HEALTH PLAN and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the independent review process under Wis. Stat. § 632.835 and Wis Adm. Code § INS 18.11.

(2) The PARTICIPANT may also request an independent review as provided under Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must

be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.

(3) The HEALTH PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 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.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of DEPARTMENT Administrative Review Rights

In the final grievance decision letters, the HEALTH PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request a review by an Independent Review Organization in accordance with Wis. Adm. Code § INS 18.11, using the language approved by the DEPARTMENT. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefits contractual provision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision. In the event they disagree with the grievance committee's final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the date of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of the PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy, when signed by the PARTICIPANT or PARTICIPANT'S representative, to give written authorization for release of information to the DEPARTMENT. 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 working days, or by an earlier date as requested by the DEPARTMENT.

(8) Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the HEALTH PLAN as a defendant, the HEALTH PLAN must notify the DEPARTMENT'S chief legal counsel within ten working days of notification of the legal action. This requirement does not extend to cases of subrogation.

(9) If a departmental determination overturns a HEALTH PLAN'S decision on a PARTICIPANT'S grievance, the HEALTH PLAN must comply with the determination within 90 days of the date of the determination or a $500 penalty will be assessed for each day in excess of 90 days. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within 90 days.

3.3 SELECTION OF COVERAGE

(1) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on or after the date the application is received by the EMPLOYER. No application for coverage may be rescinded on or after the EFFECTIVE DATE of coverage.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution. In accordance with Wis. Stat. § 40.51 (2), an EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements. However, when the EMPLOYEE terminates employment prior to the EFFECTIVE DATE of coverage, the application is void and any premiums paid or deducted will be refunded.

(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an EMPLOYER contribution under Wis. Stat. § 40.05 (4) (ag)1 may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Stat. § 40.05 (4) (ag) 2 to be effective upon the date of the increase in the EMPLOYER contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.

(3) (a) An EMPLOYEE eligible and enrolled for 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 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 submit the application to the DEPARTMENT.

(b) Notwithstanding paragraph 3 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single 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 60 days of the birth, adoption or placement for adoption.

(4) In addition to any enrollment period required under Wis. Stat. § 40.05 (4g), an EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same EMPLOYER subject to the following:

(a) Employment is resumed within 180 days after release from active military service, and

(b) The application for coverage is received by the EMPLOYER within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

(d) Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(5) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

(6) As required by state and federal law, a SUBSCRIBER enrolled with single coverage although eligible for family coverage, or an EMPLOYEE who deferred the selection of coverage, has a special enrollment opportunity to add eligible children as required by a National Medical Support Notice.

(7) (a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or is a member of the US Armed Forces, or is a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, the EMPLOYEE may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the other plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) If permitted by state or Federal law, an eligible EMPLOYEE may defer or dis-enroll from coverage if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care. Family status changes under this provision remain subject to Section 125 of the Internal Revenue Code. If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to the DEPARTMENT.

(c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, marriage or domestic partnership, provided he or she submits an application within 60 days of the birth, adoption or

placement for adoption, or within 30 days of the marriage or effective date of the domestic partnership.

(d) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) or (c) above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(8) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician, clinic or care system available, upon notice to the EMPLOYER that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application. The HEALTH PLAN may not simply reassign a primary physician, clinic or care system.

(9) PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may reenroll in any HEALTH PLAN without underwriting restrictions as follows:

(a) Coverage for those who have escrowed under Wis. Stat. § 40.05 (4) (b) and (be) may enroll during the DUAL-CHOICE enrollment period and be effective the first day of the month selected by the PARTICIPANT of the following year as provided in section 3.4 (1).

(b) For the PARTICIPANTS defined in Wis. Stat. § 40.02 (25) (b) (6e) and (6g) whose sick leave has been preserved under Wis. Stat. § 40.05 (4) (bc), coverage will begin on the first of the month following the DEPARTMENT'S receipt of the health insurance application, unless otherwise specified on the application.

(c) PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. A PARTICIPANT enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS are covered under the other plan and lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person’s coverage. Coverage shall be effective on the date of termination of the prior plan or the date of the event. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(10) Eligible retired EMPLOYEES or former EMPLOYEES of the State who have reenrolled under section 3.10 (4) may select any offered plan.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child become newly eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage. The SUBSCRIBER can add the DEPENDENT by filing an application with the

EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the SUBSCRIBER requests to terminate coverage for the adult dependent within 30 days of the DEPENDENT'S eligibility and enrollment in other health insurance coverage, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT during Open Enrollment effective the following January 1, whichever occurs first.

(12) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during the annual DUAL-CHOICE enrollment period for coverage effective the following January 1.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(1) The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES, ANNUITANTS and currently insured CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51. Unless otherwise provided by the BOARD, the DUAL-CHOICE enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a DUAL-CHOICE enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous DUAL-CHOICE enrollment period will be allowed a DUAL-CHOICE enrollment provided an application is filed during the 30-day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual DUAL-CHOICE enrollment materials. A move from a medical facility to another facility by the SUBSCRIBER is not considered a residential move. An application must be filed during the 30 day period, which begins on the date the SUBSCRIBER moves.

(5) A SUBSCRIBER under (3) and (4) above who does not file an application to change plans within this 30 day enrollment period may change plans at the next DUAL-CHOICE enrollment period.

(6) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, domestic partnership, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. This also applies to ANNUITANTS as if Federal law required it. Coverage with the new HEALTH PLAN will be

effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

(7) The HEALTH PLAN shall accept any individual who transfers from one plan to another or from individual to family coverage without requiring evidence of insurability, waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3).

(8) If the HEALTH PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make a DUAL-CHOICE election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same HEALTH PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the EMPLOYER receives the SUBSCRIBER'S request to change networks, whichever is later.

(9) Applications from ANNUITANTS and CONTINUANTS changing plans during the DUAL-CHOICE enrollment period must be received by the DEPARTMENT postmarked no later than the last day of the DUAL-CHOICE enrollment period, unless otherwise authorized by the DEPARTMENT.

3.5 INITIAL PREMIUMS

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

3.6 CONSTRUCTIVE WAIVER OF COVERAGE

Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the EMPLOYER for a period of 12 consecutive months, shall be deemed to have prospectively waived coverage upon a 30-day notice to the EMPLOYEE, unless all required PREMIUMS are paid. Coverage then may be obtained only under the deferred coverage provisions of section 3.10.

3.7 BENEFITS NON-TRANSFERABLE

No person other than a PARTICIPANT, as recorded in the office of the HEALTH PLAN, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stat. § 939.51 (3) (a).

3.8 NON-DUPLICATION OF BENEFITS

The HEALTH PLAN'S administration of BENEFITS provisions must conform to Wis. Adm. Code § INS 3.40.

3.9 REHIRED OR TRANSFERRED EMPLOYEE COVERAGE

(1) Any insured EMPLOYEE who terminates employment with the state and is re-employed by the state in a position eligible for health insurance within 30 days or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § ETF 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

(2) Rehired ANNUITANTS who terminate their annuity and participate in the Wisconsin Retirement System may continue the same health insurance coverage by filing an application with the EMPLOYER within 30 days following the Wisconsin Retirement System participation begin date.

Rehired ANNUITANTS at the UW System are not eligible for the health insurance program under Wis. Stat. § 40.52 (3) for graduate assistants regardless of whether they are eligible to participate in the Wisconsin Retirement System.

(3) If an insured EMPLOYEE transfers from one state agency to another, an application must be filed within 30 days to maintain continuous coverage. If no application is filed within the 30 day enrollment period, continuous coverage may be reinstated by filing an application and paying back PREMIUM. The constructive waiver of coverage under section 3.6 will apply.

3.10 DEFERRED COVERAGE ENROLLMENT

(1) Any EMPLOYEE actively employed with the state who does not elect coverage during the enrollment period provided under section 3.3, 3.12 (3), or who constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only by electing coverage during the DUAL-CHOICE enrollment period as provided in section 3.4 (1).

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage may only elect family coverage during the DUAL-CHOICE enrollment period, except as provided in section 3.3.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate HEALTH PLAN during a DUAL-CHOICE enrollment period offered under section 3.4.

(4) A retired EMPLOYEE of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1); or an EMPLOYEE of the state who terminates creditable service after attaining 20 years of creditable service, remains a participant in the Wisconsin Retirement System and is not eligible for an immediate annuity may enroll for coverage during the DUAL-CHOICE enrollment period.

(5) An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of delaying initiation of post-retirement EMPLOYER premium contribution per Wis. Stat. § 40.05 (4) (b).

3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. If both spouses are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one DOMESTIC PARTNER to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the domestic partnership terminate while carrying family coverage, the former DOMESTIC PARTNER may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the termination of domestic partnership.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

(1) Any insured EMPLOYEE may continue coverage during any EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, the EMPLOYEE is not deemed to have returned to work and coverage as an active EMPLOYEE shall not be resumed.

(2) The EMPLOYER contribution toward PREMIUM continues for the first three months of the LAYOFF or leave of absence for which PREMIUMS have not already been deducted, after which the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. Each payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid. Retroactive EMPLOYER refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE are not allowed.

(3) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days of the return from leave. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. EMPLOYEES shall also have the enrollment opportunities as described in section 3.3 (7) (a) while on leave of absence. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(4) For the purpose of this provision and in accordance with Wis. Stat. §40.05 (4g), an eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving state contributions for health insurance on the date he or she is activated for duty. The thirty-six month limitation for continuing coverage, described in (1) above, does not apply.

The EMPLOYEE may elect to:

(a) Continue health insurance coverage and establish prepayment of PREMIUMS while on active duty; or

(b) Within 60 days of being activated for coverage, let his or her coverage lapse for nonpayment of PREMIUM after being activated for duty and reinstate coverage while on leave by filing a health insurance application; or

(c) Allow his or her coverage to lapse and reapply for coverage within 30 days of return to employment, provided the EMPLOYEE applies for re-employment within 90 days after release from active duty, and resumes employment within 180 days.

3.13 COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE

(1) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from his or her position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be insured from the date of the contested discharge until a final decision has been reached. Within 30 days of the date of discharge the EMPLOYEE must submit to the EMPLOYER the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS were previously paid.

(2) If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

(3) The PREMIUMS referred to in this section shall be the gross amount paid to the HEALTH PLAN for the particular coverage, including the pharmacy and administrative fees. The EMPLOYEE shall be required to pay any amounts normally considered the EMPLOYER contribution. If the right of the EMPLOYEE to the position is sustained, the EMPLOYER shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE contribution.

3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS

(1) As required by Wis. Adm. Code § ETF 40.01, the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously insured 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 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.

(2) Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT for which PREMIUMS have not already been deducted, and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

(3) PREMIUMS shall be paid:

(a) From accumulated leave credits until exhausted, then

(b) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then

(c) Directly to the HEALTH PLAN.

3.15 COVERAGE OF EMPLOYEES AFTER RETIREMENT

(1) Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

(a) Retires on an immediate annuity as defined under Wis. Stat. § 40.02 (38),

(b) EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health insurance purposes. If the disability annuity terminates and the PARTICPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

(c) Terminates employment after attaining 20 years of creditable service. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment if the terminated EMPLOYEE is not eligible for an immediate annuity.

(d) Receives a long-term disability benefit as provided for under Wis. Adm. Code § ETF 50.40.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period preceding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by the DEPARTMENT shall cause the health care coverage to be cancelled.

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the Medicare hospital and medical insurance benefits (Parts A and B) become effective as the primary payor and coverage is provided under a non-employer group number.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), 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 payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., 12., b. 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 months. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the state. 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 insurance policy with another employer and that policy is the primary payor 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.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS, CONTINUANTS and their DEPENDENTS who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, CONTINUANT 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.

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

(7) If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this plan shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in Medicare. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this plan will again be the primary payor. No reduction in PREMIUM is available for active EMPLOYEES under this section.

(8) As required by Medicare rules, Medicare is the primary payor for DOMESTIC PARTNERS age 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.

3.17 CONTRACT TERMINATION

(1) The CONTRACT terminates on the date specified on the signatory page. The BOARD, by September 1, or the HEALTH PLAN, by the date specified in the Guidelines, section II., J., shall provide notice of its intent not to contract for the following contract year by

providing notice to the other party. The HEALTH PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the DUAL-CHOICE enrollment period.

(2) If the HEALTH PLAN terminates this CONTRACT as required by sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

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

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

(d) Confinement ceases.

(3) If the HEALTH PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the HEALTH PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the HEALTH PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT as required by sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The HEALTH PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

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

3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:

(a) The effective date of change to another HEALTH PLAN through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. 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 PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

HEALTH PLANS must notify the DEPARTMENT within one month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the HEALTH PLAN are limited to one month following the termination date.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, end of a domestic partnership, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the continuation period for which the PARTICIPANT is allowed to continue under paragraph (4) below, as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under paragraph (4) below.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason.

(i) The end of the month in which the SUBSCRIBER terminates employment.

(2) No refund of any PREMIUM under sub. (e) may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted. Except that when coverage ends by reason of termination of employment, refunds shall be made back to the end of the month in which employment terminates.

(3) Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, 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.

(4) 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 60 days of the date the PARTICIPANT is notified of the

right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for the required PREMIUM.

(5) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance 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 coverage is available and is limited to the STANDARD PLAN.

Change to an alternate HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

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.

(6) 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 physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER’S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent DUAL-CHOICE enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

(7) Except in cases of fraud or where an individual makes an intentional misrepresentation of material fact, under federal law, an EMPLOYER must not retroactively cancel or rescind coverage, except to the extent attributable to a failure to pay timely premiums towards coverage. It is not considered a rescission where due to administrative delay in record-keeping the EMPLOYER retroactively cancels coverage back to the date of termination of employment.

3.19 COVERAGE CERTIFICATION

The HEALTH PLAN certifies that providers listed on Addendum #2 or on any of the HEALTH PLAN'S publications of providers are either under contract for all of the ensuing calendar year or the HEALTH PLAN will pay charges for BENEFITS on a fee-for-service basis. Those providers have agreed to accept new patients unless specifically indicated otherwise.

3.20 ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the effective date of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency, or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC

PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums will continue to accumulate for that year.

(3) The HEALTH PLAN shall provide the PARTCIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits.

(4) The HEALTH PLAN shall apply any and all Maximum Out-of-Pocket limits as required by state and federal law.

ATTACHMENT A: *Description of BENEFITS*

Includes Uniform Benefits, with the exception of Section III., D., Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM).

ATTACHMENT B: ***Documentation of Bonding or Reinsurance***

ATTACHMENT C
TABLE 10A
CALENDAR YEAR 2014
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
STATE EMPLOYEES

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	2013
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Monday July 16th, 2012 2:00pm CDT

STATE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Preliminary Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Graduate Assistants				
6. Individual (Shall be within the range of 65%-75% of the regular individual coverage rate)		ERROR		ERROR
7. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Dental Benefit Component (incl. above)				
8. Single				
9. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
10. Single				
11. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT C

TABLE 11A– FINAL BEST BID
CALENDAR YEAR 2014
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
STATE EMPLOYEES

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	**2013**
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Friday August 10th, 2012 2:00pm CDT

STATE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Best & Final Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Graduate Assistants				
6. Individual (Shall be within the range of 65%-75% of the regular individual coverage rate)		ERROR		ERROR
7. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Dental Benefit Component (incl. above)				
8. Single				
9. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
10. Single				
11. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT D: ***Specimen Conversion Contract***

ATTACHMENT E: *Grievance Procedure* ***(Must include DEPARTMENT administrative review rights.)***

ATTACHMENT F: ***Dental Description (if applicable) and Other***

Additional documents, if necessary, and cited individually, i.e., Attachments F, G, H, etc.

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This CONTRACT sets forth the terms and conditions for the HEALTH PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered to EMPLOYERS as provided by Wis. Stat. § 40.51 (7).

ARTICLE 1 DEFINITIONS

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

1.1 "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 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).

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTINUANT" means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

1.5 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.6 "DEPARTMENT" means the Department of Employee Trust Funds.

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

- Spouse.
- DOMESTIC PARTNER, if elected.
- Child.
- Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Child of the DOMESTIC PARTNER insured on the policy.
- Grandchild if the parent is a DEPENDENT child.

(1) A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.

(2) 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. 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. The HEALTH PLAN 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 HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(b) After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is 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) Any DEPENDENT eligible for BENEFITS who is not listed on an application for coverage will be provided BENEFITS based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

1.8 "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:

- Each individual is at least 18 years old and otherwise competent to enter into a contract.
- Neither individual is married to, or in a domestic partnership with, another individual.
- The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
- The two individuals consider themselves to be members of each other's immediate family.
- The two individuals agree to be responsible for each other's basic living expenses.

- The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
  - Only one of the individuals has legal ownership of the residence.
  - One or both of the individuals have one or more additional residences not shared with the other individual.
  - One of the individuals leaves the common residence with the intent to return.

1.9 “DUAL-CHOICE” means the enrollment period referred to in DEPARTMENT materials as the It’s Your Choice 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 EMPLOYEES to enroll for coverage in any HEALTH PLAN offered by the BOARD.

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

1.11 "EMPLOYEE" means an eligible EMPLOYEE as defined under Wis. Stats. § 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.

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

1.13 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.14 “HEALTH PLAN” means the alternate health care plan signatory to this agreement.

1.15 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.16 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.17 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

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

1.19 "PREMIUM" means the rates shown on ATTACHMENT C plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

1.20 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

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

ARTICLE 2 ADMINISTRATION

2.1 AMENDMENTS

This CONTRACT may be amended by written agreement between the HEALTH PLAN and the BOARD at any time.

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this CONTRACT, the contractor agrees not to discriminate against EMPLOYEES or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The HEALTH PLAN agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

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

(4) In cases where PREMIUM rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

(5) The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLANS shall notify the DEPARTMENT within two business days of discovering that the protected health information (PHI) or personal information of one or more PARTICIPANTS has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. This notification requirement shall apply only to PHI or personal information received or maintained by the HEALTH PLANS pursuant to this agreement. The HEALTH PLANS shall make good faith efforts to communicate with the DEPARMENT about breaches by major provider groups if the HEALTH PLANS know those breaches affect DEPARTMENT PARTICIPANTS.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in certain events including, but not limited to, strike and disaster, and shall submit it to the DEPARTMENT upon request.

(7) The DEPARTMENT reserves the right to require HEALTH PLANS to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to members in a manner similar to the annual informational mailing process.

2.3 CLERICAL AND ADMINISTRATIVE ERROR

(1) Except for the constructive waiver provision of section 3.6, no clerical error made by the EMPLOYER, the DEPARTMENT or the HEALTH PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of section 3.6, if an EMPLOYEE or ANNUITANT has made application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the EMPLOYER or the DEPARTMENT, due to clerical error, to give proper notice to the HEALTH PLAN of such EMPLOYEE'S application.

(3) In the event that an EMPLOYER erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid.

(4) Except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid. 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 months and in accordance with § 3.16 (3). No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payments for all Medicare data match inquiries.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (7) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper effective date of EMPLOYER contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled, except as required by law.

2.4 REPORTING

(1) EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish electronic eligibility files to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish electronic eligibility files while the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the

DEPARTMENT'S membership files in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number and unique DEPARTMENT identifier) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

(4) Unless individually waived by the BOARD, each HEALTH PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire HEALTH PLAN membership and the state group membership where applicable. The HEALTH PLAN will include the state group membership prescription drug data from the pharmacy benefit manager in their reported prescription drug measures consistent with NCQA requirements. The data will be supplied in a format specified by the DEPARTMENT.

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than $100 per day per occurrence, to begin on the 2nd day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed $5,000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(1) The HEALTH PLAN shall provide the SUBSCRIBER with identification cards indicating the EFFECTIVE DATE of coverage, a listing of all available providers and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization and referral requirements. If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Four (4) copies of all informational materials in final form must be provided to the DEPARTMENT. 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.

(3) Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the

Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement:

> "[NAME OF HEALTH PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a HEALTH PLAN mailing to correctly inform PARTICIPANTS.

2.6 FINANCIAL ADMINISTRATION

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.

2.7 INSOLVENCY (OR SOLVENCY)

(1) ATTACHMENT B provides documentation that, in the event the HEALTH PLAN becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the confinement ceases, the attending physician determines confinement is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer to another HEALTH PLAN.

(2) The HEALTH PLAN shall submit to the DEPARTMENT on an annual basis, information on its financial condition including a balance sheet, statement of operations, financial audit reports, and utilization statistics.

2.8 DUE DATES

(1) Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the following month's coverage.

(2) The EMPLOYER shall immediately validate and enter into the DEPARTMENT'S myETF Benefits system the completed applications filed by newly eligible EMPLOYEES or require EMPLOYEES to submit their request directly through myETF Benefits. For any requests submitted by a newly eligible EMPLOYEE through myETF Benefits, the EMPLOYER shall immediately validate and approve the completed application.

2.9 CONTINUATION OR CONVERSION OF INSURANCE

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the

PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must be received by the DEPARTMENT postmarked within 60 days of the date the PARTICIPANT is notified by the EMPLOYER of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for required PREMIUMS. The HEALTH PLAN may not apply a surcharge to the PREMIUM, even if otherwise permitted under State or federal law.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S HEALTH PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the county where the PARTICIPANT resides.

(2) Such PARTICIPANT may also elect to convert to individual coverage without underwriting if application is made directly to the HEALTH PLAN within 30 days after termination of group coverage as provided under Wis. Stat. §632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The HEALTH PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options, including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of PREMIUM. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may also be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The HEALTH PLAN will automatically treat the child as a qualified DEPENDENT, as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S and/or PBM's internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with an Ombudsperson at the DEPARTMENT. The PARTICIPANT may also request a departmental determination. 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). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12). However, the Department will not issue a determination regarding denials of coverage by a HEALTH PLAN and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the independent review process under Wis. Stat. § 632.835 and Wis Adm. Code § INS 18.11.

(2) The PARTICIPANT may also request an independent review as provided under Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In

accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.

(3) The HEALTH PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 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.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of DEPARTMENT Administrative Review Rights

In the final grievance decision letters, the HEALTH PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request a review by an Independent Review Organization in accordance with Wis. Adm. Code § INS 18.11, using the language approved by the DEPARTMENT. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefits contractual provision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision. In the event they disagree with the grievance committee's final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the date of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of the PARTCIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy, when signed by the PARTICIPANT or PARTICIPANT'S representative, to give written authorization for release of information to the DEPARTMENT. 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 working days, or by an earlier date as requested by the DEPARTMENT.

(8) Notification of Legal Action

If a PARTICIPANT files a lawsuit naming the HEALTH PLAN as a defendant, the HEALTH PLAN must notify the DEPARTMENT'S chief legal counsel within ten working days of notification of the legal action. This requirement does not extend to cases of subrogation.

(9) If a departmental determination overturns a HEALTH PLAN'S decision on a PARTICIPANT'S grievance, the HEALTH PLAN must comply with the determination within 90 days of the date of the determination or a $500 penalty will be assessed for each day in excess of 90 days. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within 90 days.

ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE

(1) The group health insurance program as required by Wis. Stat. § 40.51 (7), and under which the HEALTH PLAN is participating according to the terms of this CONTRACT, shall be available beginning July 1, 1987. As recommended by the DEPARTMENT'S actuary and approved by the BOARD, requirements apply to municipalities joining the program and a surcharge applied when the risk is determined to be detrimental to the existing pool. The surcharge is determined by the BOARD's actuary and cannot be appealed. The DEPARTMENT reserves the right to separately rate underwritten groups larger than 2,000 total members, as recommended by the actuary.

(2) The governing body of an EMPLOYER shall adopt a resolution for regular or other option coverage in a form prescribed by the DEPARTMENT. An employer may elect to provide both regular and other options separately to collective bargaining units as approved by the DEPARTMENT. The resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month, or the beginning of the quarter for EMPLOYERS receiving a rate differential as determined through underwriting, on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 40 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the EMPLOYER all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small EMPLOYERS as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void.

EMPLOYEES who are on a leave of absence and not insured under the EMPLOYER'S plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the EMPLOYER'S current group health plan. Eligible EMPLOYEES who are not insured under the EMPLOYER'S current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

(3) Notwithstanding section 3.2, any EMPLOYER for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months. Any EMPLOYER who files a resolution after December 20, 1990, and who offers a non-participating plan as required by sub. (4) shall be required to remain in the program a minimum of three years. Any EMPLOYER who is assessed

a surcharge as determined by the underwriting process shall be required to remain in the program a minimum of three years.

(4) The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to or on behalf of EMPLOYEES in lieu of coverage under this program. EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical. The BOARD reserves the right to assess a surcharge as determined by the BOARD's actuary if this is not done within three years. EMPLOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision. However, the DEPARTMENT may allow any EMPLOYER to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program; and (3) that the minimum number of all of the EMPLOYER'S EMPLOYEES who are eligible under Wis. Stat. § 40.51 (7), including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in (2) above. The Plan Stabilization Contribution may be increased for that EMPLOYER if less than 50% of the participating EMPLOYEES elect the STANDARD PLAN coverage. The EMPLOYER cannot later have a bargaining unit drop from this health insurance program and carry other coverage.

(5) A Large EMPLOYER (more than 50 employees who are eligible under Wis. Stat. § 40.51 (7) may indefinitely retain a second plan, as described in (4) above, or temporarily retain a second plan for up to four years due to timing of collective bargaining or the merger or division of municipalities by executing the appropriate Resolution to Participate provided the EMPLOYER also meets the 65% participation requirement as described in (2) above. The EMPLOYER may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the EMPLOYER'S initial enrollment period due to the EMPLOYER retaining a second plan or due to the timing of collective bargaining. The EMPLOYER must notify the DEPARTMENT, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

(6) The EMPLOYER electing the deductible option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 of the Internal Revenue Code.

(7) If participation by an EMPLOYER is approved in accordance with Sub. (2) and the subsequent participation falls under the minimum requirement, the BOARD may terminate EMPLOYER participation at the end of the calendar year by notifying the EMPLOYER prior to October 1.

(8) The EMPLOYER is responsible for notifying ANNUITANTS of the availability of coverage.

(9) The EMPLOYER is responsible for notifying any CONTINUANTS of the prior group plan of the EMPLOYER'S change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.2 EMPLOYER TERMINATION

(1) The governing body of an EMPLOYER may terminate group health insurance under Wis. Stat. § 40.51 (7), for all PARTICIPANTS for whom rights to coverage were secured by the EMPLOYER'S participation by adopting a resolution in a form prescribed by the BOARD.

(2) A certified copy of the resolution in sub. (1) must be received in the DEPARTMENT by October 15 for termination to be effective at the end of the calendar year.

(3) If the EMPLOYER fails to comply with (1) or (2) above, or if the EMPLOYER fails to maintain the required participation level in the program, the DEPARTMENT may impose enrollment restrictions on the EMPLOYER as it deems appropriate to preserve the integrity of the program. The DEPARTMENT may terminate the EMPLOYER'S participation in the program on the first of the month following notification to the EMPLOYER that it has violated the terms of the CONTRACT. The DEPARTMENT may also restrict the EMPLOYER'S re-enrollment in the program beyond the restrictions set forth in item (4) below.

(4) Any EMPLOYER who terminates participation under this section may again elect to participate with an EFFECTIVE DATE not earlier than three years after the date of termination. The EMPLOYER is responsible for notifying ANNUITANTS and CONTINUANTS of coverage termination.

3.3 SELECTION OF COVERAGE

(1) (a) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on or after the date the application is received by the EMPLOYER. No application for coverage may be rescinded on or after the EFFECTIVE DATE of coverage.

(b) An EMPLOYEE shall be insured if coverage is selected as provided for in section 3.1 (2). If the EMPLOYEE is not eligible for EMPLOYER contribution toward PREMIUM at that time, section 3.3 (3) applies.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM, coverage to be effective upon becoming eligible for EMPLOYER contribution. An EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements. However, when the EMPLOYEE terminates employment prior to the EFFECTIVE DATE of coverage, the application is void and any premiums paid or deducted will be refunded.

(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (a) may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (b) to be effective upon the date of the increase in the EMPLOYER contribution. An EMPLOYEE who does not file an application at this time but who files within 30

days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.

(3) (a) An EMPLOYEE eligible and enrolled for 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 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.

(b) Notwithstanding paragraph 3 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single 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 60 days of the birth, adoption or placement for adoption.

(4) An EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same EMPLOYER subject to the following:

(a) Employment is resumed within 180 days after release from active military service, and

(b) The application for coverage is received by the EMPLOYER within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

(d) Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(5) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

(6) As required by state and federal law, a SUBSCRIBER enrolled with single coverage although eligible for family coverage, or an EMPLOYEE who deferred the selection of coverage, has a special enrollment opportunity to add eligible children as required by a National Medical Support Notice.

(7) (a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or is a member of the US Armed Forces, or is a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT

loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, the EMPLOYEE may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the other plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) If permitted by state or Federal law, an eligible EMPLOYEE may defer or dis-enroll from coverage if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care. Family status changes under this provision remain subject to Section 125 of the Internal Revenue Code. If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to the DEPARTMENT.

(c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, marriage or domestic partnership, provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage or effective date of the domestic partnership.

(d) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) or (c) above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(8) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician, clinic or care system available, upon notice to the EMPLOYER that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application. The HEALTH PLAN may not simply reassign a primary physician, clinic or care system.

(9) An ANNUITANT shall be covered if a completed DEPARTMENT application form is received as specified in section 3.1 (2).

(10) If the DEPARTMENT determines it could effectively monitor it, an ANNUITANT with comparable coverage may escrow sick leave, if available, and reenroll in any HEALTH PLAN without underwriting restrictions with coverage effective on the first of the month following the DEPARTMENT'S receipt of the health insurance application.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child becomes newly

eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage, increase in employee contribution share that exceeds the cost of coverage as a dependent under this program. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the SUBSCRIBER requests to terminate coverage for the adult dependent within 30 days of the DEPENDENT'S eligibility and enrollment in other health insurance coverage, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT during Open Enrollment effective the following January 1, whichever occurs first.

(12) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during the annual DUAL-CHOICE enrollment period for coverage effective the following January 1.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(1) The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES and currently covered ANNUITANTS and CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51 (7). Unless otherwise provided by the BOARD, the DUAL-CHOICE enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a DUAL-CHOICE enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous DUAL-CHOICE enrollment period will be allowed a DUAL-CHOICE enrollment provided an application is filed during the 30-day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual DUAL-CHOICE enrollment materials. A move from a medical facility to another facility by the SUBSCRIBER is not considered a residential move. An application must be filed during the 30 day period, which begins on the date the SUBSCRIBER moves.

(5) A SUBSCRIBER under (3) and (4) above who does not file an application to change plans within this 30 day enrollment period, may change plans at the next DUAL-CHOICE enrollment period.

(6) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, domestic partnership, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within

30 days of the event. This enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. This also applies to ANNUITANTS as if Federal law required it. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

(7) The HEALTH PLAN shall accept any individual who transfers from one plan to another or from individual to family coverage without requiring evidence of insurability, waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3).

(8) If the HEALTH PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make a DUAL-CHOICE election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same HEALTH PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the EMPLOYER receives the SUBSCRIBER'S request to change networks, whichever is later.

(9) Applications from ANNUITANTS and CONTINUANTS changing plans during the DUAL-CHOICE enrollment period must be received by the DEPARTMENT postmarked no later than the last day of the DUAL-CHOICE enrollment period, unless otherwise authorized by the DEPARTMENT.

3.5 INITIAL PREMIUMS

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

3.6 CONSTRUCTIVE WAIVER OF COVERAGE

Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the EMPLOYER for a period of 12 consecutive months, shall be deemed to have prospectively waived coverage upon a 30-day notice to the EMPLOYEE, unless all required PREMIUMS are paid. Coverage then may be obtained only under the deferred coverage provisions of section 3.10.

3.7 BENEFITS NON-TRANSFERABLE

No person other than a PARTICIPANT, as recorded in the office of the HEALTH PLAN, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stat. § 939.51 (3) (a).

3.8 NON-DUPLICATION OF BENEFITS

The HEALTH PLAN'S administration of BENEFITS provisions must conform to Wis. Adm. Code § INS 3.40.

3.9 REHIRED EMPLOYEE COVERAGE

(1) Any insured EMPLOYEE who terminates employment with an EMPLOYER participating under Wis. Stat. § 40.51 and is re-employed by the same EMPLOYER within 30 days in a position eligible for health insurance or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § ETF 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

(2) Rehired ANNUITANTS who terminate their annuity and participate in the Wisconsin Retirement System may continue the same health insurance coverage by filing an application with the EMPLOYER within 30 days following the Wisconsin Retirement System participation begin date.

3.10 DEFERRED COVERAGE ENROLLMENT

(1) Any EMPLOYEE actively employed with an EMPLOYER participating under Wis. Stat. § 40.51 who does not elect coverage during the enrollment period provided under section 3.3 or who constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only by electing coverage during the DUAL-CHOICE enrollment period as provided in section 3.4 (1).

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage may only elect family coverage during the DUAL-CHOICE enrollment period, except as provided in section 3.3.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate HEALTH PLAN during a DUAL-CHOICE enrollment period offered under section 3.4.

(4) An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40)who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of using post-retirement EMPLOYER premium contribution.

3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER

If both spouses or both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin or a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse or one DOMESTIC PARTNER to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses or DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of marriage or the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar

month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced or the domestic partnership terminated while carrying family coverage, the divorced spouse or former DOMESTIC PARTNER may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce or termination of domestic partnership. An EMPLOYER may, at its option, allow both spouses or both DOMESTIC PARTNERS to enroll for family coverage or one for single and one for family and coverage can be changed from one spouse or one DOMESTIC PARTNER to the other without restrictions. Upon an EMPLOYER'S request, the DEPARTMENT may approve at its discretion a special enrollment opportunity for affected employees due to a change in policy for coverage of spouses or DOMESTIC PARTNERS.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

(1) Any insured EMPLOYEE may continue coverage during any EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, the EMPLOYEE is not deemed to have returned to work and coverage as an active EMPLOYEE shall not be resumed.

(2) Except as provided in section 3.21, the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. Each payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid. Retroactive EMPLOYER refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE are not allowed.

(3) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days of the return from leave. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. EMPLOYEES shall also have the enrollment opportunities as described in section 3.3 (7) (a) while on leave of absence. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

3.13 COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE

(1) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from his or her position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be insured from the date of the contested discharge until a final decision has been reached. Within 30 days of the date of discharge the EMPLOYEE must submit to the EMPLOYER the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS were previously paid.

(2) If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

(3) The PREMIUMS referred to in this section shall be the gross amount paid to the HEALTH PLAN for the particular coverage, including the pharmacy and administrative fees. The EMPLOYEE shall be required to pay any amounts normally considered the EMPLOYER contribution. If the right of the EMPLOYEE to the position is sustained, the EMPLOYER shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE contribution.

3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS

(1) As required by Wis. Adm. Code § ETF 40.01, the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously insured 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 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.

(2) Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT unless the EMPLOYER provides for additional months of PREMIUM payment after the date of death, and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

(3) PREMIUMS shall be paid:

(a) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then

(b) Directly to the HEALTH PLAN.

3.15 COVERAGE OF EMPLOYEES AFTER RETIREMENT

(1) Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

(a) Retires on an immediate annuity as defined under Wis. Stat. § 40.02 (38), and the EMPLOYER submits verification of insured status.

(b) EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health insurance purposes.

(c) Terminates employment after attaining 20 years of creditable service and is eligible for an immediate annuity but defers application. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment.

(d) Receives a long-term disability benefit as provided for under Wis. Adm. Code § ETF 50.40.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period preceding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by the DEPARTMENT shall cause the health care coverage to be irrevocably canceled.

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT becomes eligible for the Medicare hospital and medical insurance benefits (Parts A and B) become effective as the primary payor and coverage is provided under a non-employer group number.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), 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 payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV,. A., 12., b. 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 months.In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV,. A., 12., b. 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. In such cases, the HEALTH PLAN will make claims adjustments prospectively.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the participating 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 insurance policy with another employer and that policy is the primary payor 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.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS, CONTINUANTS and their DEPENDENTS who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, CONTINUANT 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.

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

(7) If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this plan shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in Medicare. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this plan will again be the primary payor. No reduction in PREMIUM is available for active EMPLOYEES under this section.

(8) As required by Medicare rules, Medicare is the primary payor for DOMESTIC PARTNERS age 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.

3.17 CONTRACT TERMINATION

(1) The CONTRACT terminates on the date specified on the signatory page. The BOARD, by September 1, or the HEALTH PLAN, by the date specified in the Guidelines, section II., J., shall provide notice of its intent not to contract for the following contract year by

providing notice to the other party. The HEALTH PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the DUAL-CHOICE enrollment period.

(2) If the HEALTH PLAN terminates this CONTRACT as required by sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

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

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

(d) Confinement ceases.

(3) If the HEALTH PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the HEALTH PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the HEALTH PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT as required by sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The HEALTH PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

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

3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:

(a) The effective date of change to another HEALTH PLAN through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. 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 PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

HEALTH PLANS must notify the DEPARTMENT within one month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the HEALTH PLAN are limited to one month following the termination date.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT for whom the EMPLOYER has no reporting responsibilities, or a later date as specified on the cancellation of coverage notice. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, end of a domestic partnership, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the continuation period for which the PARTICIPANT is allowed to continue under paragraph (4) below, as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under paragraph (4) below.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason.

(i) The end of the month in which the SUBSCRIBER terminates employment.

(j) The first day of the month following the DEPARTMENT’S written notice to a SUBSCRIBER who is ineligible for coverage but, due to EMPLOYER or DEPARTMENT error, was enrolled for coverage. The SUBSCRIBER (and any eligible DEPENDENTS) will be offered a special continuation period of up to 36 months. The continuation period will be administered in accordance with paragraph (4) below.

(k) The effective date of the termination of EMPLOYER participation for all PARTICIPANTS for whom coverage was secured as a result of the EMPLOYERS participation.

(2) No refund of any PREMIUM under sub. (e) may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

(3) Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, 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.

(4) 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 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for the required PREMIUM.

(5) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance 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 coverage is available and is limited to the STANDARD PLAN.

Change to an alternate HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

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.

(6) 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 physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent DUAL-CHOICE enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular DUAL-CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

(7) In the situation where the EMPLOYER violates the terms of the CONTRACT, coverage for all its PARTICIPANTS, including ANNUITANTS and CONTINUANTS, terminates the first of the month following notification from the DEPARTMENT of 30 days or more.

3.19 COVERAGE CERTIFICATION

The HEALTH PLAN certifies that providers listed on Addendum #2 or on any of the HEALTH PLAN'S publications of providers are either under contract for all of the ensuing calendar year or the HEALTH PLAN will pay charges for BENEFITS on a fee-for-service basis. Those providers have agreed to accept new patients unless specifically indicated otherwise.

3.20 ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the effective date of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums will continue to accumulate for that year.

(3) The HEALTH PLAN shall provide the PARTCIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits.

(4) The HEALTH PLAN shall apply any and all Maximum Out-of-Pocket limits as required by state and federal law.

3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM

(1) The EMPLOYER contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but not more than 88% of the gross PREMIUM of the average cost qualified alternate plan approved by the BOARD which is in the service area of the EMPLOYER. EMPLOYERS who determine the EMPLOYEE PREMIUM contribution based on the tiered structure established for state EMPLOYEES must do so in accordance with Wis. Adm. Code § ETF 40.10. The DEPARTMENT shall determine the service area of the EMPLOYER. The effective date of the EMPLOYER contribution shall not be later than the first of the month after which the EMPLOYEE completes 6 months service with the EMPLOYER under the Wisconsin Retirement System.

(2) Notwithstanding sub. (1), the amount of EMPLOYER contribution toward PREMIUM for ANNUITANTS, EMPLOYEES on approved leave of absence or LAYOFF, or those whose coverage is continued under section 2.9 (1) shall be at the discretion of the EMPLOYER.

(3) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,044 hours per year shall be 25% of the lowest cost qualified alternate plan that is in the service area of the EMPLOYER and approved by the BOARD.

(4) If the amount of EMPLOYER contribution changes, a new DUAL-CHOICE offering may be made to its EMPLOYEES, as determined by the DEPARTMENT.

(5) ANNUITANTS for whom the EMPLOYER contributes toward the PREMIUM shall be treated as EMPLOYEES for the purpose of PREMIUM and coverage reporting.

ATTACHMENT A: ***Description of BENEFITS***

Includes Uniform Benefits, with the exception of Section III., D., Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM).

ATTACHMENT B: ***Documentation of Bonding or Reinsurance (If different than state)***

ATTACHMENT C
TABLE 10B
CALENDAR YEAR 2014
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	**2013**
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Monday July 16th, 2012 2:00pm CDT

LOCAL DEDUCTIBLE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Preliminary Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Deductible Coverage - $500 Ind./$1000 Fam.				
6. Individual (Shall be within the range of 88%-93% of the regular individual coverage rate)		ERROR		ERROR
7. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded.				
8. Individual (No more than 50% of individual rate)		ERROR		ERROR
9. Family - 2 persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
10. Family - 1 person eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Dental Benefit Component (incl. above)				
11. Single				
12. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
10. Single				
11. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	**2013**
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Monday July 16th, 2012 2:00pm CDT

LOCAL COINSURANCE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Preliminary Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Coinsurance Coverage - $500 Ind./$1000 Fam., with coin 90%/10%				
6. Individual (Shall be 95% of the regular individual coverage rate)		ERROR		ERROR
7. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded.				
8. Individual (No more than 50% of individual rate)		ERROR		ERROR
9. Family - 2 persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
10. Family - 1 person eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Dental Benefit Component (incl. above)				
11. Single				
12. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
10. Single				
11. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT C
TABLE 11B
CALENDAR YEAR 2014 – FINAL BEST BID
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	**2013**
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Friday August 10th, 2012 2:00pm CDT

LOCAL DEDUCTIBLE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Best & Final Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Deductible Coverage - $500 Ind./$1000 Fam.				
6. Individual (Shall be within the range of 88%-93% of the regular individual coverage rate)		ERROR		ERROR
7. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded.				
8. Individual (No more than 50% of individual rate)		ERROR		ERROR
9. Family - 2 persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
10. Family - 1 person eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Dental Benefit Component (incl. above)				
11. Single				
12. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
13. Single				
14. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

Health Plan Name:	
Service Area (including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	**2013**
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Friday August 10th, 2012 2:00pm CDT

LOCAL REGULAR & COINSURANCE EMPLOYEES

Dental Included (Y,N)	Y	VALID		
	2012 Inforce Rates (Monthly)	**Validation**	**2013 Best & Final Rates (Monthly)**	**Validation**
Regular Coverage				
1. Individual		ERROR		ERROR
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
3. Individual (Shall be no more than 50% of the regular individual coverage rate)		ERROR		ERROR
4. Family 2 - All persons eligible for Medicare (shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
5. Regular Family 1 - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Coinsurance Coverage - $500 Ind./$1000 Fam., with coin 90%/10%				
7. Individual (Shall be 95% of the regular individual coverage rate)		ERROR		ERROR
8. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded., with coin 90%/10%				
9. Individual (No more than 50% of individual rate)		ERROR		ERROR
10. Family - 2 persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
11. Coinsurance Family - 1 person eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Dental Benefit Component (incl. above)				
12. Single				
13. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Wellness Benefit Component (incl. above)				
14. Single				
15. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT D: ***Specimen Conversion Contract (If different than state)***

ATTACHMENT E: *Grievance Procedure* ***(If different than state; must include DEPARTMENT administrative review rights)***

ATTACHMENT F: ***Dental Description (if applicable) and Other***

Additional documents, if necessary, and cited individually, i.e., Attachments F, G, H, etc.

UNIFORM BENEFITS

As of the 1994 coverage year, all Health Plans offering coverage to State employees must provide the Uniform Benefits described in this Attachment A. The Health Plan may not alter the language, benefits or exclusions and limitations of the Uniform Benefits plan. Health Plans are required to provide State and participating local government employees with a description of any Prior Authorization or Referral requirements of the Health Plan. Any such requirements must be submitted to the DEPARTMENT, along with all promotional material, for approval and for inclusion in the "It's Your Choice" guides by the dates designated in the Time Table in Section J of the Guidelines.

The Uniform Benefits set forth in this section will be described to all Subscribers via the "It's Your Choice" brochure. The Health Plan does not need to recreate the description of benefits nor distribute it to its members.

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I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master 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 a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at $0 with the exception of the prescription annual out-of-pocket limit. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin Group Health Insurance Program.

NOTE: - *Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of $500 per individual / $1,000 per family, per calendar year for all medical services except for preventive services required under Section III., A., 5., i. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.*

- *For Participants enrolled in a Preferred Provider Plan (WEA Trust PPPs and WPS Metro Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers. Out-of-network deductible amounts do not accumulate to the in-network out-of-pocket limit.*

Except as specifically stated for Emergency and Urgent Care (see Sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless you get a Prior Authorization from your Health Plan. Prior Authorization requirements are described in the Health Plan Descriptions section of the "It's Your Choice: Decision Guide."

The covered benefits that are administered by the Health Plan are subject to the following:

- Policy Coinsurance and medical Copayments: described below

Benefit	**State of Wisconsin eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**	**Medicare prime State of Wisconsin Participants and all participating Wisconsin Public Employer's eligible Participants**
Annual Medical Coinsurance	90%/10% except 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.

Annual Medical Out-of-Pocket Limit (OOPL)	$500 Participant/$1,000 aggregate family limit except as described below.	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Routine, preventive services as required by federal law	100%	100%
Illness/injury related services	90% (10% member cost to OOPL)	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 does not accumulate to OOPL, after copay 90%. (10% member cost to OOPL)	$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% (20% member cost to OOPL)	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)
Cochlear Implants for Participants age 18 and older	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).
Cochlear Implants Participants under age 18	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.
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.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.

- Policy Deductible: NONE
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: 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 Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.
- 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 Health Plan; and Hospital charges . The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum..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
- 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 out-of-pocket maximum. 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.
- 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 Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services section.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- 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.
- 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.)
- Oral Surgery: Limited to procedures listed in Benefits and Services section.
- Temporomandibular Disorders: 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.

- Dental Implants: Following accident or injury up to a maximum of $1,000 per tooth.

- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.

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

- **Prescription Drugs and Insulin (Except Specialty Medications):**

Copayments:

Level 1* Copayment for Formulary Prescription Drugs: $ 5.00

The Level 1 Copayment applies to Formulary Generic Drugs and certain lower-cost Formulary Brand Name Drugs. Level 1 Copayments accumulate toward the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 Formulary Drugs for that benefit year.

Level 2**Copayment for Formulary Prescription Drugs: $15.00

The Level 2 Copayment applies to Formulary Brand Name Drugs, and certain higher-cost Formulary Generic Drugs. Level 2 Copayments accumulate toward the Level 1/Level 2 annual OOPL until the Level 1/Level 2 OOPL is met after which You pay no more out-of-pocket expenses for Level 2 Formulary Drugs for that benefit year.

Level 3 Copayment for Covered Non-Formulary Prescription Drugs: $35.00

The Level 3 copayment applies to certain high-cost, non-Formulary Prescription Drugs for which alternative and/or equivalent Formulary drugs are available and covered. Level 3 Copayments do ***not*** accumulate toward an annual OOPL. You must continue to pay Level 3 copayments even after other annual OOPLs have been met.

Level 1/Level 2 Annual Out-of-Pocket Limit (OOPL) (The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):

$410 per individual or $820 per family for all Participants, except:

$1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.

- **Specialty Medications**

Note: The specialty prescription drug pharmacy with which the PBM is contracted shall be considered the preferred Participating Pharmacy for Specialty Medications.

Copayments:Level 4 Copayment for Formulary and Covered, Non-Formulary Specialty Medications: $50.00

Formulary Specialty Medications: the Level 4 Copayment applies when medications are obtained from a Participating Pharmacy other than the preferred Participating Pharmacy. Level 4 copayments for Formulary Specialty Medications accumulate toward the Level 4

annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Formulary Specialty Medications for that benefit year.

Non-Formulary Specialty Medications: the Level 4 Copayment applies whether medications are obtained at the preferred Participating Pharmacy or another Participating Pharmacy. Level 4 copayments for non-Formulary Specialty medications do ***not*** accumulate toward any annual OOPL. You must continue to pay copayments for Level 4 Non-Formulary Specialty Medications even after other annual OOPLs have been met.

Reduced Level 4 Copayment for Formulary Specialty Medications obtained from the preferred Participating Pharmacy: $15.00

The reduced Level 4 Formulary Specialty Medications copayment applies when Formulary Specialty Medications are obtained from the preferred Participating Pharmacy. Reduced Level 4 Copayments accumulate toward the Level 4 annual OOPL until the Level 4 OOPL is met after which You pay no more out-of-pocket expenses for Formulary Specialty Medications for that benefit year. This reduced Copayment does ***not*** apply to non-Formulary Specialty Medications.

Level 4 Annual Out-of-Pocket Limit (OOPL) (The amount You pay for Your Level 4 Specialty Medications.)

$1,000 per individual or $2,000 per family for all participants.

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the prescription drug Level 1/Level 2 annual OOPL.

- 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 terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this plan.

- **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.

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

- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA 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 a Plan 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 Plan 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.

- **DEPARTMENT:** Means Department of Employee Trust Funds.

- **DEPENDENT:** Means, as provided herein, the Subscriber's:
  - Spouse.
  - Domestic Partner, if elected.
  - Child.
  - Legal ward who becomes a legal ward of the Subscriber, Subscriber's spouse or insured Domestic Partner prior to age 19, but not a temporary ward.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Child of the Domestic Partner insured on the policy.
  - Grandchild if the parent is a Dependent child.

1. A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.

2. 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. 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, 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. The Health Plan 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 Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

      b. After attaining age 26, as required by Wis. Stat. § 632.885 a Dependent includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

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 acknowledgment 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. Any Dependent eligible for benefits who is not listed on an application for coverage will be provided benefits based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the employer, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

- **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:
  - Each individual is at least 18 years old and otherwise competent to enter into a contract.
  - Neither individual is married to, or in a domestic partnership with, another individual.
  - The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
  - The two individuals consider themselves to be members of each other's immediate family.
  - The two individuals agree to be responsible for each other's basic living expenses.
  - The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
    - Only one of the individuals has legal ownership of the residence.
    - One or both of the individuals have one or more additional residences not shared with the other individual.
    - 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 Health Plan 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.

- **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 a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.

- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (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-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies.

- **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 Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.

- **HABILITATION SERVICES:** Means excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during the calendar year.

- **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 Health Plan.

- **HOSPITAL:** Means an institution that:

  1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or

  2. (a) 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 a Plan 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.

- **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 HEALTH PLAN.

- **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 Health Plan 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 Health Plan:

  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 Health Plan 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 INIDIVIDUALS 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 Plan Benefits are available under this Health Plan.

- **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 agreement and is not listed on the most current listing of the PBM’s provider directory of Participating Pharmacies.

- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's

professional directory of Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Health Plan unless it is an Emergency or Urgent Care.

- **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 Plan Service Area.

- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.

- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. 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.

- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.

- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.

- **PLAN 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 Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.

- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.

- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital, or elsewhere, necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's 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 should name Your Primary Care Provider or clinic on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in the Health Plan Descriptions section of the "It's Your Choice: Decision Guide." 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 Plan 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 Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in the Health Plan Descriptions section of the "It's Your Choice: Decision Guide." The authorization from the Health Plan 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 Health Plan 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 Health Plan You elected.

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

- **SHARED DECISION MAKING (SDM):** Means a program offered by a Health Plan or health care provider that Participants must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform Participants about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that Participants can decide the best possible course of treatment. The Health Plan or health care provider will provide the Participant with written Patient Decisions Aids (PDAs) as part of the SDM program.

- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In 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.

- **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 require special storage and handling and, as a result, are more costly and usually not available from all Participating Pharmacies.

- **STATE:** Means the State of Wisconsin as the policyholder.

- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.

- **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 Plan 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 Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member 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 a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), 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. Health Plan approved Referrals to Non-Plan Providers are not subject to Usual and Customary Charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

The benefits and services which the Health Plan and PBM agrees to provide to Participants, or make arrangements for, 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 plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a plan Hospital. In the case of non-Emergency care, the Health Plan reserves the right to determine in a reasonable manner the Provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the Health Plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for Emergency and Urgent Care, You must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan Provider or You will be financially responsible for the services. The Health Plan may also require Prior Authorization for other services or they will not be covered.

Subject to the terms and conditions outlined in this plan and the attached Schedule of Benefits, a Participant, in consideration of the employer's payment of the applicable Health Plan 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 plan. All services must be Medically Necessary, as determined by the Health Plan 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 Plan Hospital emergency rooms whenever possible. If You are not able to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan. In addition to cost sharing described in the Schedule of Benefits, Emergency care from Non-Plan Providers may be subject to Usual and Customary Charges.

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.

e. Some examples of Emergencies are:
   - Acute allergic reactions
   - Acute asthmatic attacks
   - Convulsions
   - Epileptic seizures
   - Acute hemorrhage
   - Acute appendicitis
   - Coma
   - Heart attack
   - Attempted suicide
   - Suffocation
   - Stroke
   - Drug overdoses
   - Loss of consciousness
   - 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 returns to the Plan Service Area to receive such care from a Plan Provider.

b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan.

c. Some examples of Urgent Care cases are:
   - Most Broken Bones
   - Minor Cuts
   - Sprains
   - Most Drug Reactions
   - Non-Severe Bleeding
   - 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 16. of this section.

Prior Authorization is required for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the health plan 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 Shared Decision Making (SDM) program provided by the Health Plan or its contracted providers consistent with the Prior Authorization requirement.

4. Reproductive Services and Contraceptives

The following services do not require a Referral to a Plan Provider who specializes in obstetrics and gynecology, however, the Health Plan 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 plan 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:
   - Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
   - IUDs and diaphragms, as described under the Durable Medical Equipment provision.
   - 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 Health Plan 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 Health Plan may request that it be notified 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 approved Provider.

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 Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)

f. Injectable and infusible medications, except for Self-Administered Injectable medications.

g. Nutritional Counseling provided by a participating registered dietician or Plan Provider.

h. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

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 this plan. 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 approved Provider.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider. Methadone Treatment shall be covered only when Medically Necessary and provided by an approved provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) 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 Plan's Service Area, the Health Plan or Plan 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 a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations. Prior authorization is required for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the plan for members with a history of low back pain and 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 Rehabilitation services and treatment as a result of Illness or Injury, provided by a Plan 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 Health Plan 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 Plan 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 a Health Plan physician; 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:

1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.

2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.

3) 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 physician 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 Health Plan 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 six months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice Care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care is available to a Participant who is Confined. 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 six-month period if authorized by the Health Plan.

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

Inpatient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility.

When benefits are payable under both this Hospice Care benefit and the Home Care benefit, 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 Health Plan 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 approved Plan 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 Health Plan 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 Health Plan prior to any oral surgery to determine if Prior Authorization by the Health Plan is required. When performed by Plan 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 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 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 Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease.

a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
   - Aplastic anemia
   - Acute leukemia
   - Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
   - Wiskott-Aldrich syndrome
   - Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
   - Hodgkins and non-Hodgkins lymphoma
   - Combined immunodeficiency
   - Chronic myelogenous leukemia
   - Pediatric tumors based upon individual consideration
   - Neuroblastoma
   - Myelodysplastic syndrome
   - Homozygous Beta-Thalassemia
   - Mucopolysaccharidoses (e.g. Gaucher’s disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
   - Multiple Myeloma, Stage II or Stage III
   - 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:
   - Corneal opacity
   - 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

- Corneal ulcer
- Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - Congestive Cardiomyopathy
   - End-Stage Ischemic Heart Disease
   - Hypertrophic Cardiomyopathy
   - Terminal Valvular Disease
   - Congenital Heart Disease, based upon individual consideration
   - Cardiac Tumors, based upon individual consideration
   - Myocarditis
   - Coronary Embolization
   - Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - Extrahepatic Biliary Atresia
   - Inborn Error of Metabolism
     - Alpha -1- Antitrypsin Deficiency
     - Wilson's Disease
     - Glycogen Storage Disease
     - Tyrosinemia
   - Hemochromatosis
   - Primary Biliary Cirrhosis
   - Hepatic Vein Thrombosis
   - Sclerosing Cholangitis
   - Post-necrotic Cirrhosis, Hbe Ag Negative
   - Chronic Active Hepatitis, Hbe Ag Negative
   - Alcoholic Cirrhosis, abstinence for six or more months
   - Epithelioid Hemangioepithelioma
   - Poisoning
   - Polycystic Disease

g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.

h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan 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 A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan 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:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (see DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- 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., 1. Coverage also includes one 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 Health Plan.

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 a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Health Plan 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 Health Plan.

b. Licensed Skilled Nursing Facility: Must be admitted within 24 hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits 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 five 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 Health Plan prior to any services to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

Covers Medically Necessary services provided by a Plan 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 Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan 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.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan 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 a Non-Plan Provider, if provided as required by an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan 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 a Plan Provider for treatment of diabetes and purchased from a Plan 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 out-of-pocket limit. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.

- 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 Health Plan.

(Glucometers are available through the PBM. Refer to Section D. for benefit information.)

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, Medical Supplies and Durable Medical Equipment will be covered **subject to cost sharing as outlined in the Schedule of Benefits**.

The following supplies and equipment will be covered only when Prior Authorized as determined by the Health Plan:

- 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.

- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.

- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

- IUDs and diaphragms.

- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.

- Cochlear implants, as described in the Schedule of Benefits.

- 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.

- Ostomy and catheter supplies.

- Oxygen and respiratory equipment for home use when authorized by the Health Plan.

- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.

- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan 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 out-of-pocket limit.

4. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO 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 Plan Service Area, as required by Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area 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 plan under this health insurance 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 Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four 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 nonintensive-level services is not subject to policy exclusions and limitations. 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 benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, You may need to make 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 Health Plan.

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 out-of-pocket limit applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket limit, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual out-of-pocket limit as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket limit, all family members will have satisfied the annual out-of-pocket limit for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket limit. 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 out-of-pocket limit for Level 1 and Level 2 Formulary prescription drugs.

The Health Plan, 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 Injectable).

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 HEALTH PLAN or a contracted provider administers the injection. If the HEALTH PLAN 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 out-of-pocket limit. 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 Plan 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 Formulary 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 Injectables 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 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member 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. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on

the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.

k. The PBM reserves the right to designate certain over-the-counter drugs on the Formulary.

l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or 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 including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket limit 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 out-of-pocket limit for prescription drugs are as follows:

- Diaphragms
- Syringes/Needles
- 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 Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans 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 plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

1. Surgical Services

a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.

b. 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.

c. 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 a Plan 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 Health Plan.

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. Therapies, as determined by the Health Plan, 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.

   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 Health Plan.

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 Health Plan 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 Plan 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.

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. Mental Health Services/Alcohol and Drug Abuse

a. Hypnotherapy.

b. Marriage counseling.

c. 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.

d. Biofeedback.

10. Durable Medical or Diabetic Equipment and Supplies

a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.

b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.

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 Health Plan.

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 Health Plan. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in 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.

11. 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 Injectable 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 for spilled, stolen or lost prescription drugs.

12. 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 Health

Plan 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. Maintenance Care.

k. Habilitation services and treatment, except as required by state law, including Wis. Stat. §§ 632.895 (5), (12m), and (16).

l. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

m. 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.

n. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

o. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

p. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan 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 Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan’s network. In this instance, the liability will remain with the previous insurer.

q. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery.

r. 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.

s. Charges for any missed appointment.

t. 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 Health Plan 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).

u. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

v. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:

   1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.

   2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.

   3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.

w. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.

x. Coma stimulation programs.

y. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.

z. Any diet control program, treatment, or supply for weight reduction.

aa. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.

bb. 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.

ab. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.

ac. 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 a Plan Provider or Prior Authorized by the Health Plan. The treatment of the

complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

ad. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct a functional impairment related to Congenital bodily disorders or conditions or when associated with 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.

ae. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.

af. 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.

ag. Sexual counseling services related to infertility and sexual transformation.

ah. 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.

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 Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals 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 Non-Plan Providers and/or Non-Participating Pharmacies.

5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan 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 Health Plan, Plan 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 Non-Plan Providers and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.

7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

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:

1. "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.

2. "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.

3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

   a. 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.

   b. 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.

4. "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.

5. "This Plan" means the part of your 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":

   1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

   2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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:

1) first, the Plan of the parent with custody of the child;

2) then, the Plan of the spouse of the parent with the custody of the child; and

3) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to 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

1) 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:

   i. 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.

   ii. Second, the benefits under the continuation coverage.

2) 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.

3. Coordination of Dental Benefits

The dental benefits under Uniform Benefits provided by a Health Plan are considered to be primary with regards to stand-alone or wrap-around dental plans that are approved by the Group Insurance Board and held by employees, annuitants, and continuants pursuant to Wis. Adm. Code Ins. 3.40 (9) (d).

D. Effect On The Benefits Of The Plan

1. When This Section Applies

This Section D. 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 Health Plan has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under This Plan must give the Health Plan 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 Plan. If it does, the Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. The Health Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right Of Recovery

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

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

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

A. Right To Obtain and Provide Information

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations.

Each Participant agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the Health Plan and/or PBM but also disclosures to:

1. Health care Providers as necessary and appropriate for treatment;

2. Appropriate Department employees as part of conducting quality assessment and improvement activities, or reviewing the Health Plan'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 Health Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this plan (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the Health Plan, each Participant shall be deemed to have waived any legal rights 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 Health Plan may employ a professional staff to provide case management services. As part of this case management, the Health Plan or the Participant's attending physician may recommend that a Participant consider receiving treatment for an Illness or Injury which differs from the current treatment if it appears that:

a. the recommended treatment offers at least equal medical therapeutic value; and

b. the current treatment program may be changed without jeopardizing the Participant's health; and

c. the charges (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the Health Plan agrees to the attending physician's recommendation or if the Participant or his/her authorized representative and the attending physician agree to the Health Plan's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for

example, biofeedback, acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

D. Disenrollment

No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance 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.

Change to an alternate Health Plan via It's Your Choice enrollment is available during a regular It's Your Choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

The Department may at any time request such documentation as it deems necessary to substantiate Subscriber or Dependent eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent It's Your Choice enrollment periods. Reenrollment in the Health Plan is available during a regular It's Your Choice enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery Of Excess Payments

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

Each Participant agrees to reimburse the Health Plan and/or PBM for all payments made for benefits to which the Participant was not entitled. Reimbursement must be made immediately upon notification to the Subscriber by the Health Plan and/or PBM. At the option of the Health Plan and/or PBM, benefits for future charges may be reduced by the Health Plan and/or PBM as a set-off toward reimbursement.

F. Limit On Assignability Of Benefits

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 insurer under these Uniform Benefits, whether that is a Health Plan or the Department, shall be subrogated to a Participant's rights to damages, to the extent of the benefits the insurer 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 insurer's rights of full recovery may be from any source, including but not limited to:

- The third party or any liability or other insurance covering the third party

- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- 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 insurer to such extent.

The insurer subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the insurer's prior written consent shall be deemed to prejudice the insurer's rights. Each Participant shall promptly advise the insurer in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the insurer such additional information as is reasonably requested by the insurer. The Participant agrees to fully cooperate in protecting the insurer's rights against a third party. The insurer 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 insurer and the Participant over the question of whether or not the Participant has been "made whole", the insurer 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 insurer 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 insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer 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 insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer 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 insurer 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 Health Plan and PBM.

Failure to notify a Plan Provider of Your membership in the Health 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 receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Health Plan, clearly indicating the Health Plan'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 Health Plan and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the Health Plan and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating Health Plans and the PBM are required to make a reasonable effort to resolve members' problems and complaints. If You have a complaint regarding the Health Plan's and/or PBM's administration of these benefits (for example, denial of claim or Referral), You should contact the Health Plan 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 Health Plan and/or PBM. Contact the Health Plan and/or PBM for specific information on its Grievance procedures.

If You exhaust the Health Plan'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 Health Plan and/or PBM. The Health Plan 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 Health Plan 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, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. You may request an independent review pursuant to Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, you have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision that is final and binding has been rendered in accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. 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, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. These appeals are reviewed only to determine whether the Health Plan and/or PBM breached its contract with the Group Insurance Board.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

All dental benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. The Uniform Dental Benefits are wholly incorporated in the Master Contract.

This is a list of Uniform Dental Benefits and is based upon the Current Dental Terminology © American Dental Association. Codes are provided as a reference and may be subject to change; Plans may substitute alternative codes to provide essentially equivalent coverage.

No payment will be made for a benefit that is not listed.

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- During the first year a person is insured, benefits begin on the effective date and continue through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for Plan review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.
- Note that uniform medical benefit may provide coverage for oral surgery.

LIMITATIONS

The following services ***are limited*** under this **Plan**:

- Oral Exams limited to two per year.
- Full Mouth or Panoramic x-rays limited to once every 60 months.
- Bite wing x-rays limited to two sets per year.
- Cleaning of teeth limited to two times per year.
- Fluoride treatment allowed only for a child under age 19, limited to two times per year.
- Sealants allowed only for a child under age 16, and must be applied to non-restored, non-decayed first and second permanent molars, limited to once per tooth per lifetime.
- Routine pediatric dental services as required under federal law.

Special note on fillings: On anterior (front) teeth you will have 100% coverage subject to your benefit maximum for both amalgam (silver) and composite/resin (tooth colored) fillings. On posterior (back) teeth, you have 100% coverage subject to your benefit maximum for amalgam (silver) fillings only. If you have a composite/resin (tooth colored) filling on a posterior tooth, you will be responsible for the difference between the amount your provider charges for an amalgam and a composite/resin filling.

EXCLUSIONS

The following are **not Covered Services** under this **Plan**:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer Liability laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this **Dental Plan**.

3. Prescription drugs, pre-medications or relative analgesia charges for anesthesia connection with covered oral surgery procedures.
4. Preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. Appliances, restorations or procedures for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques or for splints, unless necessary as a result of accidental injury.
9. Replacement of lost or broken retainer.
10. Treatment by other than a **Dental Provider**, his or her employees, or his or her agents. A Plan may designate and authorize out-of-network providers in the absence of an existing in-network provider or provider network.
11. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
12. Claims not submitted to **Dental Plan** within 90 days from the date the procedure was provided.
13. Dental procedures in cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Procedures and services not specifically provided under this **Certificate of Coverage** and procedures and services excluded by **Dental Plan**.
15. Any oral surgical procedures not specifically listed as a covered benefit or for which coverage exists under the medical policy.

Types of Dental Providers:

- **In-Network Dental Provider** – Services as provided in the grid below.
- ***Designated Out-of-Network Dental Provider** – A health plan may designate and authorize out-of-network providers so that at least one dentist is available in each county or major city, if applicable. Services as provided in the grid below.
- **Other Out-of-Network Dental Provider** – When a health plan has an existing network of providers in a particular county or major city, if applicable, and the dental provider that you want to see is neither an In-Network Dental Provider nor a Designated Out-of-Network Dental Provider as described above, services for other Out-of-Network Dental Providers will be paid at 0%. If you are uncertain about whether your preferred dental provider is an in-network provider, designated out-of-network provider, or other out-of-network provider, contact your health plan.

Key Plan Provisions			Covered Services (Examples)
	In-Network Provider	**Designated Out-of-Network Provider***	
Deductible:	$0	$0	

Key Plan Provisions			Covered Services (Examples)
Annual Benefit Max:	$1,000	$1,000	
Diagnostic / Preventive:	100%	75%	• Routine Evaluations • X-Rays • Fluoride
Restorative:	100%	50%	• Fillings
Periodontal:	80%	50%	• Limited to Periodontal Maintenance
Adjunctive Services:	80%	50%	• Local Anesthesia
Orthodontia:	50% (Children Only)	50% (Children Only)	
Ortho Lifetime Max:	$1,500	$1,500	

DIAGNOSTIC/PREVENTATIVE:

ROUTINE ORAL EVALUATION - exams are limited to two per year. Note that comprehensive exams are not done multiple times in a year.

- D0120 Periodic oral evaluation.
- D0145 Oral evaluation for patients under three years of age.
- D0150 Comprehensive oral evaluation – new/established patient or a patient who has been absent from dental care for more than three years; included as one of the two exams per year.
- D0160 Detailed & extensive oral evaluation.
- D0180 Comprehensive perio evaluation – new/established patient; included as one of the two exams per year.

LIMITED ORAL EVALUATION

- D0140 Limited oral evaluation - problem focused.

COMPLETE SERIES OR PANORAMIC FILM: limited to one (either D0210 or D0330) once every 60 months.

- D0210 Intraoral - Complete including bitewings.
- D0330 Panoramic radiographic image.

OTHER XRAYS

- D0220 Intraoral periapical first radiographic image.
- D0230 Intraoral periapical additional radiographic image.
- D0240 Intraoral occlusal radiographic image.

- D0250 Extraoral first radiographic image.
- D0260 Extraoral each additional radiographic image.

BITEWING FILMS - limited to two sets per year.
- D0270 Bitewing single radiographic image.
- D0272 Bitewings two radiographic images.
- D0273 Bitewings three radiographic images.
- D0274 Bitewings four radiographic images.
- D0277 Vertical bitewings 7 to 8 radiographic images.

PROPHYLAXIS (CLEANING) AND FLUORIDE

PROPHYLAXIS: D1110, D1120
- D1110 Prophylaxis (cleaning) – Adult; limited to twice per year.
- D1120 Prophylaxis (cleaning) – Child; limited to twice per year.

FLOURIDE - limited to twice per year up to age 19.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride.

SEALANT
- D1351 Sealant - per tooth; limited to once per lifetime up to age 16, first and second molars only.

SPACE MAINTAINERS - limited to primary teeth lost prematurely.
- D1510 Space maintainer fixed unilateral.
- D1515 Space maintainer fixed bilateral.
- D1520 Space maintainer removable unilateral.
- D1525 Space maintainer removable bilateral.
- D1550 Recementation space maintainer.
- D1555 Removal of fixed space maintainer.

RESTORATIVE:

AMALGAM RESTORATIONS
- D2140 Amalgam filling - one surface.
- D2150 Amalgam filling - two surfaces.
- D2160 Amalgam filling - three surfaces.
- D2161 Amalgam filling – four/more surfaces.

RESIN RESTORATIONS
- D2330 Resin filling - one surface anterior.
- D2331 Resin filling - two surfaces anterior.
- D2332 Resin filling - three surfaces anterior.
- D2335 Resin filling – four/more surfaces anterior.
- D2390 Resin Crown anterior.
- D2391 Resin filling - one surface posterior; benefits limited.
- D2392 Resin filling - two surfaces posterior; benefits limited.
- D2393 Resin filling - three surfaces posterior; benefits limited.
- D2394 Resin filling – four/more surfaces posterior; benefits limited.

MISCELLANEOUS RESTORATIVE
- D2940 Sedative filling; limited to once per lifetime per tooth.
- D2951 Pin retention per tooth; limited to once per tooth.

- D2999 Unspecified restorative procedure by report.

PERIODONTIC:

- D4910 Periodontal maintenance. Coverage is limited to two procedures per one benefit period.

ORAL SURGERY:

Please note that eligible oral surgical procedures are covered under the medical plan when furnished by a Plan Provider.

ADJUNCTIVE SERVICES:

- D9110 Emergency treatment/palliative.
- D9210 Local anesthesia not in conjunction with operative or surgical procedures.
- D9215 Local anesthesia used in conjunction with operative or surgical procedures.
- D9610 Therapeutic parenteral drugs, single administration.
- D9612 Therapeutic parenteral drugs.
- D9910 Application of Desensitizing.
- D9911 Apply desensitizing resin.
- D9930 Treatment of complications.
- D9999 Unspecified adjunctive procedure.
- D9220 General anesthesia – 30 minutes.
- D9221 General anesthesia – 15 minutes.
- D9230 Nitrous oxide sedation.
- D9241 Intravenous sedation analgesia – 30 minutes.
- D9242 Intravenous sedation analgesia – 15 minutes.

ORTHODONTIC SERVICES - limited to age 19, 50% coverage.

- D8010 Limited orthodontic treatment of primary dentition.
- D8020 Limited orthodontic treatment of transitional dentition.
- D8030 Limited orthodontic treatment of adolescent dentition.
- D8040 Limited orthodontic treatment of adult dentition.
- D8050 Interceptive orthodontic treatment of primary dentition.
- D8060 Interceptive orthodontic treatment of transitional dentition.
- D8070 Comprehensive orthodontic treatment of transitional dentition.
- D8080 Comprehensive orthodontic treatment of adolescent dentition.
- D8090 Comprehensive orthodontic treatment of adult dentition.
- D8660 Pre-orthodontic treatment visit; may also be billed out as any combination of D0330, D0340, D0350, and D0470.
- D8680 Orthodontic retention (removal of appliances, construction/placement).
- D8690 Orthodontic treatment (alternative billing to a contract fee).
- D8999 Unspecified orthodontic procedure, by report.
- D9310 Consultation – diagnostic services other than requesting provider.