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

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

Contract by Authorized Board

Commodity or Service:

Medicare Advantage Plans for Medicare-Enrolled Participants in the State of Wisconsin Group Health Insurance and Wisconsin Public Employer Programs

Contract/Request for Proposal No:

ETH0020 - Amendment Number 5

Authorized Board: Group Insurance Board

Contract Period: January 1, 2022 – December 31, 2023 with the option for renewal for one (1) additional two (2) year period.

1. This Contract Amendment Number 5 is entered into by the State of Wisconsin Department of Employee Trust Funds (Department or ETF) on behalf of the State of Wisconsin Group Insurance Board (Board), and **Sierra Health and Life Insurance Company, Inc. dba UnitedHealthcare** (Contractor), whose address and principal officer appear below. The Department is the sole point of contact for the Contract.

2. Whereby the Department agrees to direct the purchase and Contractor agrees to supply the Contract requirements in accordance with the documents specified in the order of precedence below, which are hereby made a part of the Contract by reference.

3. Amendment 2: a) revised Exhibit A – Contract Changes, b) replaced RFP Exhibit 1 – State of Wisconsin Group Health Program Agreement dated August 22, 2018 with the State of Wisconsin Group Health Program Agreement dated November 25, 2019, and c) replaced RFP Exhibit 5 – Department Terms and Conditions dated April 17, 2018 with the Department Terms and Conditions dated June 24, 2020. The parties agreed that Amendment 2 and all changes in Exhibit A dated August 18, 2020, and the revised State of Wisconsin Group Health Program Agreement dated November 25, 2019, as amended by Exhibit A attached hereto, retroactively applied starting January 1, 2020.

4. Amendment 3: a) revised Exhibit A – Contract Changes, b) replaced RFP Exhibit 1 – State of Wisconsin Group Health Program Agreement dated November 25, 2019 with the State of Wisconsin Group Health Program Agreement dated August 1, 2020, and c) replaced RFP Exhibit 5 – Department Terms and Conditions dated June 24, 2020 with the Department Terms and Conditions dated September 8, 2020.

5. Amendment 4: a) revised Exhibit A – Contract Changes, and b) replaced RFP Exhibit 1 – State of Wisconsin Group Health Program Agreement dated August 1, 2020, with the State of Wisconsin Group Health Program Agreement for UnitedHealthcare dated August 16, 2021.

6. This Amendment 5: a) Contract Exhibit 1 – State of Wisconsin Group Health Insurance Program Agreement for UnitedHealthcare for Plan Year 2022 with the release date of August 16, 2021, is replaced with the attached, revised Exhibit 1 – State of Wisconsin Group Health Insurance Program Agreement for UnitedHealthcare for Plan Year 2022 with the release date of January 11, 2022; and b) Contract Appendix 8 – Certificate of Coverage is replaced with the attached, revised Appendix 8 – Certificate of Coverage with the release date of January 11, 2022.

7. For purposes of administering the Contract, the order of precedence is:

   (a) This Contract Amendment Number 5;
   (b) Contract Amendment Number 4 signed by the Board on August 27, 2021;
   (c) Contract Amendment Number 3 signed by the Board on October 1, 2020;
   (d) Contract Amendment Number 2 signed by the Board on August 25, 2020;

(e) Contract Amendment Number 1 signed by the Board on September 7, 2018;
(f) The Contract signed by the Board on May 18, 2018;
(g) The Certification to Health Insurance Issuer for Disclosure of Personal Health Information (PHI) to Department signed by the Contractor on June 1, 2018;
(h) RFP Exhibit 1 – State of Wisconsin Group Health Program Agreement for UnitedHealthcare released January 11, 2022, and all appendices thereto;
(i) Exhibit A – Contract Changes (revised August 16, 2021);
(j) RFP Exhibit 5 – Department Terms and Conditions dated September 8, 2020;
(k) ETF Request for Proposal (RFP) ETH0020 dated October 17, 2017, as revised November 14, 2017; and,
(l) Contractor's proposal dated November 28, 2017.

Contract Number & Service: ETH0020 Amendment Number 5 - Medicare Advantage Plans for Medicare-Enrolled Participants in the State of Wisconsin Group Health Insurance and Wisconsin Public Employer Programs

This Contract Amendment Number 5 shall become effective upon the date of last signature below (the "Effective Date").

State of Wisconsin Department of Employee Trust Funds
Authorized Board: State of Wisconsin Group Insurance Board
By *(Name):* Herschel Day, Chair, Group Insurance Board
Signature: DocuSigned by: A5F7C939CDEE401...
Date of Signature: 1/17/2022
Email ETFsmbProcurement@etf.wi.gov should questions arise regarding this document.

Contractor
Legal Company Name: Sierra Health and Life Insurance Company, Inc.
Trade Name: UnitedHealthcare
Taxpayer Identification Number: 94-0734860
Contractor Address (Street Address, City, State, Zip): UnitedHealthcare Insurance Company 185 Asylum Street Hartford, CT 06103-3408
Name & Title (print name and title of person authorized to legally sign for and bind Contractor): Greta Redmond, Vice President, FSA, MAAA
Signature: DocuSigned by: Greta Redmond 91B75BB7AF80488...
Date of Signature: 1/14/2022

State of Wisconsin
Group Health Insurance Program
Agreement for UnitedHealthcare

Plan Year 2022

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

Release Date: January 11, 2021

TABLE OF CONTENTS

I. Definitions

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

ACCESS PLAN means the plan design option available to active EMPLOYEES and their DEPENDENTS that provides broad statewide and nationwide access to PROVIDERS and includes in- and out-of-network benefits.

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

ANNUITANT, when not otherwise specified, means a retired EMPLOYEE of the State of Wisconsin or a participating LOCAL EMPLOYER.

BENEFITS means those items and services provided for by the CERTIFICATE OF COVERAGE.

BOARD means the Group Insurance Board.

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

CERTIFICATE OF COVERAGE means the document, appended to this AGREEMENT, that specifies the UNIFORM BENEFITS and services applicable to PARTICIPANTS of the GROUP HEALTH INSURANCE PROGRAM.

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

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

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

DAY means calendar day unless otherwise indicated.

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

DEPENDENT is as defined in the CERTIFICATE OF COVERAGE.

EMPLOYEE
When not specified, EMPLOYEE or EMPLOYEES means STATE EMPLOYEE and LOCAL EMPLOYEE.

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

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

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

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

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

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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) is as defined in the CERTIFICATE OF COVERAGE.

HOSPITAL is as defined in the CERTIFICATE OF COVERAGE.

IN-NETWORK refers to a provider who has agreed in writing to provide, prescribe or direct health care services, supplies or other items covered under UNIFORM BENEFITS to PARTICIPANTS. The provider's written participation agreement with a CONTRACTOR must be in force at the time such services, supplies or other items covered under UNIFORM BENEFITS are provided to a PARTICIPANT. The CONTRACTOR agrees to give PARTICIPANTS lists of affiliated providers. Some providers require prior authorization by the CONTRACTOR in advance of the services being provided.

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

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

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

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

PHARMACY BENEFIT MANAGER (PBM) as defined in UNIFORM BENEFITS.

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

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

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

STATE means the State of Wisconsin.

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

UNIFORM BENEFITS means the BENEFITS described in the CERTIFICATE OF COVERAGE that are administered to PARTICIPANTS.

II. Statutory & Board Authority

A. Statutory & Legal Authority

The HEALTH INSURANCE PROGRAM is established by Chapter 40, Subchapter IV of Wisconsin Statutes (Wis. Stats. §40.51). The DEPARTMENT administers the HEALTH BENEFIT PROGRAM on behalf of the BOARD. The CONTRACTOR must meet the minimum requirements of Chapter 40, other applicable state and federal laws, and the requirements in this AGREEMENT.

The CONTRACTOR is subject to the provisions of Wis. Stats. Chapter 40 and the administrative rules of the DEPARTMENT. The CONTRACTOR will also be subject to all applicable federal laws currently in force, as well as any new legislation passed during the term of the AGREEMENT.

B. Board Authority

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

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

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

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

III. Program Administration

A. Enrollment & Eligibility Maintenance

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

1. Eligibility

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

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

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

d) The CONTRACTOR must resolve all enrollment discrepancies between the DEPARTMENT'S database and the CONTRACTOR'S database in addition to the exception report described below within one (1) BUSINESS DAY of being notified by the DEPARTMENT of such a discrepancy or identification by the CONTRACTOR.

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

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

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

h) The daily and full file compare of the DEPARTMENT'S HIPAA 834 enrollment files must be fully tested and ready for program operation no later than forty-five (45) calendar DAYS prior to the start of OPEN ENROLLMENT or another date as defined by the DEPARTMENT.

2. Enrollment

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

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

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

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

3. Errors

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

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

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

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

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

4. Identification (ID) Cards

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

b) The CONTRACTOR must issue new ID cards upon enrollment and following BENEFIT changes that impact the information printed on the ID cards.

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

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

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

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

5. Enrollment & Eligibility Information for PARTICIPANTS

a) The CONTRACTOR must provide the following information, at a minimum, to PARTICIPANTS upon enrollment:
   i. Information about PARTICIPANT responsibilities and plan requirements, including prior authorizations and referrals.
   ii. Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website and directions on how to request a printed copy of the provider directory.
   iii. Directions on how to change the PARTICIPANT'S Primary Care Provider or Primary Care Clinic.
   iv. The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, telehealth services, and website address.

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

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

6. Coverage Termination & Continuation

a) 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. The CONTRACTOR shall bill the continuing PARTICIPANT directly for the required PREMIUM.

b) The CONTRACTOR must provide the SUBSCRIBER, upon the SUBSCRIBER'S request, written notification of how to enroll in a conversion policy set forth in Wis. Stats. § 632.897, and/or a Marketplace plan, in the event of termination of employment. Upon discovery, the CONTRACTOR must report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS. The CONTRACTOR must provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT.

B. PREMIUM

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

1. Services Included in Premium

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

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

2. PREMIUM Payments from the DEPARTMENT

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

b) The CONTRACTOR shall support ACH payments of premium by the DEPARTMENT.

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

3. Direct Pay PREMIUMs

a) The CONTRACTOR must collect PREMIUMS directly from certain SUBSCRIBERS identified by the DEPARTMENT. The applicable portion of PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. When coverage is continued, the CONTRACTOR shall bill the CONTINUANT directly for required PREMIUMS.

b) The CONTRACTOR must allow SUBSCRIBERS to submit direct pay PREMIUM payments via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving written notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first.

4. PREMIUM Payments for Surviving DEPENDENTS

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

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

5. SUBSCRIBER Nonpayment of PREMIUMS

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

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

6. LOCAL EMPLOYER Group Program Participation

a) The CONTRACTOR must provide coverage for both STATE and LOCAL PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

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

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

C. Rate Setting

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

1. Annual Rate Bidding Process (for MEDICARE ADVANTAGE see Section V.III.C.1 below)

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

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

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

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

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

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

g) Rates shall be uniform statewide for each separate plan. CONTRACTORS may submit different rates which result from separate plans with mutually exclusive provider networks. Each network

will be separately held to the Provider Access standards described in Section III.F. Provider Access.

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

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

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

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

l) Rates may not exceed the calculated rate in the utilization data submission without written justification.

m) The CONTRACTOR must provide coverage and rates for the following PREMIUM categories allowed by the BOARD:
   i. Individual (EMPLOYEE Only)
   ii. Family (EMPLOYEE Plus Eligible DEPENDENTS)
   iii. Family rates (regular coverage) must be 2.5 times the individual rate

n) The CONTRACTOR must provide coverage and rates for the following HEALTH BENEFIT PROGRAM options:
   i. Program Option 01 (STATE $250 deductible health plan and high-deductible health plan)
   ii. Program Option 02/12 (LOCAL Traditional Plan)
   iii. Program Option 04/14 (LOCAL Deductible Plan)
   iv. Program Option 06/16 (LOCAL Health Plan)
   v. Program Option 07/17 (LOCAL HDHP)

o) The CONTRACTOR must offer the following Medicare coordinated coverage for the program options allowed by the BOARD:
   i. Individual: Individual rates must be justified by experience and may not exceed the calculated rate in the utilization data submission without written justification. Rates may not exceed 50% of the single rate for regular, non-Medicare coverage, unless the BOARD's consulting actuary determines that percentage to be lower.
   ii. Family 2 (all insureds under Medicare): Medicare Family 2 eligible rates shall be twice the individual Medicare coordinated rate.

iii. Family 1 (at least 1 under Medicare, at least 1 other not under Medicare): Medicare Family 1 rates shall be the sum of the individual rate for regular coverage and the individual rate for Medicare-eligible coverage.

p) The CONTRACTOR must provide rates for Graduate Assistants, regardless of geographic area of operation, as follows:
   i. Individual: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate.
   ii. Family: Family rate must be within a range of 65% to 75% of the family regular coverage rate.

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

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

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

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

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

2. Prohibited Fees

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

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

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

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

3. Quality

a) The CONTRACTOR must collect Healthcare Effectiveness Data and Information Set (HEDIS) measures and administer the Consumer Assessment of Healthcare Providers and Systems

(CAHPS) survey as specified by the National Committee for Quality Assurance (NCQA) guidelines. Upon request by the DEPARTMENT, the CONTRACTOR shall provide information about subcontractors used to audit the HEDIS results and administer the CAHPS survey.

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

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

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

D. Data & Information Security

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

1. Information Systems

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

b) The CONTRACTOR shall verify and commit that during the length of the CONTRACT, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. Examples of a major system change include a new platform for enrollment, claims payment or data submission system. This does not apply to any program fixes, modifications and enhancements. If the CONTRACTOR has plans to migrate to a different data or web platform, the DEPARTMENT must be notified no less than six (6) months in advance of the migration.

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

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

e) The CONTRACTOR'S staff must be trained and follow SECURE computing best practices. Wireless networks must be protected using strong encryption and password policies. Connectivity to all networks, wired or wireless, must be protected from unwanted/unknown connections.

f) All data backups must be handled or transmitted SECURELY. Offsite storage must be audited for compliance (i.e. physical security, all used tapes are accounted for). A business recovery plan must be documented and tested annually, at a minimum, by the CONTRACTOR, and submitted to the DEPARTMENT within sixty (60) calendar DAYS following the end of each calendar year.

2. Information Systems Security Audit

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

b) Upon request from the DEPARTMENT, the CONTRACTOR shall furnish the DEPARTMENT with a copy of an independent service auditor's report.

c) The DEPARTMENT's preferred annual attestation is an SSAE No. 18 (SOC 2, Type 2) audit report. SOC 2, Type 2 requirements are outlined in Section 6.2 and Section 28.0(3) of the Department Terms and Conditions.

d) The SOC 2, Type 2 audit shall include all programs under the CONTRACT and be conducted at the CONTRACTOR'S expense.

e) The CONTRACTOR shall determine which of the five SOC 2, Type 2 Trust Services Criteria (TSC) are applicable to the CONTRACTOR'S overall book of business. The DEPARTMENT does not require a specific number or configuration of TSCs. The five TSCs are:
   i. Security
   ii. Availability
   iii. Processing Integrity
   iv. Confidentiality
   v. Privacy

f) If the Contractor's SSAE 18 (SOC 2, Type 2) audit covers less than twelve (12) months of a calendar year, the CONTRACTOR will provide a bridge letter to the DEPARTMENT, stating whether processes and controls have changed since the SSAE 18 (SOC 2, Type 2) audit.

g) The CONTRACTOR may submit one or more of the following documents to the DEPARTMENT in lieu of a SOC 2, Type 2 audit report:
   i. Independent attestation of certification, including but not limited to:
      a. HITRUST Certification; or
      b. International Standards Organization (ISO) / International Electrotechnical Commission (IEC) 27001 Certification; or
      c. NIST800-53 compliance or certification/accreditation; or
      d. CIS Critical Security Controls for Effective Cyber Defense compliance; or
      e. HIPAA Security Rule - 45 CFR Part 155 and Subparts A and C of Part 164
   ii. Information Security Plan scope statement; or
   iii. An alternate submission, comprised of one or more documents, previously submitted and mutually agreed upon between the CONTRACTOR and the DEPARTMENT.

h) If the CONTRACTOR is unable to produce one of the above documents, the CONTRACTOR may satisfy the requirement by providing the assurances to the requirements outlined in Section 28.0(h) of the Department Terms and Conditions.

i) The DEPARTMENT reserves the right to require the CONTRACTOR to provide more than one of the documents outlined above.

j) The CONTRACTOR must submit a letter of attestation indicating the CONTRACTOR's receipt of management's assertion of control compliance from the CONTRACTOR'S subcontractors, as outlined in Section 6.22 of the Department Terms and Conditions.

3. Data Integration and Technical Requirements

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

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

4. Data Integration and Use

a) The CONTRACTOR shall provide all data and other information related to this AGREEMENT as needed in the file format specified by the DEPARTMENT. The CONTRACTOR shall place no restraints on the use of the data; provided that the DEPARTMENT shall not disclose to third parties any data received from the CONTRACTOR that constitutes a trade secret as defined under Wisconsin law.

b) The CONTRACTOR shall also provide data at the request of the DEPARTMENT, to a DEPARTMENT designee for purposes of assisting in the implementation and management of disease management programs or other programs desired by the BOARD.

c) Using the most recent file and data specifications provided by the DEPARTMENT, the CONTRACTOR shall fully incorporate available pharmacy claims data into data reporting, including, but not limited to:
   i. HEDIS data;
   ii. Wisconsin Health Information Organization (WHIO) claims data;
   iii. Information requested on the DEPARTMENT'S disease management program survey;
   iv. Catastrophic claims data;
   v. Other data as required by the DEPARTMENT. Where appropriate, such as for the catastrophic claims data report, the CONTRACTOR shall separate out pharmacy claims from the DEPARTMENT'S PBM from any pharmacy claims that are paid by the CONTRACTOR.

d) The CONTRACTOR agrees to use the identification (ID) numbers established by the DEPARTMENT for both the group and the SUBSCRIBER. ID numbers must not correlate to Social Security numbers. Social Security numbers shall be incorporated into the PARTICIPANT'S data file and may be used for identification purposes only and not disclosed and used for any other purpose, unless the parties have agreed upon a different identification system. The CONTRACTOR must keep a record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit, unique member ID number that is assigned by the DEPARTMENT. Any costs incurred by the DEPARMENT because of CONTRACTOR'S failure to comply with this requirement will be paid by the CONTRACTOR.

e) In addition to data transfers to the DEPARTMENT's data warehouse, the CONTRACTOR's data transfers shall include, but will not be limited to:
   i. Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and

integrate the data as required later in this section. The file shall be in a file format compliant with the most recent Pharmacy Data Specifications provided by the DEPARTMENT in consultation with the PBM. If directed by the DEPARTMENT, the CONTRACTOR shall establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse.

ii. Wellness and Disease Management Data – The CONTRACTOR must be able to accept and accommodate a weekly file from the DEPARTMENT's wellness and disease management vendor that includes data for the CONTRACTOR'S PARTICIPANTS and integrate that data into the CONTRACTOR'S medical management program. This data may include results from biometric screenings, health risk assessments, and unique PARTICIPANT information regarding enrollment in wellness health coaching and/or disease management programs. The file format must comply with the most recent Wellness Data Specifications as provided by the DEPARTMENT.

iii. WHIO Data – The CONTRACTOR shall submit all claims (except Medicaid) data to WHIO for the CONTRACTOR'S commercial and Medicare covered lives residing in Wisconsin at a minimum. CONTRACTOR shall submit claims to WHIO in a manner compliant with WHIO requirements.

f) For data transfers between vendors of STATE and LOCAL programs not specified in this AGREEMENT, the CONTRACTOR shall establish vendor to vendor data transfers within ninety (90) calendar DAYS of written notification from the DEPARTMENT to do so. Such data shall be accurate, complete and timely. The CONTRACTOR shall not place restrictions on the use of the data provided to the STATE and LOCAL program vendors.

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

5. Data Warehouse File Requirements

a) The CONTRACTOR shall comply with the DEPARTMENT'S specifications for submission of the required data in the formats attached to this AGREEMENT, and as updated by the DEPARTMENT. To comply with the data submission requirements, the CONTRACTOR shall follow the specified data file layout and formatting of all data elements within the specified data file layout and the DEPARTMENT'S specifications for data filtering and extraction. All file formats are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM.

b) Data submitted by the CONTRACTOR to the DEPARTMENT'S data warehouse shall include all the following:

i. Data on payments for BENEFITS provided to PARTICIPANTS under this AGREEMENT. Payment data shall include claim payments made or denied, capitation or per-member

payments, administrative payments, and payments made after coordinating responsibility with third parties.

ii. Data on other financial transactions associated with claim payments, including charged amount, allowed amount, per-claim rebates, discounts, payments made by third-party insurance, including Medicare, and charges to members as co-payments, coinsurance, and deductibles.

iii. Data on the providers of BENEFITS provided under this AGREEMENT.

iv. Data for all claims processed for PARTICIPANTS, as specified by the DEPARTMENT.

v. Data for all IN-NETWORK providers including subcontracted providers, as specified by the DEPARTMENT.

vi. Other data, as specified by the DEPARTMENT.

c) Data submitted to the DEPARTMENT's data warehouse shall meet all the following requirements:

i. The CONTRACTOR shall submit, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS.

ii. The CONTRACTOR shall submit, in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK providers including subcontracted providers.

iii. The claim adjustment data the CONTRACTOR submits shall follow the logic the DEPARTMENT's data warehouse vendor defines in the data specifications.

iv. A unique person/member identifier is required on all data files and the identifier shall match the person identifier on the DEPARTMENT'S eligibility file.

v. On all files, the CONTRACTOR shall supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES), if applicable.

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

e) The CONTRACTOR shall submit the required data monthly, or other frequency agreed upon by the CONTRACTOR and the DEPARMENT. Specifically:

i. All data for claims paid in the previous month shall be submitted in the correct file layout to the DEPARTMENT'S data warehouse. The file shall be submitted to the data warehouse vendor on the date approved by the DEPARTMENT.

ii. All network provider enrollment data for the previous month shall be submitted to the DEPARTMENT'S data warehouse in the correct file layout. The file shall be submitted to the data warehouse vendor on the date approved by the DEPARTMENT.

f) The CONTRACTOR shall communicate any delays in submitting the required program data to the DEPARTMENT'S data warehouse vendor via email to the DEPARTMENT Program Manager or

designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) BUSINESS DAY before the scheduled transfer as described above.

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

h) The DEPARTMENT shall charge the CONTRACTOR a penalty for each data file submitted after the deadlines established above. For files that are delayed by no more than five (5) calendar DAYS and for which CONTRACTOR provided the DEPARTMENT with notice of delay at least one (1) BUSINESS DAY prior to the scheduled transfer date, the penalty shall be waived.

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

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

6. Data Warehouse File Submission Quality

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

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

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

d) During the onboarding of a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data as described in subsection a) above to the DEPARTMENT's data warehouse. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor. During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT's data warehouse vendor notifies the CONTRACTOR of an error on its initial data submission, as described in 6.a above, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor.

e) The penalties assessed in Section D and Section IV do not apply to the penalty maximum described in Section L. See Section IV for data warehouse deliverable and penalty details.

E. Communications

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

1. Open Enrollment Materials

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

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

c) The CONTRACTOR shall submit the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the annual OPEN ENROLLMENT period:
   i. CONTRACTOR contact information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number (if applicable), and website address.
   ii. Content for the CONTRACTOR'S plan description page, including available features.
   iii. Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory.

d) The CONTRACTOR shall submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval prior to distribution by the CONTRACTOR.

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

2. Informational / Marketing Materials

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

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

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

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

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

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

3. CONTRACTOR Web Content and Web-Portal

a) The CONTRACTOR must host a website providing dedicated HEALTH BENEFIT PROGRAM web content (that may be provided via a microsite that meets all criteria below) and a web-portal. Web content will provide basic HEALTH BENEFIT PROGRAM information. The CONTRACTOR'S

web-portal will be used to present and track PARTICIPANT level information, such as claim status and BENEFIT accumulation.

b) The CONTRACTOR must host and maintain customized web content and a web-portal dedicated to PARTICIPANTS.

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

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

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

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

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

h) The CONTRACTOR'S web-portal must be SECURED with a minimum of SHA2-256 (or similar system such as SHA-256 as approved by the DEPARTMENT) bit EV certificates to provide the latest in encryption and cryptography.

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

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

k) After CONTRACTOR'S initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website and web-portal test environment for the DEPARTMENT'S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website and web-portal.

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

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

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

o) Basic information must be available on the CONTRACTOR'S website without requiring login credentials, including:
   i. General information about the HEALTH BENEFIT PROGRAM and other programs offered by the BOARD;
   ii. Directions on how to access the HEALTH BENEFIT PROGRAM provider directory and Summary of Benefits and Coverage (SBC);
   iii. Information about PARTICIPANT HEALTH BENEFIT PROGRAM requirements, including prior authorizations and referrals;
   iv. Ability for PARTICIPANTS to submit questions via the CONTRACTOR'S website; and,
   v. Contact information including the CONTRACTOR'S dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and mailing address.

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

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

r) The CONTRACTOR'S data center network shall include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of midnight and 5:00 a.m. CST/CDT or another time agreed to by the DEPARTMENT Program Manager, and must be scheduled in advance with a

notification on the CONTRACTOR'S website/web-portal dedicated to the HEALTH BENEFIT PROGRAM. Unscheduled disruption to the availability of the website or web-portal must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

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

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

u) The CONTRACTOR must have web-portal content and functionality updated, tested and approved by the DEPARTMENT Program Manager or designee at least fourteen (14) calendar DAYS prior to the benefit period start date. The web-portal will SECURELY authenticate the user. After the user is authenticated, all web-portal features must be available without the need for an additional login. Available features must include:
    i. Username and password creation and recovery;
    ii. Enrollment confirmation;
    iii. Secure upload functionality for submitting program required documentation;
    iv. Communication functions that allow users to submit SECURE questions to the CONTRACTOR and allow the CONTRACTOR to push general and targeted communications to users via United States Postal Service mail, e-mail, text and other standard communication vehicles, as requested by the DEPARTMENT; and,

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

F. Provider Access

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

1. Provider Access Standards

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

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

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

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

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

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

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

2. OUT-OF-NETWORK Services

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

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

3. Continuity of Care

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

b) At least thirty (30) calendar DAYS (or as soon as is practicable) prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR must:
   i. Send written notification to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information:
      a. How to find a new IN-NETWORK provider or facility;
      b. The continuity of care provision as it relates to this situation; and,
      c. Contact information for questions.
   ii. Update the provider directory on the CONTRACTOR'S website.

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

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

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

G. Care Management

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

1. DEPARTMENT Initiatives

a) The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives upon request by the DEPARTMENT. DEPARTMENT Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS.

The CONTRACTOR may coordinate with HOSPITALS, provider groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.

b) The current DEPARTMENT Initiatives are:
   i. Care Coordination – The CONTRACTOR must ensure care coordination is offered for PARTICIPANTS with high-risk health condition(s) by conducting outreach within three (3) to five (5) BUSINESS DAYS of a PARTICIPANT'S initial discharge from an INPATIENT HOSPITAL stay of more than twenty-four (24) hours.
   ii. High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.
   iii. Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis 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 or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.
   iv. Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion.
   v. Advance Care Planning (ACP) / Palliative Care – The CONTRACTOR must provide a credible ACP program that includes hospice care and palliative care. The CONTRACTOR must ensure ACP conversation(s) and/or palliative care consultation(s) are offered to all PARTICIPANTS with a serious disease and/or a likely survival of less than twelve (12) months.
   vi. Monitoring of Potentially Low-Value Services – The CONTRACTOR must provide reporting on select services identified by the DEPARTMENT as potentially low value to PARTICIPANTS. The DEPARTMENT will develop the list of services to be studied on an annual basis. The CONTRACTOR will provide analysis of the utilization of services and potential impact of alternate care pathways.

2. Primary Care Provider/Clinic Designation

a) If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP that is not IN-NETWORK with the selected CONTRACTOR, the CONTRACTOR shall notify the SUBSCRIBER within five (5) BUSINESS DAYS of the DEPARTMENT'S transmission of the enrollment data, and aid the person in selecting an IN-NETWORK PCP.

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

3. Care & Disease Management

a) The CONTRACTOR will apply effective methods for containing costs for medical services, HOSPITAL confinement or other BENEFITS to be provided with effective peer and utilization review mechanisms for monitoring health care costs.

b) The CONTRACTOR must offer complex case management programming to PARTICIPANTS. The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data at stated in Section D. 3. above and in Section 4 of Certificate of Coverage.

c) The CONTRACTOR shall use the PARTICIPANT level data from DEPARTMENT'S wellness and disease management vendor to identify PARTICIPANTS appropriate for complex/chronic case management and enroll PARTICIPANTS in such programs.

d) To the extent that the CONTRACTOR offers disease management programming, the CONTRACTOR must make attempts to coordinate that programming with the DEPARTMENT'S wellness and disease management vendor.

4. Pilot Programs

a) At the request of the DEPARTMENT, the CONTRACTOR may offer a pilot or limited-term trial to PARTICIPANTS.

b) Pilot programs cannot include financial or other incentives for participation unless approved by the DEPARTMENT.

c) The CONTRACTOR must provide a pilot proposal to the DEPARTMENT that includes a plan for evaluating the outcomes of the pilot; the CONTRACTOR must report annually to the DEPARTMENT on the progress and outcomes of the pilot.

d) Guidance for submitting pilot programs and criteria for evaluation and approval will be determined by the DEPARTMENT.

H. Administrative Services & Supports

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

1. Account Management and Staffing

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

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

available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT.

c) The CONTRACTOR'S Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

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

e) The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. Key staff are staff in positions of executive or managerial responsibility and/or whose performance affects the services provided under this AGREEMENT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the CONTRACTOR'S key staff, which the DEPARTMENT will share with EMPLOYERS.

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

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

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

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

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

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

2. Claims

a) Targets for claims processing performance standards and associated penalties are specified in Section IV. M.

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

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

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

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

3. Customer Service

a) The CONTRACTOR shall operate a customer service department for the HEALTH BENEFIT PROGRAM during normal CONTRACTOR business hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT, except official State of Wisconsin holidays as listed under Wis. Stat. §230.35(4)(a). The CONTRACTOR must report its standard customer service department hours of operation and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARMENT. The CONTRACTOR must report any unanticipated CONTRACTOR customer service closures promptly to the DEPARTMENT in the format specified by the DEPARTMENT.

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

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

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

e) The CONTRACTOR must monitor and report to the DEPARTMENT on the performance standards for the HEALTH BENEFIT PROGRAM that include call answer timeliness and call abandonment rate. Targets for the customer service performance standards and associated penalties are specified in Section IV. Performance Standards & Penalties.

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

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

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

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

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

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

4. Incentives

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

5. Recovery of Overpayments

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

6. Subrogation and Other Payers

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

7. Gifts and/or Kickbacks Prohibited

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

8. Notice of Significant Events

a) The CONTRACTOR shall notify the DEPARTMENT Program Manager in writing of any "Significant Event" within ten (10) calendar DAYS after the CONTRACTOR becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect on the CONTRACTOR'S ability to meet its obligations under this AGREEMENT, including, but not limited to, any of the following:
   i. Disposal of major assets;
   ii. Loss of fifteen percent (15%) or more of the CONTRACTOR'S membership;
   iii. Termination or modification of any contract or subcontract if such termination or modification will have a material effect on the CONTRACTOR'S obligations under this AGREEMENT;

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

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

c) The DEPARTMENT and the BOARD agree to keep the information disclosed as required above confidential under Wis. Stat. § 19.36 (5) of the Wisconsin Public Records Law until the earliest of one of the dates noted in item d) below, unless:
i. The CONTRACTOR waives confidentiality, or
ii. A court orders the DEPARTMENT or BOARD to disclose the information, or
iii. The DEPARTMENT or BOARD determines that, under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records.

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

e) Information disclosed by a CONTRACTOR concerning any change in ownership or controlling interest, any merger, or any acquisition of another entity will be disclosed by the DEPARTMENT as a public record beginning on the earliest of the following dates:
i. The date the pending change in ownership or controlling interest, any merger or any acquisition of another entity becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.
ii. The date such action becomes effective.
iii. Sixty (60) calendar DAYS after the DEPARTMENT receives the information.

9. Bonding, Reinsurance & Insolvency

a) The CONTRACTOR shall maintain appropriate bonding and/or reinsurance and shall submit documentation evidencing such upon request by the DEPARTMENT. The appropriate bonding

and/or reinsurance ensures that, in the event the CONTRACTOR becomes insolvent or otherwise unable to meet the financial provisions of the CONTRACT, bonding or reinsurance exists to pay those obligations.

b) Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT confined as an INPATIENT, BENEFITS shall continue until:
   i. the confinement ceases;
   ii. the attending physician determines confinement is no longer medically necessary;
   iii. the end of 12 months from the date of insolvency; or
   iv. the contract maximum is reached, whichever occurs first.

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

d) In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a "Significant Event," a significant loss of primary providers and/or hospitals, or no longer meets the minimum provider access standards defined under Wis. Stat. § 609.22 and Wis. Admin. Code INS 9.32, and included in Section III.F.1. Provider Access Standards, or if the BOARD so directs due to a "Significant Event," the BOARD may do any of the following, including any combination of the following:
   i. Terminate the CONTRACT upon any notice it deems appropriate, including no notice.
   ii. Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR change to another benefit plan.
   iii. Authorize a special enrollment period so that a SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR may voluntarily change to another benefit plan.
   iv. Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.
   v. Require that prior to making a selection between benefit plans, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.
   vi. Take no action.

10. Contract Termination

a) In the event the CONTRACT is terminated by the CONTRACTOR, the CONTRACTOR shall continue to cover BENEFITS for any PARTICIPANT who is admitted to a HOSPITAL as an INPATIENT on the date of CONTRACT termination until the earliest of the following dates:
   i. The BENEFIT maximum is reached;
   ii. The attending physician determines that INPATIENT confinement in a hospital is no longer medically necessary;
   iii. The end of twelve (12) months after the date of CONTRACT termination; or
   iv. The PARTICIPANT'S confinement ends.

b) If the BOARD terminates the CONTRACT, all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in

attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the CONTRACT termination date. Such arrangements may include, but are not limited to, transferring the patient to another facility or permitting OUT-OF-NETWORK providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.

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

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

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

f) See Section 16.0 of the Department Terms and Conditions for additional requirements related to CONTRACT termination.

11. Transition Plan

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

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

12. Expert Services

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

b) The CONTRACTOR shall also have legal and technical staff available to the DEPARTMENT for consultation as needed for program administration, and for assistance with any appeals processes. The CONTRACTOR shall monitor the development of and provide notification and

information to the DEPARTMENT in a timely manner concerning state or federal regulations or legislation that may affect the HEALTH BENEFITS PROGRAM.

13. Mailing & Postage

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

I. Grievances & Appeals

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

1. Grievance Process Overview

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

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

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

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

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

2. Claim Review

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

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

3. PARTICIPANT Notice

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

4. Investigation and Resolution Requirements

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

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

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

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

b) If the PARTICIPANT disagrees with the grievance committee’s final decision, the PARTICIPANT may submit a written request for review to the DEPARTMENT within sixty (60) calendar DAYS of the date of the final grievance decision letter. The DEPARTMENT will review and communicate the outcome of the review to the PARTICIPANT. If the PARTICIPANT disagrees with the outcome, and the grievance committee’s final decision is not eligible for external review, they may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within sixty (60) calendar DAYS of the date of the DEPARTMENT’S final review letter.

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

d) The DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, or the rescission of a policy or certificate that can be resolved through the external review process under applicable federal or STATE law. See Section III.I.6. External Review, below.

e) If the PARTICIPANT disagrees with a determination by the DEPARTMENT, the PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and . This process may include an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative reviews, including administrative hearings, requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with the guidelines, rules, and regulations promulgated by the DEPARTMENT.

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

6. External Review

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

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

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

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

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

7. Provision of Complaint Information

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

b) Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolve disputes or to formulate determinations. Such information must be provided to the DEPARTMENT at no charge within fifteen (15) BUSINESS DAYS of the DEPARTMENT'S request, or by an earlier date as requested by the DEPARTMENT.

8. DEPARTMENT Request for Grievance

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

9. Notification of Legal Action

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

10. Compliance with Departmental Determinations (for MEDICARE ADVANTAGE, see Section V.III.I.1)

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

J. Audits & Disclosure Requirements

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

1. Audit and Other Services

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

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

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

d) The CONTRACTOR shall address any areas for improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. The BOARD shall be notified of all identified areas for improvement and the status of all improvements as necessary.

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

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

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

h) The CONTRACTOR shall submit financial stability documentation to the DEPARTMENT on an annual basis, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles).

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

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

2. Examination of Records

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

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

   i. Keep confidential and properly safeguard each "medical record" and all "personal information," as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;
   ii. Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,
   iii. Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record, provided by the DEPARTMENT to the CONTRACTOR, that would violate Wis. Stat. § 40.07 (1) or (2).

3. Record Retention

a) The DEPARTMENT and the BOARD shall have the right to examine any of the CONTRACTOR'S pertinent records or other documentation and those of any parent, affiliate, or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the CONTRACTOR involving transactions related to this AGREEMENT, until the expiration of seven (7) years after the termination of the CONTRACT and any extensions.

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

c) The CONTRACTOR shall accurately maintain records for seven (7) years after the termination of the CONTRACT. This requirement shall supersede the period set forth in Section 37.0 of the Department Terms and Conditions.

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

4. Requirement to Review Providers

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

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

K. Reporting Requirements

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

1. Reporting Requirements

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

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

c) The DEPARTMENT reserves the right to modify reporting requirements or frequency as deemed necessary to monitor the CONTRACT and programs. The CONTRACTOR must comply with such

changes within forty-five (45) calendar DAYS, or another timeframe as approved by the DEPARTMENT. Instructions and specific due dates will be provided by the DEPARTMENT annually.

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

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

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

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

2. Reporting on Compliance with Federal Mandates

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

b) Reporting on compliance will, at minimum, provide evidence that the CONTRACTOR has met the requirements of the compliance activities. Additional information may be required by the DEPARTMENT based upon the type of compliance activity being reported.
   i. Specifically pertaining to the transparency requirements set forth in the Consolidated Appropriations Act of 2021, the CONTRACTOR must attest annually that transparency-related requirements have been met beginning with each compliance year specified by the Act and rules as they are drafted by federal authorities. The CONTRACTOR must also make compliance reports required by the Act specific to Mental Health Parity available to the DEPARTMENT upon request, and in the event that reporting is required by the federal government. The CONTRACTOR must also notify the DEPARTMENT if any aspect of the DEPARTMENT's HEALTH BENEFIT PROGRAM design or administrative requirements create risks to compliance.

IV. Performance Standards & Penalties

This section contains the performance standards and associated penalties for the services contained in this AGREEMENT.

A. Performance Standards & Penalties

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

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

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

B. Deliverable Reporting Requirements

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

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

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

C. Penalty Assessments

1. The total penalties assessed to CONTRACTOR in Section IV and Section V shall not exceed three percent (3%) of the CONTRACTOR'S total medical premium in any given quarter.

2. The data warehouse penalties assessed in Section III.D and Section IV.J - L are not subject to an assessment maximum in any given quarter.

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

D. Administrative Deliverables

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

1) Approval of Communications	
Description	The CONTRACTOR shall receive pre-approval from the DEPARTMENT of all communication materials specified by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS participating in the HEALTH BENEFIT PROGRAM. This includes written and electronic communication, such as marketing collateral, informational notices, standard letters, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections III.E.2. Informational / Marketing Materials and III.E.3. CONTRACTOR Web Content and Web-Portal.)*
Frequency	As needed, certified QUARTERLY
2) Assignment of Primary Care Provider (PCP) or Primary Care Clinic (PCC)	
Description	If a PARTICIPANT does not choose a PCP/PCC, or the PCP/PCC is no longer available, the CONTRACTOR shall assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC. *(See Section III.G.2 Primary Care Provider/Clinic Designation and Certificate of Coverage.)*
Frequency	As needed
3) Coordination of Benefits (COB) Report	
Description	The CONTRACTOR shall collect from SUBSCRIBERS COB information necessary to coordinate BENEFITS under Wis. Admin. Code §3.40 and report this information to the DEPARTMENT as needed. *(See Section III.A.2. Enrollment.)*
Frequency	As needed
4) Enrollment Discrepancy Tracker	
Description	The CONTRACTOR shall maintain an exception report spreadsheet that includes the error details and final resolution and submit it to the DEPARTMENT. *(See Section III.A.1. Eligibility.)*
Frequency	As directed by the DEPARTMENT
5) External Review Request Notification	
Description	Within five (5) DAYS of the CONTRACTOR'S receipt of a PARTICIPANT'S request for external review, the CONTRACTOR shall notify the DEPARTMENT of the request in the format specified by the DEPARTMENT. *(See Section III.I.6. External Review.)*
Frequency	See description

6) External Review Determination	
Description	Within fourteen (14) DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR shall notify the DEPARTMENT of the outcome. Within thirty (30) DAYS, the CONTRACTOR must provide a redacted copy of the determination to the DEPARTMENT. *(See Section III.I.6 External Review.)*
Frequency	See description
7) Identification (ID) Cards (for MEDICARE ADVANTAGE see Section V.IV)	
Description	The CONTRACTOR shall provide PARTICIPANTS with ID cards indicating, at a minimum, the effective date of coverage, and the emergency room and office visit copayment amounts, if applicable. *(See Section III.A.4. Identification (ID) Cards.)*
Frequency	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
8) ID Card Issuance Delay Notification	
Description	The CONTRACTOR shall notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section III.A.4. Identification (ID) Cards.)*
Frequency	Upon identification of issue
9) Key Contacts Listing (ET-1728)	
Description	The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section III.H.1 Account Management and Staffing.)*
Frequency	January, April, July, October
10) Major Administrative and Operative System Changes	
Description	The CONTRACTOR shall submit written notice to the DEPARTMENT at least one hundred eighty (180) DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM. *(See Section III.D.1. Information Systems.)*
Frequency	As needed
11) Medicare Enrollment Denial	
Description	The CONTRACTOR shall notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare. (*See Certificate of Coverage.)*
Frequency	See description
12) Notification of Account Manager or Key Staff Changes	
Description	The CONTRACTOR shall notify the DEPARTMENT via ETFSMBInsuranceSubmit@etf.wi.gov and the Health Program Manager if the Account Manager, backup or key staff changes. *(See Section III.H.1. Account Management and Staffing.)*
Frequency	As needed
13) Notification of Legal Action	
Description	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR shall notify the DEPARTMENT'S chief legal counsel via ETFSMBOfficeofLegalServices@etf.wi.gov within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section III.I.9. Notification of Legal Action.)*
Frequency	As needed

14) Notification of Privacy Breach	
Description	The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the protected health information (PHI) and/or personally identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by STATE and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. *(See Department Terms and Conditions.)*
Frequency	As needed
15) Notification of Significant Events	
Description	The CONTRACTOR shall notify the DEPARTMENT of all Significant Events as described in Section II.B. Board Authority and Certificate of Coverage Section 7.
Frequency	As needed
16) Over-Age Disabled Child Review Notification	
Description	The CONTRACTOR shall notify the DEPARTMENT of individual over-age disabled DEPENDENT review results per DEPARTMENT submission instructions. CONTRACTOR may perform individual reviews at any time of the year. If it is found that the child no longer meets the criteria, termination of the child's coverage must be prospective. The DEPARTMENT must be copied on the notification of the CONTRACTOR'S review prospectively and as described in the submission instructions. *(See Certificate of Coverage Section 7.)*
Frequency	Prior to termination of DEPENDENT'S coverage
17) PARTICIPANT Enrollment Information	
Description	The CONTRACTOR shall provide the minimum following information described in section III.A.5, at a minimum, to all PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website and directions on how to request a printed copy of the provider directory. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section III.A.5. Enrollment & Eligibility Information for Participants.)*
Frequency	Upon enrollment
18) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	
Description	In the final grievance decision letter, the CONTRACTOR shall inform the PARTICIPANT of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an external review in accordance with applicable federal or STATE law, using the language approved by the DEPARTMENT. *(See Section III.I.5. Notification of DEPARTMENT Administrative Review Rights or External Review Rights.)*
Frequency	See description
19) PARTICIPANT Notification of Grievance Rights	
Description	The CONTRACTOR shall provide the PARTICIPANT with notice of their grievance rights and a period of ninety (90) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the UNIFORM BENEFITS contractual provision(s) upon which the denial is based. *(See Section III.I.1. Grievance Process Overview or Section IV. Performance Standards & Penalties.)*

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

E. Administrative Performance Standards and Guarantees

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

1) Data Management	
Performance Standards	*Penalties*
a) Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. *(See Department Terms and Conditions.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
2) Enrollment	
Performance Standards	*Penalties*
a) Enrollment File: The CONTRACTOR shall accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. The CONTRACTOR shall certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Sections III.A.1.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met

b) **Enrollment Discrepancies and Exceptions:** The CONTRACTOR shall resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT. The CONTRACTOR shall certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.A.1. Eligibility.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
c) **ID Card Issuance for Elections During the Plan Year:** The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in Section IV) regarding ID cards issued during the OPEN ENROLLMENT PERIOD. The CONTRACTOR shall certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.A.4. Identification (ID) Cards.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
d) **ID Card Issuance for Elections During the OPEN ENROLLMENT Period:** The CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the OPEN ENROLLMENT period through December 5. For enrollment files specific to the OPEN ENROLLMENT period generated after December 5 (i.e. between December 6 or December 31), ID cards shall be mailed within 10 BUSINESS DAYS of receipt of the enrollment file. CONTRACTOR will confirm each ID card mailing date(s) and if any delays or changes to the mailing dates occur or are expected. Specific deliverable dates may be defined by the DEPARTMENT. *(See Section III.A.4. Identification (ID) Cards.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
e) **Direct Pay Terminations:** The CONTRACTOR shall provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section III.B.2. PREMIUM Payments from the DEPARTMENT.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
3) Other	
Performance Standards	*Penalties*
a) **Audit:** The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section III.J.1.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
b) **Major System Changes and Conversions:** The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred eighty (180) calendar DAYS to the DEPARTMENT. The CONTRACTOR shall certify QUARTERLY in the format directed by the DEPARTMENT the performance standard was met. *(See Section III.D.1. Information Systems.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
c) **Non-Disclosure:** The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section II.B. Board Authority and Certificate of Coverage Section 7.)*	Five thousand ($5,000) dollars per incident

F. Annual Deliverables

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

1) 1095-B Issuance Notification	
Description	The CONTRACTOR shall submit a written notification to the DEPARTMENT Program Manager indicating the date(s) 1095-Bs were issued, or when the web notice was posted, as required by federal law. *(See Section III.A.5. Enrollment & Eligibility Information for PARTICIPANTS.)* **Note:** 1095-Bs are not required for Medicare plans.
Frequency	Annually
2) Annual ID Card Issuance Confirmation	
Description	The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section III.A.4. Identification (ID) Cards.)*
Frequency	Annually (January)
3) Customer Service Department Operating Hours and Anticipated Closures	
Description	The CONTRACTOR shall report standard customer service department operating hours and anticipated closures to the DEPARTMENT on an annual basis in the format specified by the DEPARTMENT. The CONTRACTOR must promptly report any unanticipated closures to the DEPARTMENT in the format specified by the DEPARTMENT. *(See Section III.H.3. Customer Service.)*
Frequency	Annually
4) Model Audit Review Certification	
Description	The CONTRACTOR shall submit a Model Audit Rule (MAR) on an annual basis. *(See Section III.J.1. Audit and Other Services.)*
Frequency	Annually (August)
5) Open Enrollment Informational Materials Review	
Description	The CONTRACTOR shall submit all informational materials intended for distribution to PARTICIPANTS during the annual OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section III.E.1. Open Enrollment Materials.)*
6) SUBSCRIBER Notification of Changes Review	
Description	The CONTRACTOR shall submit the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the annual OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. The CONTRACTOR shall issue the written notice after DEPARTMENT approval. *(See Section III.E.1. Open Enrollment Materials.)*
Frequency	Annually (September)
7) SUBSCRIBER Notification of Changes Issuance Confirmation	
Description	The CONTRACTOR shall submit a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in Item 10) above was issued to PARTICIPANTS. *(See Section III.E.1. Open Enrollment Materials.)*
Frequency	Annually (October)

8) Summary of Benefits and Coverage	
Description	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual OPEN ENROLLMENT materials mailing process. *(See Section III.A.1. Eligibility.)*
Frequency	As needed
9) Utilization Review Meeting	
Description	The CONTRACTOR shall meet with DEPARTMENT staff on an annual basis to report and discuss annual experience and utilization in relation to: • Disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors: • Demonstrating support for technology and automation; • DEPARTMENT experience by disease and risk categories; • Comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends; and • DEPARTMENT Initiatives, which currently include: Care Coordination, High Tech Radiology, Low Back Surgery, Shared Decision Making, Advanced Care Planning, and Low-Value Care. (Not all apply to MEDICARE ADVANTAGE.) This information shall be presented in a format as determined by the DEPARTMENT. The DEPARTMENT will provide additional reporting criteria in advance of the meeting. *(See Section III.G.1 DEPARTMENT Initiatives and Certificate of Coverage Section 4.)*
Frequency	Annually

G. Annual Reporting Requirements

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

1) Business Recovery Plan and Simulation Report	
Description	The CONTRACTOR shall submit to the DEPARTMENT a business recovery plan that is documented and tested annually, at a minimum. *(See Section III.D.1. Information Systems.)*
Frequency	Annually
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
2) CAHPS Survey Results Report	
Description	The CONTRACTOR shall submit the results of its annual CAHPS survey to the DEPARTMENT. *(See Section III.C.3. Quality.)*
Frequency	Annually
Penalty	Disqualification from Quality Credit
3) Customer Service Inquiry System Certification	
Description	The CONTRACTOR shall certify that their customer service inquiry system meets the requirements in Section III.H.3. on an annual basis. *(See Section III. H.3. Customer Service.)*
Frequency	Annually
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met

4) Financial and Utilization Data Submission	
Description	The CONTRACTOR shall submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. *(See Sections II.B. Board Authority and III.C.1. Annual Rate Bidding Process.)*
Frequency	Annually (May)
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
5) Financial Stability Documentation	
Description	The CONTRACTOR shall submit financial stability documentation, including a balance sheet, statement of operations and financial audit reports (i.e., an annual audited financial statement by a certified public account in accordance with generally accepted accounting principles). *(See Section III.J.1.)*
Frequency	Annually (June)
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
6) Grievance Summary Report	
Description	The CONTRACTOR shall retain records of grievances and submits an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. *(See Section II.B. Board Authority and Certificate of Coverage Section 7.)*
Frequency	Annually
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
7) HEDIS Results Report	
Description	The CONTRACTOR shall submit audited HEDIS data results for the previous calendar year for its commercial membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. *(See* Section *C.3.)*
Frequency	Annually
Penalty	Disqualification from Quality Credit
8) Model Audit Rule (MAR) Certification	
Description	The CONTRACTOR shall submit a MAR Certification. *(See Section J.1.)*
Frequency	Annually
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
9) Over-Age Disabled Child Eligibility Verification Report and Certification	
Description	The CONTRACTOR shall report and certify to the DEPARTMENT total results from its process to verify the eligibility of adult disabled children age twenty-six (26) or older, which includes checking that the: • Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year; and, • Support and maintenance requirement is met; and, • Child is not married. *(See Certificate of Coverage Section 7.)*
Frequency	Annually
Penalty	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

H. QUARTERLY Reporting Requirements

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

1) Fraud and Abuse Review Results	
Description	The CONTRACTOR shall perform QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Certificate of Coverage Section 7.)*
Frequency	QUARTERLY
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met
2) CONTRACTOR QUARTERLY Performance Report	
Description	The CONTRACTOR shall submit and certify all data as required to measure performance standards on a QUARTERLY basis in the format specified by the DEPARTMENT. *(See Section IV. Performance Standards & Penalties.)*
Frequency	QUARTERLY, unless otherwise noted
Penalty	One thousand ($1,000) dollars per DAY for which the standard is not met

I. QUARTERLY Performance Standards and Penalties

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

1) Claims Processing	
Performance Standards	*Penalties*
a) Processing Accuracy: At least ninety-seven percent (97%) level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section III.H.2. Claims.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter
b) Claims Processing Time: At least ninety-five percent (95%) of all claims received must be processed within thirty (30) calendar DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section III.H.2. Claims.)*	
2) Customer Service	
Performance Standards	*Penalties*
a) Call Answer Timeliness: At least eighty percent (80%) of calls received by the CONTRACTOR'S customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section III.H.3. Customer Service.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter
b) Call Abandonment Rate: No more than three percent (3%) of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section III.H.3. Customer Service.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter

c) Open Call Resolution Turn-Around-Time: At least ninety percent (90%) of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section III.H.3. Customer Service.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter
d) Electronic Written Inquiry Response: At least ninety-eight percent (98%) of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section III.H.3. Customer Service.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each quarter

J. Data Warehouse Deliverable Requirements

The CONTRACTOR must report to the DEPARTMENT's data warehouse vendor in the file format specified by the DEPARTMENT.

1) Claims Data Transfer to Data Warehouse	
Description	The CONTRACTOR shall submit to the DEPARTMENT'S data warehouse, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS. *(See Section III.D.4. Data Integration and Use.)*
Frequency	Monthly
2) Provider Data Transfer to Data Warehouse	
Description	The CONTRACTOR shall submit to the DEPARTMENT'S data warehouse, in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK providers including subcontracted providers. *(See Section III.D.4. Data Integration and Use.)*
Frequency	Monthly

K. Data Warehouse Performance Standards

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

Performance Standards	*Penalties*
a) Claims Data Transfer: The CONTRACTOR shall submit on a monthly basis to the DEPARTMENT'S data warehouse vendor, in the most recent file format specified by the DEPARTMENT, all claims processed for PARTICIPANTS according to the schedule established in Section III.D. Data & Information Security. *(See Section III.D.4. Data Integration and Use.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
b) Provider Enrollment Data Transfer: The CONTRACTOR shall submit on a monthly basis to the DEPARTMENT's data warehouse vendor in the most recent file format specified by the DEPARMENT, the specified data for all IN-NETWORK providers including subcontracted providers according to the schedule established in Certificate of Coverage Section 7. *(See Section III.D.4. Data Integration and Use.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met

Performance Standards	*Penalties*
a) Data Warehouse Submission Delays: The CONTRACTOR shall communicate any delays in submitting program data to the DEPARTMENT'S data warehouse vendor via email to the DEPARTMENT Program Manager or designee and the designated data warehouse vendor as soon as the delay is known, but at least one (1) DAY before the scheduled transfer. *(See Section III.D.4. Data Integration and Use.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
b) Data File Corrections: Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse vendor or the DEPARTMENT. *(See Section III.D.4 Data Integration and Use.)*	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met
c) Two-Chance Rule: During the implementation of the DEPARTMENT'S data warehouse or a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor. *(See Section III.D.4. Data Integration and Use.)*	One thousand seven hundred fifty dollars ($1,750) for each submission after the allowed submissions.
d) One-Chance Rule: During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT'S data warehouse vendor identifies an error with the CONTRACTOR's initial data submission, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor. *(See Section III.D.4. Data Integration and Use.)*	
e) Pass-Through Data Warehouse Penalties: The DEPARTMENT will pass through any penalties assessed by the DEPARTMENT'S data warehouse vendor for failure to submit data in accordance with this CONTRACT. *(See Section III.D.4. Data Integration and Use.)*	The amount charged by the DEPARTMENT'S data warehouse vendor for the CONTRACTOR'S failure to meet data submission requirements not otherwise subject to a penalty as described above

L. Payment of Penalty Amounts Owed by Contractor

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

V. State of Wisconsin Group Health Insurance - Medicare Advantage Provisions

V.I. Definitions

In addition to the definitions provided in Section I. Definitions, above, the following additional definitions apply this Section V. State of Wisconsin Group Health Insurance - Medicare Advantage Provisions.

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

COST RATIO (hereinafter referred to as "CR") is calculated by dividing TOTAL MEDICAL COSTS by TOTAL REVENUES.

CONTRACT YEAR is any one-year period during which the CONTRACTOR'S PLAN offered under the HEALTH BENEFIT PROGRAM is in effect.

GROUP PREMIUM is the applicable per PARTICIPANT per month premium amount.

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

PLAN means the MEDICARE ADVANTAGE plan design option available to MEDICARE eligible SUBSCRIBERS administered by the CONTRACTOR.

TOTAL MEDICAL COSTS consist of medical claims incurred by PARTICIPANTS during the applicable CONTRACT YEAR, irrespective of the date such claims are paid, and includes paid claims and claims incurred but not yet paid. TOTAL MEDICAL COSTS shall include the cost of care management, disease management, and any in-home assessment programs delivered to PARTICIPANTS and quality improvement work that is considered a claim cost under the Patient Protection and Affordable Care Act (PPACA).

TOTAL REVENUES consist of the payments CONTRACTOR receives from CMS for MEDICARE ADVANTAGE on behalf of PARTICIPANTS enrolled in the PLAN during the applicable CONTRACT YEAR and the GROUP PREMIUM for PARTICIPANTS enrolled in the PLAN during the applicable CONTRACT YEAR.

V.II. Statutory & Board Authority

In addition to the Statutory and Board Authority requirements provided in Section II. Statutory & Board Authority, above, Section V. State of Wisconsin Group Health Insurance - Medicare Advantage Provisions, contains the following additional requirements.

A. Statutory & Legal Authority

The CONTRACTOR must comply with all CMS MEDICARE ADVANTAGE and MEDICARE Part D requirements, including provider network access, care utilization review, grievances and appeals, the quality improvement program, eligibility and enrollment, customer service, marketing, and claims

processing, except as waived by CMS for employer group waiver plans. In cases where CMS requirements and the non-Medicare requirements of this AGREEMENT differ, the more rigorous standard shall supersede.

V.III. Program Administration

In addition to the Program Administration requirements provided in Section III. Program Administration, above, Section V. State of Wisconsin Group Health Insurance - Medicare Advantage Provisions, includes the following additional (or substitute) requirements.

A. Enrollment & Eligibility Maintenance

This section addresses the CONTRACTOR'S role in enrolling PARTICIPANTS and maintaining eligibility files for PARTICIPANTS in the PLAN.

1. Enrollment

a) The DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR shall maintain an enrollment/eligibility system to support the HEALTH BENEFIT PROGRAM.

b) The CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both MEDICARE Parts A and B by the PARTICIPANT'S effective date of coverage. If a PARTICIPANT disenrolls from Medicare Parts A or B after the effective date of coverage, the CONTRACTOR shall notify the DEPARTMENT on the BUSINESS DAY after the CONTRACTOR identifies the PARTICIPANT as having disenrolled from Medicare Parts A or B and the effective date of termination.

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

d) The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the latter of either the receipt of the DEPARTMENT'S enrollment file. The CONTRACTOR'S notification must be provided within two (2) BUSINESS DAYS of the later of the receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

2. Errors

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

In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by

Medicare for either medical or prescription drug claims, not to exceed six (6) months and in accordance with UNIFORM BENEFITS.

3. PARTICIPANT Information

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

a) Information about PARTICIPANT requirements, including prior authorizations and referrals.

b) Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website and directions on how to request a printed copy of the provider directory.

c) Directions on how to change their Primary Care Provider.

d) The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, telehealth services, and website address.

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

4. Cancellation of Participant Coverage

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

B. Premiums

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

1. Direct Pay PREMIUM Process

The EMPLOYER may determine how much of an ANNUITANT'S PLAN beneficiary PREMIUM it will subsidize, subject to the following conditions in determining the PLAN beneficiary PREMIUM subsidy:

a) The EMPLOYER may subsidize different amounts for different classes of ANNUITANTS in the PLAN provided such classes are reasonable and based on objective business criteria, such as

years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly); and

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

C. Rate Setting

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

1. Annual Bidding Process

This Section V.III.C.1. <u>replaces</u> Section III.C.1. Annual Bidding Process, above, in its entirety.

a) The CONTRACTOR must submit rates for each following benefit year as directed by the DEPARTMENT. The CONTRACTOR'S sealed rates are submitted in the format specified by the DEPARTMENT. The rates will be reviewed for reasonableness, considering plan utilization, experience, and other relevant factors. Rates are subject to negotiation by the BOARD and the rate guarantees included in this AGREEMENT. The BOARD reserves the right to reject any rate or take other action up to and including limiting new enrollment with the CONTRACTOR when the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.

b) The CONTRACTOR must submit statistical report(s) showing utilization and claims data on the PLAN as a whole (if community rated), or specifically the STATE and LOCAL PARTICIPANTS covered thereunder if experience rated. If the PREMIUM is community-rated then the CONTRACTOR should give some indication of the percentage the STATE and LOCAL groups represent of the total covered community. The BOARD will require the CONTRACTOR to provide an explanation of rate methodology and the rate calculation developed by the CONTRACTOR'S actuary or consultant along with supporting documentation deemed necessary by the BOARD's consulting actuary.

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

d) Rates shall be uniform statewide, or nationwide if appropriate, except that CONTRACTOR may submit different rates which result from separate PLAN designs. The STATE and LOCAL groups must be separately rated in accordance with generally accepted actuarial principles.

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

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

2. Quality

a) The CONTRACTOR shall submit the results of its annual CAHPS survey to the DEPARTMENT. Results must be based on responses for the CONTRACTOR'S contracted membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS from insured adult members in Wisconsin (commercial or MEDICARE ADVANTAGE).

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

3. Gain Sharing

The CONTRACTOR agrees to provide the DEPARTMENT with a gain share related to the PLAN for CONTRACT YEAR(s) 2022 and 2023, pursuant to the following terms and conditions:

a) The CONTRACTOR shall provide the DEPARTMENT a gain share for the CONTRACT YEAR(s) specified in the table below if the actual CR for a CONTRACT YEAR is less than the CR stipulated in the table below for the respective CONTRACT YEAR. If the actual CR for a CONTRACT YEAR is less than the CR stipulated in the table below for that CONTRACT YEAR, the gain share will be determined as fifty percent (50%) of the amount by which TOTAL MEDICAL COSTS incurred are less than the applicable CR percentage of TOTAL REVENUES for the respective CONTRACT YEAR as set forth in the table below.

PLAN CONTRACT YEAR	COST RATIO
2022	90%
2023	90%

b) The CONTRACTOR will complete a final reconciliation and provide it to the DEPARTMENT within one (1) month following the final CMS payment to CONTRACTOR. If the DEPARTMENT does not dispute the amount of the gain share, if any, CONTRACTOR will remit payment of the gain share within thirty (30) DAYS of the DEPARTMENT providing notice of acceptance of the gain share amount in writing.

c) The gain share cannot exceed HEALTH BENEFIT PROGRAM paid PREMIUMS.

d) The DEPARTMENT must be an existing client of the CONTRACTOR in good standing on the final day of the PLAN year to receive the gain share pursuant to this gain share agreement. Any gain share determined for the CONTRACT YEAR will be forfeited by the DEPARTMENT if any component of the PLAN is no longer an active contract on the final day of the PLAN year.

e) The gain share shall be used for the benefit of the MEDICARE ADVANTAGE PARTICIPANTS to the extent required by Medicare laws and regulations and to the extent the DEPARTMENT is

required to do so under any other STATE or federal law or regulation. Any gain share the CONTRACTOR provides to the DEPARTMENT is subject to compliance with Medicare laws and regulations and is not subject to material CMS program changes.

f) This gain share agreement terminates upon expiration of the 2022-2023 contract term. Any extension of the 2022-23 contract term shall not extend this gain share agreement unless expressly agreed by the CONTRACTOR and the DEPARTMENT.

D. Data & Information Security

This section addresses requirements regarding the process of protecting data from unauthorized access and data corruption.

1. Data Integration and Use

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

The CONTRACTOR shall provide a copy of any CMS Model Output Report (MOR) file and a copy of the Monthly Membership Report (MMR) file, including all fields as received from CMS, for MEDICARE ADVANTAGE PARTICIPANTS to the DEPARTMENT as follows: The CONTRACTOR shall provide the MOR file upon the DEPARTMENT'S request, no more often than annually, within thirty (30) DAYS of the request. The CONTRACTOR shall provide the MMR file to the DEPARTMENT monthly by the end of the corresponding month.

b) This section <u>replaces</u> Section III.D.4.f. above.
For data transfers between vendors of STATE and LOCAL programs not specified in this AGREEMENT, the CONTRACTOR shall work with the vendor(s) to establish vendor to vendor data transfers as soon as possible and provide written notification from to the DEPARTMENT to do so. of the agreement to provide such transfers. Notwithstanding the foregoing, CONTRACTOR has the right to reasonably refuse such data transfer to a vendor.

E. Communications

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

1. Informational / Marketing Materials

MEDICARE ADVANTAGE PARTICIPANT Marketing Materials. The DEPARTMENT shall provide the CONTRACTOR with copies of any and all materials relating to the coverage available through the PLAN that the DEPARTMENT intends to disseminate to eligible ANNUITANTS and their eligible DEPENDENTS. The DEPARTMENT and the CONTRACTOR will work together to approve materials prior to distribution. The DEPARTMENT understands that the PLAN is subject to federal and STATE regulatory oversight, and that eligible PARTICIPANT materials and marketing materials (including, but not limited to, cover letters accompanying direct mail kits, announcement mailings, etc.) may be required to be filed with, reviewed

and approved by, CMS or STATE regulators prior to use. The DEPARTMENT agrees not to distribute such materials prior to the mutual agreement of the DEPARTMENT and the CONTRACTOR on the materials. The DEPARTMENT also agrees to comply with all relevant federal and STATE regulatory requirements regarding the distribution and fulfillment of eligible PARTICIPANT materials and/or marketing materials and applicable timeframes.

F. Provider Access

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

1. Provider Access Standards

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

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

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

G. Care Management

The following DEPARTMENT Initiatives, which are listed in Section III.G.1.b. above, do not apply to MEDICARE ADVANTAGE:

ii. High Tech Radiology
iii. Low Back Surgery
iv. Shared Decision Making (SDM)

H. Administrative Service & Support

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

1. Account Management and Staffing

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

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

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

2. Claims

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

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

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

3. Benefits

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

4. Out-of-Network Services

This section addresses CONTRACTOR'S fulfillment requirements pertaining only to a national passive PPO network.

The CONTRACTOR'S national passive PPO network must offer the same copayment, coinsurance, and deductible schedules for OUT-OF-NETWORK providers as available for IN-NETWORK providers. The CONTRACTOR will be responsible for any BALANCE BILLING if the PARTICIPANT uses an OUT-OF-NETWORK provider.

I. Grievance & Appeals

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

1. Grievance Process Overview

The CONTRACTOR will follow CMS rules set forth in 42 CFR part 422, subpart M, and Chapter 13 of the Medicare Managed Care Manual. **The provisions in Section III.I.10. Compliance with Department Determinations, above, do not apply to MEDICARE ADVANTAGE.**

J. Audits & Disclosure Requirements

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

1. Record Retention

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

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

K. DEPARTMENT Responsibility for EMPLOYER Manuals

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

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

a) The employer can subsidize different amounts for different classes of ANNUITANT'S and EMPLOYEES in the PLAN provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly); and

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

V.IV. Deliverables, Reporting, Performance Standards & Penalties

In addition to the requirements provided in Section IV. Performance Standards & Penalties, above, Section V. State of Wisconsin Group Health Insurance - Medicare Advantage Provisions includes the following additional requirements.

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

1) MEDICARE ADVANTAGE ID Cards	
Description	**Section IV.D.7. Identification (ID) Cards above does not apply to MEDICARE ADVANTAGE.** The CONTRACTOR shall provide PARTICIPANTS with ID cards indicating, at a minimum, the ID card print date and the emergency room and office visit copayment amounts, if applicable.
Frequency	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Notification of Terminated Provider Agreement	
Description	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR shall send written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility. • The continuity of care provision as it relates to the situation. • Contact information for questions. The CONTRACTOR shall send the above written notification subject to the CONTRACTOR receiving notification from the provider of their termination.
Frequency	As noted above

3) CMS Star Ratings	
Performance Standards	*Penalties*
a) On an annual basis, the CONTRACTOR must submit CMS overall Star ratings and Star ratings for each measure and each domain included in the overall rating.	One thousand ($1,000) dollars per DAY for which the standard is not met

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

5) Enrollment	
Performance Standards	*Penalties*
a) MEDICARE Disenrollment: The CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both Medicare Parts A and B by the PARTICIPANT'S effective date of coverage. If a PARTICIPANT disenrolls from Medicare Parts A or B after the effective date of coverage, the CONTRACTOR shall notify the DEPARTMENT on the BUSINESS DAY after the	One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met

CONTRACTOR identifies the PARTICIPANT as having disenrolled from Medicare Parts A or B and the effective date. *(See Certificate of Coverage Section 2.)*	
6) Taxable Incentive Payments	
Performance Standards	*Penalties*
b) Reporting on Incentive Payments: At least semi-annually, as directed by the DEPARTMENT, the CONTRACTOR shall report, as directed by the DEPARTMENT, all incentive payments or other items of monetary value that do not qualify as an IRS Section 213 (d) medical expense that were issued to PARTICIPANTS and their DEPENDENTS for DEPARTMENT distribution to EMPLOYER payroll centers for tax reporting purposes. *(See Section III.H.4.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Certificate of Coverage

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

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

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

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

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

Revised January 11, 2022

Table of Contents

1. Glossary of Terms

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

Access Plan: means the nationwide **Benefit Plan** offering available to all **Participants.**

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

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

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

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

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

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

Benefit Plan: Means the package of coverage and cost-sharing levels that you are enrolled in under the State of Wisconsin **Group Health Insurance Program**.

Benefits: Means the services that are paid for as a part of your coverage under the State of Wisconsin Group Health Insurance Program.

Certificate of Coverage (Certificate): Means this document, which includes details on the services that are covered by your **Benefit Plan** under the State of Wisconsin Group Health Insurance Program.

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

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

Confinement: Means the period of time between admission as an inpatient or outpatient to a **Hospital**, covered residential center, **Skilled Nursing Facility** or licensed **Ambulatory Surgery Center** on the advice of the **Participant's** physician; and discharge therefrom, or the time spent receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**.

Congenital: Means a condition which exists at birth.

Coinsurance: A specified percentage of the **Allowed Amount** that the **Participant** or family must pay each time those covered services are provided, subject to any limits specified in the **Schedule of Benefits**.

Copayment: A specified dollar amount that the **Participant** or family must pay each time those covered services are provided, subject to any limits specified in the **Schedule of Benefits**.

Custodial Care: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an **In-Network Provider**, has reached the maximum level of recovery. **Custodial Care** is provided to patients who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered **Custodial Care** if the **Participant** is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the **Participant** to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the **In-Network Provider**, that the medical or surgical treatment will enable that person to live outside an institution. **Custodial Care** also includes rest cures, respite care, and home care provided by family members.

Deductible: The amount the **Participant** owes for health care services the **Participant's Benefit Plan** covers before the **Benefit Plan** begins to pay. For example, if the **Participant's Deductible** is $1,500, the **Benefit Plan** will not pay anything until the **Participant** has incurred $1,500 in out-of-pocket expenses for covered health care services subject to the **Deductible**. The **Deductible** may not apply to all services.

Employee Trust Funds (ETF): Means the State of Wisconsin Department of Employee Trust Funds.

E-Visit: is an evaluation and treatment by a **Provider** using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An **E-Visit** is also called a digital visit.

Dependent: means any member or beneficiary of the **GHIP** who is not the **Subscriber**.

Durable Medical Equipment: means physical tools, implements, or items which are prescribed by a **Provider** and used primarily to treat an **Illness** or **Injury**. They are generally are not useful to a person in the absence of an **Illness** or **Injury**.

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

Employee: means a person who is working for pay.

Embedded: means when a **Participant** within a family plan meets the individual portion of **Participant** financial responsibility (e.g., **Deductible**) within the family's total financial responsibility, that **Participant** is no longer responsible for any further out of pocket costs. The remaining family **Deductible** in this example will still apply to other family **Participants**.

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

a) Serious jeopardy to the **Participant**'s health. With respect to a pregnant person, it includes serious jeopardy to the unborn child.
b) Serious impairment to the **Participant**'s bodily functions.
c) Serious dysfunction of one or more of the **Participant**'s body organs or parts.

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** requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used, or isn't yet recognized as acceptable medical practice to treat that **Illness** or **Injury** for a **Participant**'s **Illness** or **Injury**. Additional detail on the criteria used by **Health Plans** to determine what is **Experimental** is included in Section 5. A. Excluded Services, Experimental & Investigational Treatments.

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

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

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

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

Habilitation Services: means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: means the health plan entity that is under contract with the **Group Insurance Board** to provide benefits and services to **Participants** of the **Group Health Insurance Program.**

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

Home Care Benefits: means health care services provided in your home that are intended to help you recover from an **Injury** or **Illness**. The intention of **Home Care Benefits** is to help you get better, regain your independence, become as self-sufficient as possible, maintain your current condition or level of function, or slow decline.

Hospice Care: means services provided to a **Participant** whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided to ease pain and make the **Participant** as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care **Provider** approved by the **Health Plan**.

Hospital: means an institution that:

a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to **Hospitals**;
b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, **Injury** and **Illness**;
c) provides this care for fees;
d) provides such care on an inpatient basis;
e) provides continuous 24-hour nursing services by registered graduate nurses, or qualifies as a psychiatric or tuberculosis **Hospital**;
f) is a **Medicare Provider**; and
g) is accredited as a **Hospital** by the Joint Commission of Accreditation of Hospitals.

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

Hospital Confinement or **Confined in a Hospital:** means being registered as a bed patient in a **Hospital** on the advice of an **In-Network Provider,** or receiving **Emergency** care for **Illness** or **Injury** in a **Hospital**.

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

Immediate Family: means the **Dependents**, parents, brothers, and sisters of the **Participant** and their spouses.

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

In-Network Provider: a **Provider** who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to members of the **Health Plan**. The **Provider's** written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a **Participant**.

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

Local Employee: means a person who is working for pay for a city, county, or other municipal unit of government in Wisconsin that has opted to participate in the State of Wisconsin **Group Health Insurance Program**, and eligible as defined under Wis. Stat. § 40.02 (46) or 40.19 (4) (a), of an **Employer** as defined under Wis. Stat. § 40.02 (28), other than the state, which has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its **Employees**.

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.

Medical Supplies: means non-durable or disposable health care materials that are ordered or prescribed by a **Provider** for medical purposes.

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

Medicare Advantage: means a **Benefit Plan** created by Title 18, Part C of the U.S. Social Security Act of 1965 that is only available to retired **Participants** who are enrolled in **Medicare.**

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 because of the care necessary for an **Illness** or other condition requiring inpatient or outpatient hospitalization for which 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**.

Non-Participating Pharmacy: means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the **PBM's** directory of **Participating Pharmacy.**

Non-Preferred Drug: means a drug the **PBM** has determined offers less value and/or cost-effectiveness than Preferred Drugs. This would include Non-Preferred generic drugs, Non-Preferred brand name drugs and Non-Preferred **Specialty Medications** included on the **Formulary**, which are covered by the benefits of this program with a higher **Copayment**.

Maximum-Out-of-Pocket Limit (MOOP): means the most the **Participant** pays during a policy period (usually a calendar year) before the **Benefit Plan** begins to pay 100% of the **Allowed Amount**. This limit never includes **Premium**, balance-billed **Charges** or **Charges** for health care that the **Benefit Plan** does not cover. Payments for out-of-network services or other expenses do not accumulate toward this limit.

Open Enrollment: means the yearly period where all members may make changes to their **GHIP Benefits**. The dates for this time period are set each year by **ETF** and the **Group Insurance Board.**

Out-of-Area Service: means any services provided to **Participants** outside the **Service Area**.

Out-of-Network Provider: A provider who does not have a signed participating **Provider** agreement and is not listed on the most current edition of the **Health Plan**'s professional directory of providers. Care from an **Out-of-Network Provider** may require prior-authorization from the **Health Plan** unless it is **Emergency** or **Urgent Care**.

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

Participant: the **Subscriber** or any of his/her **Dependents** who have been specified for enrollment and are entitled to benefits.

Participating Pharmacy: means a pharmacy who has agreed in writing to provide the services to

Participants that are administered by the **PBM** and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a **Participant**.

Pharmacy Benefit Manager (PBM): the **PBM** is a third-party administrator that is contracted with the **Group Insurance Board** to administer the prescription drug benefits under this health insurance program. 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: means any of the following which provides benefits or services for, or because of, medical, pharmacological, or dental care or treatment:

- 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.
- Coverage under a governmental plan or coverage that is required or provided by law. This does not include **Medicare Advantage** as this provision is preempted by federal law. This does not include a state plan under **Medicaid** (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). 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 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**.

Postoperative Care: means the medical observation and care of a **Participant** necessary for recovery from a covered surgical procedure.

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

Preferred Provider Organization (PPO) and **PPO Network**: mean a **Health Plan** offering that includes both **In-Network** and **Out-of-Network Providers**. These **Health Plans** usually cover **In-Network Provider** services with lower costs to **Participants** than **Out-of-Network Providers**. The different levels of **Benefits** are described in their **Schedule of Benefits**.

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

Preoperative Care: means the medical evaluation of a **Participant** prior to a covered surgical procedure. It is the immediate preoperative visit in the **Hospital**, or elsewhere, necessary for the physical examination of the **Participant**, the review of the **Participant**'s medical history and assessment of the laboratory, x-ray, and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

Primary Care Clinic (PCC): means an **In-Network** clinic that can be named as the center where a **Participant**'s **Primary Care Providers** are co-located.

Primary Care Provider (PCP): means an **In-Network Provider** who is named as a **Participant's** primary health care contact. They provide entry into the health care system. They also evaluate a **Participant**'s total health needs and provide medical care in one or more medical fields. When medically needed, they then preserve continuity of care. They are also in charge of coordinating other **Provider** health services and refer the **Participant** to other **Providers**.

Primary Plan/Secondary Plan: the order of benefit determination rules state whether the **GHIP** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person. When the **GHIP** is **a Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits. When the **GHIP** 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, the **GHIP** may be a **Primary Plan** as to one or more other **Plans** and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

Prior Authorization: means obtaining approval from the **Health Plan** before obtaining the services. Unless otherwise indicated by the **Health Plan**, **Prior Authorization** is required for care from any **Out-of-Network Providers** unless it is an **Emergency** or **Urgent Care**. The **Prior Authorization** must be in writing. **Prior Authorizations** are at the discretion of the **Health Plan**. Some prescriptions may also require **Prior Authorization**, which must be obtained from the **PBM** and are at its discretion.

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

Referral: when a **Participant**'s **Primary Care Provider** sends them to another **Provider** for covered services

Rehabilitation Services: means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or

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

Remote Patient Monitoring : is the collection and interpretation of a person's physiologic data that is sent digitally to a health care **Provider** to support treatment and management of medical conditions.

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

Service Area: specific zip codes in those counties in which the **In-Network Providers** are approved by the **Health Plan** to provide professional services to **Participants** covered by the **GHIP**.

Shared Decision Making (SDM): means a program offered by a **Health Plan** or health care **Provider** that **Participants** must complete when considering whether to undergo certain medical or surgical interventions. **SDM** programs are designed to inform **Participants** about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that **Participants** can decide the best possible course of treatment. The **Health Plan** or health care **Provider** will provide the **Participant** with written Patient Decisions Aids (PDAs) as part of the **SDM** program.

Skilled Care: means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving **Skilled Care** are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, **Skilled Care** is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require **Skilled Care** and are considered **Custodial Care**.

Skilled Nursing Facility: means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a **Skilled Nursing Facility**.

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

State Annuitant: means any retired **Employee** of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a currently insured recipient of a disability benefit under Wis. Stat. § 40.65, or a terminated **Employee** with twenty (20) years of creditable service.

State Employee: means a person who works for a State of Wisconsin agency, the University of Wisconsin, or UW Hospitals and Clinics, and an eligible **Employee** as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., or 8.

Subscriber: an eligible employee or annuitant who is enrolled in the State of Wisconsin **Group Health Insurance Program**.

Telehealth: is a service delivered via real-time audio and video. **Telehealth** may also be called telemedicine, online or virtual evaluation and management, or a video visit.

Telephone Visit: is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

Urgent Care: means care for an accident or **Illness** which is needed sooner than a routine doctor's visit. This does not include follow-up care unless such care is necessary to prevent a **Participant's** health from getting seriously worse before they can reach their **Primary Care Provider**. It also does not include care that can be safely postponed until the **Participant** returns to the **Service Area** to receive such care from an **In-Network Provider**. The **Health Plan** must hold the **Participant** harmless from any effort(s) by third parties to collect from the **Participant** the amount above the **Usual and Customary Charges** for medical/**Hospital** services.

Usual and Customary Charge: an amount for a treatment, service or supply provided by an **Out-of-Network Provider** that is reasonable, as determined by the **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 situations where the service is provided by an **In-Network Provider** or an approved **Out-of-Network Provider**, the **Participant** is held harmless for the difference between the billed and paid **Charge(s)**, other than the **Copayments**, **Coinsurance,** or **Deductibles** 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** or **Prior Authorizations** to **Out-of-Network Providers** are not subject to **Usual and Customary Charges**; **Participants** may be responsible for costs beyond **Usual and Customary Charges** for services obtained from **Out-of-Network Providers** for services that are non-**Emergency** or non-**Urgent** and which are not previously approved for **In-Network** reimbursement by the **Health Plan**. **Emergency** or **Urgent Care** services from an **Out-of-Network Provider** may be subject to **Usual and Customary Charges**, however, the **Health Plan** must hold the **Participant** harmless from any effort(s) by third parties to collect from the **Participant** the amount above the **Usual and Customary Charges** for medical/**Hospital**/dental services.

Virtual Check-In : is a brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than **Telehealth, Telephone Visits, or E-Visits**.

2. Eligibility, Enrollment, and Termination

A. Subscriber Eligibility

The following people can enroll as **Subscribers** in the State of Wisconsin **Group Health Insurance Program**:

1) Active state agency and University of Wisconsin **Employees** who participate in the Wisconsin Retirement System (WRS), as described in Wis. Stat. § 40.02 (25) (a);
2) Elected state officials, including members of the legislature (Wis. Stat. § 40.02 (25) (a) 2);
3) Employees of the legislature (Wis. Stat. § 40.02 (25) (a) 2);
4) Any blind employees of Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3;
5) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority (Wis. Stat. § 40.02 (25) (b)):
    a) Any teacher who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.
    b) Any teacher who is a participating **Employee** and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.
    c) Certain visiting faculty members in the UW System.
    d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.
    e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.
    f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim appointment of twenty-eight percent (28%) or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one percent (21%) or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.
    g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.
    h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.
6) **Local Employees** as described in Wis. Stat. § 40.02 (46) or 40.19 (4) (a).
7) **Annuitants** and **Continuants** (Wis. Stat. § 40.02 (25) (b)), which include the following:

a. Any covered **Participant** who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).
b. The surviving spouse of a **Subscriber**.
c. Covered **Participants** who terminate employment, have attained minimum retirement age, have twenty (20) years of WRS creditable service, and defer their annuity (if a timely application is submitted).
d. Any participating **State Employee** who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant, and is ineligible for an immediate annuity (that is, under the minimum retirement age). See Section 2. I. Re-Enrollment below for more information.
e. Any rehired **Annuitant** electing to return to active WRS participation is immediately eligible to apply for coverage through their **Employer**.
f. Any **Local Employee** under Wis. Stat. § 40.02 (25) (b) 11 who retires and is receiving an annuity under the Wisconsin Retirement System (but not those only receiving a duty disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)),
g. Any **Dependent** of a **Local Annuitant**, who is receiving a continuation of the **Local Annuitant's** annuity, and, if eligible, who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).
h. Any **Local Annuitant** receiving an annuity through a program administered by **ETF** under Wis. Stat. § 40.19 (4) (a).
i. **Participants** who meet federal or **State** continuation provisions. See Section 260.

8) Disabled persons entitled to benefits under Wis. Adm. Code § ETF 50.40 or Wis. Stat. § 40.65 including:
    a. Insured **Employees** or former **Employees** who choose to continue coverage when the **Employee's** Long-Term Disability Insurance (LTDI) benefit under Wis. Adm. Code § ETF 50.40 or a duty disability benefit under Wis. Stat. § 40.65 is approved.
    b. Previously insured **Employees** or former **Employees** whose coverage lapsed and who are eligible and apply for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65.

B. Dependent Eligibility

A **Subscriber** may also be able to enroll certain family members in the **GHIP** as a part of their plan. These **Participants** are generally described as **Dependents.** A **Dependent** can be a **Subscriber's:**

1) Spouse.
2) Child.
3) Legal ward who becomes a permanent legal ward of the **Subscriber** or **Subscriber's** spouse prior to age 19.
4) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
5) Stepchild.
6) Grandchild if the parent is a **Dependent** child.

A **Dependent's** eligibility for coverage may change, based on age or a change in legal relationship to the **Subscriber**. See Section 2. H. Qualifying Life Events for more information on when **Dependent** eligibility for coverage can change.

Most children cease to be eligible for health insurance coverage when they turn 26, but there are some exceptions.

Under Wisconsin law, a **Dependent** child who is called to federal active duty in the military when they are under age 27 and enrolled in full-time higher education can remain covered regardless of age, as long as they are still attending school full time (see Wis. Stat. § 632.885).

Over-Age Disabled Child Eligibility

An unmarried **Dependent** child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued (at least one year) or indefinite duration is an eligible **Dependent**, regardless of age, as long as the child remains disabled and is **Dependent** on the you (or the other parent) for at least 50% of their support and maintenance. This is demonstrated by the support test done for federal income tax purposes, whether you claim the child on your taxes. If you die, your disabled adult **Dependent** must still meet the remaining disabled criteria and be incapable of self-support. Your **Health Plan** will follow up no more than once per year to verify that your child still qualifies for coverage. If your child no longer qualifies because either their disability improves or they become able to support themselves, their coverage under your plan will end. If you disagree with a **Health Plan's** determination of disability, you can appeal that decision to **ETF**.

The **Health Plan** shall notify the **ETF** of individual over-age disabled child reviews per **ETF** submission instructions. The **Health Plan** may perform the annual individual reviews at any time of the year. If it is found that your child no longer meets the criteria for an over-age disabled child, termination of the child's coverage must be prospective. **ETF** must be copied on the notification of the **Health Plan's** review as described in the submission instructions.

In addition, the **Health Plan** must report and certify to **ETF** the total results from its process to verify the eligibility of over-age disabled children age twenty–six (26) or older, which includes checking that the:

1) Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year (reviewed annually except if the child has **Medicare Parts A** and **Part B**, or has been found permanently disabled; if so, the medical review must be done at least once every 3 years), and

2) Support and maintenance requirement is met (per IRS 501 Worksheet 2, reviewed annually), and

3) Child is not married (reviewed annually).

C. Program Option Eligibility

The **GHIP** offers different **Benefits Plans,** sometimes called Program Options. The **Benefit Plans** available to you will depend upon your status (e.g., **Employee, Annuitant**) and the **Employer** who is providing your **Benefits** (e.g., **Local, State**).

You can choose a **Benefit Plan** design. A minimum of two (2) competing **Benefit Plans** is required by Wisconsin law (see Wis. Stat. § 40.51 (6)).

To figure out which **Benefit Plan** you have, see the **Schedule of Benefits** attached to your **Certificate of Coverage**, or visit **ETF**'s website at http://etf.wi.gov/benefits-by-employer and search for your **Employer**.

Annuitants who are eligible for and enrolled in **Medicare** have additional **Benefit Plan** options available to them. See Section 2. F. Medicare Enrollment for more information.

D. Individual & Family Coverage

Individual Coverage

Individual coverage covers only the **Subscriber**. If you are enrolled in individual coverage, only your health care services will be covered by your policy. You may change between individual and family coverage when you have a **Qualifying Life Event** or during the annual **Open Enrollment** period.

Family Coverage

Family coverage allows you to cover both yourself (the **Subscriber**) and your **Dependents**. All eligible **Dependents** must be listed on your application and are covered under family coverage. You cannot choose to exclude any eligible **Dependent** from family coverage unless that **Dependent** is already covered under the **GHIP** through either their own policy or another **Subscriber**.

E. No Double Coverage & Spouse-to-Spouse Transfer

A **Dependent** or **Subscriber** cannot be covered at the same time by more than one **Subscriber** of the **Group Health Insurance Program** (including **State** and **Local**). If a **Dependent** on your **Benefit Plan** is covered by another **GHIP Subscriber**, you and the other **Subscriber** will be notified. You will have thirty (30) calendar days to decide which of you will keep your **Dependent** on your plan. Whoever does not keep the **Dependent** must submit an application to remove the **Dependent**. The **Effective Date** of the change will be the first of the month following receipt of the application.

If no application is submitted within the thirty (30) calendar day period, **ETF** will select one **Subscriber** and re-enroll all other **Participants** as **Dependents**.

If you and your spouse are both employed by a **State** or **Local Employer** that offers the **GHIP**, and you are both enrolled under a family policy provided by one employer, you can opt to change which of you is the **Subscriber** for your **GHIP** coverage. Note that you will only be able to select the **Benefit Plans** available to you under the **Subscriber's Employer**. If you change mid-year, you may be able to transfer the amounts you have already paid towards your benefit maximums; see Section 3. D. Transfer of Benefit Maximums, Deductibles, and Out-of-Pocket Limits below for more information.

F. Medicare Enrollment

If you are an **Annuitant**, you and your **Dependents** (or your surviving **Dependents** if you die) who enroll in Medicare may continue your coverage at reduced **Premium** rates.

You (and your eligible **Dependents**) do not need to enroll in Medicare while you are an active **Employee** of your **State Employer** or participating **Local Employer**. If you retire or otherwise leave active employment, you (and your eligible **Dependents**) must enroll in **Medicare Part A** and **Part B** as soon as you are eligible. You must provide your Medicare enrollment information to **ETF.**

You and your **Medicare-**eligible **Dependents** must remain enrolled in **Medicare Parts A and Part B** once you retire. If you are not enrolled in **Part B** when you retire or if you disenroll from **Part B**, you will have to pay all of the costs for services your receive out of pocket that **Part B** would have covered.

If your **Health Plan** discovers that you are required to enroll in **Medicare Part A** and **Part B** and have either not elected **Part B** coverage or have disenrolled in **Part B** coverage, your **Health Plan** is required to provide information, including the total dollars in claims you have used, and any other documentation needed to **ETF**. Your **Health Plan** will then contact you to explain the financial impacts to you of disenrolling in **Part B** coverage, and will provide assistance to you to re-enroll in **Part B**. If you refuse to re-enroll in **Part B** coverage, your **Health Plan** will notify **ETF** for additional follow up.

If you are an **Annuitant** or **Continuant** who is enrolled in **Medicare Part A** and **Part B**, you are eligible to enroll in **Medicare Advantage** or **Medicare Plus** for individual coverage. If you would like to enroll in family **Medicare Advantage** or **Medicare Plus** coverage, your **Dependents** must also enroll in **Medicare Parts A** and **B.** If you have a **Dependent** on your plan who is not enrolled in **Medicare**, you may be able to split your coverage so that you can enroll in the **Medicare Plus** or **Medicare Advantage** plan; your non-**Medicare Dependent** will be enrolled in a non-**Medicare** benefit plan.

If you or your **Dependent** enroll in **Medicare Advantage**, your **Medicare Advantage** plan will verify that you are enrolled in **Medicare Part A** and **Part B** continuously. If you drop either part of **Medicare** while you are enrolled in the **Medicare Advantage** plan, your **Medicare Advantage** plan provider will notify **ETF**, and you will be moved to **Medicare Plus**. In addition, you will be responsible for any claims costs that would have been paid by **Medicare**. **ETF** strongly recommends that you not disenroll from **Part A** or **Part B** once you have enrolled.

If you remain enrolled in the same **Health Plan** you had when you were an **Employee** after you retire, your **Health Plan** will provide **Benefits** and services as described in this document to you once you are enrolled in **Medicare**, carving out the benefits paid by **Medicare.** This means you will receive the same **Benefits** level provided to you when you were an **Employee**. You may also opt to enroll in **Medicare Advantage** or **Medicare Plus**; these programs have slightly different benefits but offer robust coverage. See **ETF's** Health Benefits in Retirement webpage for more information (https://etf.wi.gov/retirement/living-retirement/health-benefits-retirement).

Your **Health Plan** must notify **ETF** in writing if **Medicare** does not allow you to enroll in **Medicare** for any reason once you retire.

G. Exceptions to Mandatory Medicare Enrollment

Mandatory enrollment in Medicare is waived if you or your Medicare age **Dependent** would be required to pay premiums for **Part A** coverage. However, if you or your Medicare-age **Dependent** do not enroll in

Part A, regardless of the requirement to pay premium, you will not be eligible for the reduced **Premium** rate or for enrollment in the **Medicare Advantage** plan.

If you are an **Annuitant** and you or your spouse are covered under another group **Health Plan** through a different employer that is the primary payer for **Medicare Part A** and **Part B** charges, you and/or your spouse may delay **Part B** enrollment (to the extent allowed by federal law). More information is available in Section 3. C. Medicare Participant Premiums below.

H. Qualifying Life Events

If you have recently had a change in marital status, a baby, or a change of home address, you may have the opportunity to enroll or change coverage outside of the annual **Open Enrollment** period. More information is available online; go to https://etf.wi.gov and search "Life Event."

Some events may cause your **Dependents** to no longer be eligible for coverage under your **Health Plan.** If you are aware that one of the following events will happen soon, contact your Human Resources department if you are an active **Employee**, or **ETF** if you are an **Annuitant** or **Continuant**. If your **Health Plan** finds that one of your **Dependents** is no longer eligible, the **Health Plan** will also notify **ETF**. If your non-qualified **Dependent** received benefits during a time they should not have been on your plan, their claims will be adjusted, and they may be responsible for costs.

Marriage

If you get married while you are enrolled in the **GHIP**, you can add your new spouse to your **Health Plan** within thirty (30) days of your marriage. If your new spouse has children, you must also add those children to your policy.

Divorce

If you divorce your spouse while enrolled in the **GHIP**, your spouse and any stepchildren on your plan will no longer be eligible for coverage. Spouses and stepchildren stop being **Dependents** at the end of the month in which a marriage is terminated by either divorce or annulment.

New Dependent

If you gain a new **Dependent** because of a birth, adoption or adoption placement, transfer of custody, paternity order, National Medical Support Notice (NMSN) or legal guardianship, you may add that new **Dependent** to your plan. You must apply to add your new dependent within sixty (60) calendar days of the event, except for a custody change, where you have thirty (30) calendar days.

Children Born Outside of Marriage

A child born outside of marriage becomes a **Dependent** of the father on:

- The date of a court order declaring paternity, or;
- 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.

You should file an application within sixty (60) calendar days of the child's birth, court order, or paternity acknowledgement. When an acknowledgment of paternity is filed within 60 calendar days of the birth, and an application is received or online enrollment is performed within the 60-day time frame, family coverage is effective on the date of birth.

Dependent Grandchildren

If your minor **Dependent** child has a child while they are covered by your **GHIP** policy, you may add your grandchild as a **Dependent**. Your grandchild will no longer be a **Dependent** at the end of the month in which your **Dependent** child (the grandchild's parent) turns age 18.

Adult Children Aging Out

Your children cease to be **Dependents** at the end of the month in which they turn 26 years of age, unless they are disabled or in some cases where a child is called to active duty, as described in Section 2. B. Dependent Eligibility above.

Adult Children Who Become Eligible Employees

If your **Dependent** child enrolls in their own **GHIP** insurance policy because they start working for a participating **Employer**, they are no longer eligible to be covered by your policy.

Eligibility for Other Coverage

If you become eligible for coverage through your spouse, you may be able to cancel your **GHIP** coverage. You must file an application to change within thirty (30) days of becoming eligible for other coverage.

Involuntary Loss of Employer Contribution

If you or one of your **Dependents** either lose eligibility for coverage or lose employer contributions for other health insurance coverage, you may enroll in the **GHIP**. You must file an application to join or change your policy within thirty (30) days of the involuntary loss of coverage or contribution. This does not apply if you or your **Dependent** voluntarily drop coverage.

Increased Employer Contribution

If your job changes such that your **Employer** would increase their contribution to your health insurance (e.g., moving from half to full time employment), you may enroll in the **GHIP**. You must file your application to join within thirty (30) days of this change.

Move to New County

If you move to a new county where you will be for at least three months, you can change which **Health Plan** you receive your **GHIP** coverage through. You must file to change **Health Plans** within 30 days of your move.

Retirement

If you were not already covered by the **GHIP** when you decide to retire, you may be able to enroll to help preserve your sick leave credits if that is available to you through your employer. Enrollment options are limited, so you should discuss this as soon as possible with your Human Resources department and/or at your **ETF** retirement counseling appointment before you retire.

If you are covered by the **GHIP** when you become a retiree, you may be able to move from family to single coverage, or cancel your coverage. If you do not cancel, your coverage will automatically continue for you into retirement.

If you are already retired and you become **Medicare** eligible, you must enroll in **Parts A and B** (See Section 2. F. Medicare Enrollment). When you first enroll in **Medicare**, you could also choose to move to a

different **Benefit Plan**, such as IYC Medicare Advantage or IYC Medicare Plus, or you may choose to cancel your **GHIP** coverage. You must file an application within thirty (30) days of enrolling in **Medicare**, or you may submit up to three months before your **Medicare** coverage takes effect.

Death of a Spouse

If your spouse dies while they are enrolled in the **GHIP**, you may change from family coverage to single if no one else is on your policy; if you have other **Dependents**, you must keep your family coverage. If you were enrolled in your spouse's non-**GHIP** insurance and lost eligibility or all the employer contribution due to their death, you may enroll in the **GHIP**. You should submit your application within thirty (30) calendar days of losing your other coverage.

If you are enrolled in a **Medicare** coordinated **Benefit Plan** in the family **Premium** category and one or more family members enrolled in **Medicare Part A** and **Part B** dies, the family **Premium** category in effect shall not change solely as a result of the death.

Death of Subscriber

If you die with **Dependents** (spouse, children, or grandchildren) enrolled on your plan, your **Dependents** can continue coverage under the **GHIP**. If your **Dependent** regains eligibility and was previously covered under your policy when you die, if you were in the process of adopting a child when you die, or if you have a child who was born within nine (9) months of your death, those **Dependents** will be eligible to enroll in coverage in the **GHIP** for as long as they continue to be eligible.

New coverage for your **Dependents** would be effective on the first day of the calendar month following the date of your death. It will continue until coverage would normally end for a **Dependent**. See above for situations that might change a **Dependent's** eligibility.

I. Re-Enrollment (State Employees)

Any participating **State Employee** who terminates employment after reaching twenty (20) years of WRS creditable service, remains an inactive WRS participant, and is not eligible for an immediate annuity because they are less than minimum retirement age may enroll in the **Health Benefit Program** after they become eligible for their annuity. They must enroll during the **Open Enrollment** period for coverage effective the following January 1, unless there is a different qualifying event.

J. COBRA/Continuation

If you leave employment, you may be eligible for COBRA Continuation of your **GHIP** coverage. Your **Employer** will provide you with the paperwork you need to file. You must submit a completed application to the **ETF** that is postmarked within sixty (60) calendar days of the date you were notified of the right to continue, or sixty (60) calendar days from the date your coverage would otherwise end, whichever is later.

If you or your **Dependent** ceases to be eligible for coverage, you may elect COBRA continuation for a maximum of thirty-six (36) months from the date of the qualifying event or the date of your **Employer**

notifies you regarding the end of eligibility, whichever is later. Your continuation coverage will end in the following circumstances:

- When coverage is canceled;
- When **Premiums** are not paid when due; or
- When coverage is terminated as permitted by state or federal law.

K. Layoffs & Leaves of Absence

If you are laid off or you take a leave of absence, you may continue your health insurance coverage.

A leave of absence under Wisconsin law is, "any period during which an employee has ceased to render services for a participating employer and receive earnings and there has been no formal termination of the employer-employee relationship" (see Wis. Stat. § 40.02 (40)). If you are on leave of absence, you can continue coverage as long as your **Premiums** are paid. A leave of absence cannot last more than three years under Wisconsin law.

You may also continue your coverage if you are on layoff. In some cases, **State Employees** may be able to use their accumulated unused sick leave to pay **Premiums** (see Wis. Stat. § 40.02 (40)).

L. Benefits Are Not Assignable

This policy is the personal policy for you and your **Dependents**. You cannot assign any benefits to any other person not named as a **Participant** on this **Benefit Plan**.

3. Premiums & Financial Responsibility

A. Premium Payment

For **Employees** and most **Annuitants**, your **Premium** payments will be arranged through deductions from salary, your accumulated sick leave account (**State Employees** only), your annuity, or by converting your life insurance under certain circumstances. If you are no longer working and do not have an annuity, sick leave, or converted life insurance, you must pay your **Premiums** directly to your **Health Plan.** If you are paying your **Health Plan** directly and you either stop paying **Premiums** or otherwise tell your **Health Plan** you no longer want coverage, your **Health Plan** will notify the **ETF**.

B. Premium Tiers

Health Plan Premiums will differ by **Health Plan** due to a variety of factors, including which counties are included in the **Health Plan**'s network **Service Area** and what provider systems are included. To help you navigate **Health Plan Premium** costs, **ETF** and the **Board** divide **Premiums** into three tiers. The most efficient plans will be placed in Tier 1, which will have the lowest **Employee Premium** contribution level. Moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest **Employee Premium** contribution level.

Your **Premium** contribution will be a fixed amount or percentage per tier, as determined by which **Employer** (**State** or **Local**) you work for. Your **Employer** shall contribute the balance of the total **Premium**. Contact your **Employer** for more information on what your **Premium** contribution will be in a given year.

For **State Employees** the State of Wisconsin's contribution toward the total **Premium** for **Employees** (non-retired) for individual and family coverage is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The Division of Personnel Management (DPM) in the Wisconsin Department of Administration sets the **Employee** contribution amounts annually. **State Employees** should watch for information provided as a part of the annual **Open Enrollment** period to determine what the cost is for their plan.

The **Premium** share that **Employees** pay for individual coverage and family coverage differs; if you change coverage levels, your share of **Premium** will change. For changes in coverage that are effective after the 1st of the month, the difference in **Premium** between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

Local Employers that base their contribution on a percentage of the average of the lowest cost qualified plans must pay at least 50% but no more than 88% for plans in the **Local Employer's** service area (exceptions may apply for employees who are less than half time or employees who are part of a collective bargaining agreement). The county that the **Local Employer** is located in is considered the service area, unless otherwise determined by **ETF**.

C. Medicare Participant Premiums

Annuitants who enroll in **Medicare Parts A** and **Part B** pay less for their **GHIP Premiums**. The reduction in **Premium** is effective on the first day of the month on or after the date the you and/or your **Medicare-**eligible **Dependents** are eligible for **Medicare Parts A** and **Part B** as your primary health benefit coverage and you, the **Subscriber**, are no longer covered as an **Active Employee.** This reduced-**Premium** coverage is also referred to as **Medicare** coordinated coverage. In addition to opting for **Medicare** coordinated

coverage, you may also choose to enroll in **Medicare Plus** or **Medicare Advantage**. These programs also have lower **Premiums** that share costs with **Medicare**, and both have some additional benefits and services that vary from **Uniform Benefits**. Additional Information is available in Section 4. Benefits & Coverages below.

As discussed in Section 2. F. Medicare Enrollment, you must enroll in **Medicare Part A** and **Part B** if you are continuing your health insurance coverage when you retire. If you don't, it could affect your health insurance **Premiums** and your overall benefits coverage.

Except in cases of fraud, if you either do not enroll in **Medicare Part B** at the time you enroll in a **Medicare** coordinated benefit plan and when **Medicare** is first available as the primary payer, or if you cancel **Medicare** coverage, your coverage will be limited and you will be responsible for any costs that **Medicare** would have paid.

If you are found to have either not enrolled or disenrolled in **Medicare Part B** while on a **Medicare** coordinated benefit plan, retrospective adjustments to **Premium** or claims shall be limited to the shortest retroactive enrollment limit set by **Medicare** for either medical or prescription drug claims, not to exceed six (6) months. In such a case, you (or your **Medicare** eligible **Dependent**) must enroll in **Medicare Part B** at the next available opportunity.

If you or your **Medicare** eligible **Dependent** are enrolled in **Medicare** and subsequently cancel **Medicare** coverage, you will be disenrolled from the **Medicare Advantage** and enrolled in **Medicare Plus** effective as of the date of loss of **Medicare** coverage. That **Medicare Plus** coverage will only cover costs beyond what **Medicare** would have paid; you will be responsible for the costs **Medicare** would have covered.

If you are enrolled in non-**Medicare** coordinated coverage while enrolled in **Medicare Parts A** and **Part B** and are retired, **ETF** will refund any **Premium** paid in excess of the **Medicare**-reduced **Premium** for any months for which **Benefits** were coordinated. In such cases, your **Health Plan** will make claims adjustments prospectively. However, **Premium** refunds for retroactive enrollment in a coordinated **Benefit Plan** will correspond with the retroactive enrollment limits and requirements established by **CMS** for medical and/or prescription drug coverage. This may limit the amount of **Premium** refund you are eligible to receive.

There may be additional limitations to retrospective enrollment for the **Medicare Advantage** plan. You should review your **Medicare Advantage** Evidence of Coverage document and/or contact the **Medicare Advantage Health Plan** to verify these limitations.

D. End Stage Renal Disease & Medicare Enrollment

Your **GHIP Benefits** will pay as the primary payer for the first thirty (30) months after you become eligible for **Medicare** due to kidney disease, whether or not you or your **Dependent** are enrolled in **Medicare**. The **Premium** rate for non-**Medicare Advantage Health Plans** will be the non-**Medicare** rate during this period.

Medicare becomes the primary payer after the thirty (30)-month period ends, upon enrollment in **Medicare Part A** and **Part B**. If you or your **Dependent** have more than one period of **Medicare** enrollment based on kidney disease, there is a separate thirty (30)-month period during which the **GHIP** will again be the primary payer. No reduction in **Premium** is available for active **Employees**.

E. Transfer of Benefit Maximums, Deductibles, and Out of Pocket Limits

As discussed in Section 2. H. Qualifying Life Events, you may have the opportunity to change **Health Plans** or **Benefit Plans** (e.g. change from or to the **HDHP**) during a **Benefit Period** in certain situations. In some cases, you may be able to transfer amounts you have already paid under your former coverage to your new coverage.

The amounts that you have already paid toward your **Deductible** and **Out of Pocket Limits (OOPLs)** are referred to as Accumulations. Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** under your **GHIP** coverage will continue to accumulate for the **Benefit Period** in the following situations if you do not change **Health Plans**:

a) If you change the level of coverage (e.g., single to family);
b) If you change benefit plans (e.g. change from or to the **HDHP**);
c) If a you have a spouse-to-spouse transfer resulting in a change of **Subscriber**; or
d) If you have a **Dependent** change (e.g. following a divorce) resulting in a change of **Subscriber**.

Accumulations to annual medical **Benefit** maximums, medical **Deductibles**, and medical **OOPLs** will start over at zero ($0) dollars as of the **Effective Date** of the change if you change from being a **Participant** of the **State** program to the **Local** program, or vice versa.

Accumulations to the annual pharmacy and uniform dental (if applicable) benefits continue to accumulate for the **Benefit Period** regardless of a **Benefit Plan**/**Health Plan** change. See your Uniform Pharmacy Benefits document and Uniform Dental Benefits for more information. For **HDHPs**, medical and pharmacy accumulations are combined.

Your **Health Plan** will apply all **Maximum Out-of-Pocket (MOOP)** limits as required by Wisconsin and federal laws.

F. Recovery of Premium Overpayments

If you or your **Dependents** receive coverage or **Benefits** that you were not entitled to, you will need to reimburse your **Health Plan** for those services. You must reimburse your **Health Plan** immediately upon receiving notification from the **Health Plan** and/or **PBM**. At the option of the **Health Plan** and/or **PBM**, payments for future **Benefits** may be reduced by the **Health Plan** and/or **PBM** in order to offset a balance owed.

4. Benefits & Coverages

This section describes the **Benefits** and services provided under the **GHIP**. Services and **Benefits** are available to you and your enrolled **Dependents** if they are received after the date this policy becomes effective and your **Premiums** are paid.

Medicare Advantage benefits may differ slightly based upon **CMS** requirements; see your Evidence of Coverage issued by your **Medicare Advantage Health Plan** for details.

A. Services Must be Received In-Network

Except in limited circumstances that are specifically described in this Section, you and your **Dependents** must receive services from **Providers** that are a part of your **Health Plan's** defined **Provider** network. If you are having trouble finding an **In-Network Provider** to provide a service, you should contact your **Health Plan** for assistance.

B. Exceptions to In-Network Care Requirement

1. Specialty Care Not Available In-Network

If you have a medical condition that requires highly specialized care that is not available in your **Health Plan's** network, you may be able to request access to an **Out-of-Network Provider**. All **Out-of-Network** care requires written **Prior Authorization** from your **Health Plan** before any services are received, unless you are enrolled in the **Access Plan** or your **Health Plan** offers a **PPO Network**. You should contact your **Health Plan** before receiving any **Out-of-Network** care to verify your coverage.

2. Urgent or Emergency Room Care

If you require **Urgent Care** or **Emergency Room** services, and you are not able to return to your network for services (e.g., you are traveling out of state), your **Out-of-Network** services will be covered by your **Health Plan**. Please note that only services that require immediate or **Urgent Care** will be covered; services that might safely be delayed in order for you to return to your **Health Plan's Service Area** may be reviewed by your **Health Plan**.

3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit

Sometimes after a visit to an **Emergency Room** or **Urgent Care**, you may need additional follow-up appointments to manage an **Illness** or **Injury**. In most cases, you will be required to return to your **Health Plan's Service Area** for follow-up care. Some limited exceptions might be granted if you are physically unable to return to the **Service Area**. You must notify your **Health Plan** immediately if follow-up care is necessary, and your **Health Plan** will provide written **Prior Authorization** on a case-by-case basis for any follow-up care that is received from an **Out-of-Network Provider**. If you do not receive written **Prior Authorization** before an **Out-of-Network** follow-up appointment, you will be responsible for the full cost of the visit.

4. Out-of-Network Coverage for Full-Time Students

If your **Dependent** is a full-time student attending school outside of your **Health Plan's Service Area**, certain outpatient mental health services and treatment of alcohol or drug abuse will be covered **Out-of-Network**, as required by Wis. Stat. § 609.655. See Mental Health & Substance Use Disorder Services below for more information.

Your **Dependent** may have a clinical assessment by an **Out-of-Network Provider** when **Prior Authorized** in writing by the **Health Plan**. If outpatient services are recommended, your **Dependent** will be allowed coverage for five (5) visits outside of the **Service Area** when **Prior Authorized** by your **Health Plan**. Your **Health Plan** may approve additional visits. If your student **Dependent** is unable to maintain full-time student status, they must obtain services from an **In-Network Provider** for treatment to be covered.

5. Benefit Plans with Out-of-Network Access

Some **Benefit Plans** offered by **ETF** may include **Out-of-Network** coverage as a part of the **Benefit Plan**; these include the **Medicare Advantage Plan,** the **Medicare Plus Plan,** the **Access Plan,** and any **Health Plan** that is considered a **PPO**. Please refer to your **Schedule of Benefits** (or your **Evidence of Coverage** if you are enrolled in **Medicare Advantage**) and the **Provider** listing supplied by your **Health Plan** for information on whether you have **Out-of-Network Benefits** included in your **Plan**, as well as any limitations on those **Benefits.**

C. Cost Sharing May Apply

Your benefits are subject to the **Copayments**, **Coinsurance,** and other limitations shown in the **Schedule of Benefits** for your **Benefit Plan.** If you are unsure whether a service is subject to cost sharing, you should contact your **Health Plan** to verify.

D. Medical Necessity

All services must be medically necessary, as determined by your **Health Plan.** A service, treatment, procedure, equipment, drug, device or supply that is provided by a **Hospital**, physician or other health care **Provider** and is required to identify or treat a **Participant's Illness** or **Injury** is considered medically necessary when it is:

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

Your **Health Plan** will determine if all the above criteria have been met to determine which services are covered. If you or your provider disagree with the determination made by your **Health Plan**, you may seek external review. See Section 8. Grievances & Appeals below.

E. Disease Management, Prior Authorizations, & Utilization Review

Your **Health Plan** will collaborate with other vendors who provide your **GHIP** benefits to provide disease management services. Disease management programs support you in managing your medical conditions, and in some cases provide nursing or other health professional support to find strategies to improve your overall health.

Your health plan may require **Prior Authorization** for some services. **Prior Authorization** is intended to help ensure that the services you receive are the most appropriate for your condition. Your **Health Plan** will use evidence based medical policy development process to determine **Prior Authorization** criteria and will provide you a copy of these policies on request.

Your **Health Plan** may also require a **Referral** from your **Primary Care Provider** in order to obtain certain specialty services. In many cases, the **Referral** must be in writing and on the **Health Plan's Prior Authorization** form and approved by the **Health Plan** in advance of a **Participant**'s treatment or service. **Referral** requirements are determined by each **Health Plan**. The authorization from the **Health Plan** will state the type or extent of treatment authorized and 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.

In some cases, your **Health Plan** may use a process called utilization management or utilization review to ensure that the services you receive are evidence-based and focus on quality, positive health outcomes, and cost savings. The **Health Plan** must demonstrate effective and appropriate means of identifying, monitoring and directing **Participant**'s care by providers such as utilization review (UR) and chronic care/disease management, and wellness/prevention programs. The **Health Plan** shall report annually to the **Board** its utilization and disease management capabilities and effectiveness in improving the health of **Participants** and encouraging healthy behaviors, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the **ETF**. The **Health Plan** shall also include details on the **GHIP's** overall experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the **Health Plan** believes will be useful to **ETF** staff and the **Board** in understanding the source of cost and utilization trends in a format as determined by the **ETF**.

F. Covered Services

The following services and supplies are covered under your **GHIP Benefits** if they are medically necessary for the treatment of an **Injury** or **Illness.** See Section 4. D. Medical Necessity for details on how services are determined to be medically necessary.

Ambulance Services

Your plan covers licensed professional ambulance services (or comparable **Emergency** transportation if authorized by your **Health Plan**) when transportation to a **Hospital** is an **Emergency** or **Urgent** and medical attention is required en route. This includes licensed professional air ambulance when another mode of ambulance service would endanger the **Participant's** health. **Emergency** Air Ambulance services are limited to only those services necessary for transport to the nearest medical facility equipped to handle the **Emergency**. Ambulance services include medically necessary transportation and all associated supplies and services provided therein. If the **Participant** is not in the **Health Plan's Service Area**, the **Health Plan** should be contacted, if possible, before transport.

Ancillary Services

Ancillary services are those services that are generally provided in conjunction with another medically necessary service. Some examples include anesthesia provided for a surgery or a lab test to diagnose an **Illness**. If you receive anesthesiology, radiology, or pathology services (including all lab tests) at an **In-**

Network clinic or **Hospital**, those services will be covered at the **In-Network** level of **Benefits,** even if the service is not provided by an **In-Network Provider**.

Anesthesia Services

Anesthesia services are covered when provided in connection with other medical and surgical services covered under this policy.

Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m) and the Federal Mental Health Parity and Equity Act (MHPAEA). Autism spectrum disorder means any of the following:

- Autism disorder,
- Asperger's syndrome, or
- Pervasive developmental disorder not otherwise specified.

Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following **In-Network Providers**:

- Psychiatrist,
- Psychologist,
- Social worker,
- Behavior analyst,
- Paraprofessional working under the supervision of any of the above four types of **Providers**,
- Professional working under the supervision of an outpatient mental health clinic
- Speech-language pathologist, or
- Occupational therapist.

The therapy limit does not apply to this benefit.

Back Surgeries

Prior Authorization is required for **Referrals** to orthopedists and neurosurgeons if you have a history of low back pain but have not completed an optimal regimen of conservative care. **Prior Authorizations** are not required if you have a clinical diagnosis that requires immediate or expedited orthopedic, neurosurgical or other specialty **Referral,** or for **Medicare Advantage**-enrolled **Participants**.

Bariatric Surgery

Bariatric surgery is covered for **Participants** with a body mass index (BMI) of 35 or greater, provided the **Participant** meets all criteria established by the **Health Plan**. Surgeries may be covered for **Participants** with a BMI of less than 35 as approved by the **Health Plan**. All bariatric surgery services require **Prior Authorization** to obtain the surgery and associated preparatory services. **Prior Authorization** criteria is determined by the **Health Plan**.

Biofeedback

Biofeedback is covered when provided in order to treat the following conditions:

- Headaches,
- Spastic torticollis,
- Urinary incontinence.

Biofeedback is not covered for treatment of any other conditions; see Section 5. Exclusions, for additional information.

Cancer Clinical Trials

Your policy will cover routine patient care administered if you participate in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

Cardiac Rehabilitation

Phase I and Phase II cardiac **Rehabilitation Services** are covered by your **Benefit Plan.** Phase II services must be **Prior Authorized** by the **Health Plan** and provided in an outpatient department of a **Hospital**, in a medical center, or through a clinic program.

Case Management/Alternate Treatment

Your **Health Plan** employs a professional staff to provide case management services to help you manage complex medical conditions. As part of this case management, your **Health Plan** or your **Provider** may recommend that you consider receiving treatment for an **Illness** or **Injury** which differs from your current treatment if it appears that:

- The recommended treatment offers at least equal medical therapeutic value, and
- The current treatment program may be changed without jeopardizing your health, and
- The costs (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If your **Health Plan** agrees to the **Provider's** recommendation, or if you or your authorized representative and the **Provider** agree to your **Health Plan's** recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which **Benefits** are not otherwise payable, payment of **Benefits** will be as determined by the **Health Plan**.

Chiropractic Services

Chiropractic services are covered when performed by an **In-Network Provider** to treat an acute **Injury** or **Illness**. **Maintenance Care** is not covered. Your **Health Plan** may periodically review the treatment progress information provided by your **Provider** to ensure that your treatment plan is progressing.

Colorectal Cancer Screenings & Tests

Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m) and the Affordable Care Act are covered by your policy. Screening tests may be provided at no cost to you if you are in the age group recommended by the United States Preventive Services Task Force (USPSTF). Diagnostic tests or tests done outside of the recommended age group may be subject to cost sharing. See your **Schedule of Benefits** for details.

Congenital Defects and Birth Abnormalities

Treatment of **Congenital** defects and birth abnormalities is covered as required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d). Coverage includes treatment for the repair or restoration of any

body part when necessary to achieve normal functioning. If required by Wisconsin law, this includes orthodontia and dental procedures if necessary to restore normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

Diagnostic Services

Medically necessary testing and evaluations are covered 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;
- Home or laboratory sleep studies when ordered and performed by an **In-Network Provider**.

Prior Authorizations are required for high-tech radiology tests including MRI, CT scans, and PET scans, except for **Medicare Advantage**-enrolled **Participants**. **Prior Authorization** may be required for other diagnostic services as determined by the **Health Plan**.

Drugs Administered in a Home Health or Health Care Setting

Your **Health Plan**, not the **PBM**, will be responsible for covering prescription drugs that are administered during home care, in an office setting, during a **Confinement**, **Emergency** room visit or **Urgent Care** setting, if those drugs are covered under this policy. Injectable and infusible medications, except for **Self-Administered Injectable** medications, are included in this coverage.

Prescriptions for covered drugs written in any of the above settings that do not require an office visit to administer will be the responsibility of the **PBM** and payable as provided under the terms and conditions of Uniform Pharmacy Benefits. See Prescription Drugs and Other Benefits Administered by the PBM below for additional information.

Durable Diabetic Equipment and Related Supplies

Durable diabetic equipment and the supplies that are required for use with the durable diabetic equipment will be covered when prescribed by and purchased from an **In-Network Provider** for treatment of diabetes. Cost sharing may apply; see your **Schedule of Benefits** for more information.

Durable diabetic equipment includes automated injection devices, continuous glucose monitoring devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year and you must use the pump for thirty (30) calendar days before purchase.

Glucometers are available through the **PBM**. Refer to the Uniform Pharmacy Benefits document for more information.

Durable diabetic equipment and supplies may require **Prior Authorization** from your **Health Plan.**

Durable Medical Equipment and Medical Supplies

When prescribed by an **In-Network Provider** for treatment of a diagnosed **Illness** or **Injury** and purchased from an **In-Network Provider** outside of a **Hospital** setting, **Medical Supplies** and **Durable Medical Equipment** will be covered subject to cost sharing as outlined in the **Schedule of Benefits**.

All **Durable Medical Equipment** purchases, or monthly rentals must be **Prior Authorized** as determined by your **Health Plan**. In addition, the following **Durable Medical Equipment** and **Medical Supplies** may require **Prior Authorization** by your **Health Plan:**

- Initial acquisition of artificial limbs and eyes, including replacements due to significant physiological changes, such as physical maturation, when medically necessary and when refitting of any existing prosthesis is not possible.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces, and appliances.
- Custom-made orthotics, limited to one orthotic per foot per calendar year.
- Rental or, at the option of the **Health Plan**, purchase of equipment including, but not limited to, wheelchairs and **Hospital**-type beds.
- IUDs and diaphragms.
- An initial external lens per eye directly related to cataract surgery (contact lens or framed lens) or keratoconus (hard contact lens). Any subsequent lenses after the first lens will not be covered (See Section 5. Exclusions).
- Elastic support hose, for example, JOBST, when prescribed by an **In-Network Provider**. Limited to two pairs per calendar year.
- One hearing aid per ear, as described in the **Schedule of Benefits**. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
- Ostomy and catheter supplies.
- Oxygen and respiratory equipment for home use.
- Other medical equipment and supplies as approved by your **Health Plan**. Rental or purchase of equipment/supplies is at the option of the **Health Plan**.
- Repairs, maintenance and replacement of covered **Durable Medical Equipment** and **Medical Supplies**, including replacement of batteries. When determining whether to repair or replace the **Durable Medical Equipment** or **Medical Supplies**, your **Health Plan** will consider whether:
  (1) The equipment/supply is still useful or has exceeded its lifetime under normal use, or
  (2) Your condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Durable Medical Equipment models or devices that have features over and above that which are medically necessary will be limited to the standard model as determined by your **Health Plan**. This includes the upgrade of equipment, models, or devices to better or newer technology when the existing equipment, models, or devices are sufficient and there is no change in your condition nor is the existing equipment, model or device in need of repair or replacement.

Cost sharing will apply as described in your **Schedule of Benefits**.

Emergency & Urgent Care

Emergency Care

Medical care for an **Emergency** is covered under your policy. When you go to an **Emergency** room, you may receive additional tests or treatments as a part of the **Emergency** room visit. Those tests or treatments are often billed separately from the visit itself, and you may be responsible for a **Copayment**

or **Coinsurance** associated with those tests and treatments, in addition to your **Emergency** room visit **Copayment**. See your **Schedule of Benefits** for more details.

You should use an **In-Network Emergency** room whenever possible. If you are not able to go to an **In-Network Emergency** room, go to the nearest appropriate medical facility. You will be held harmless for any charges unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will work with **Out-of-Network Emergency Providers** to settle claims and manage or reduce costs.

If you must go to an **Out-of-Network Emergency** room for care, you should call your **Health Plan** as soon as possible and tell your **Health Plan** where you received **Emergency** care. You must receive non-urgent follow-up care from an **In-Network Provider** unless you have received written **Prior Authorization** from your **Health Plan.** If you have not received written **Prior Authorization** for **Out-of-Network** follow up care from your **Health Plan**, it will not be covered. **Prior Authorization** for the follow-up care is at the sole discretion of the **Health Plan**. See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

To help ensure that your claims process correctly, it's recommended that you or another person on your behalf notify your **Health Plan** of any **Hospital** admissions or facility **Confinements** that happen following an **Out-of-Network Emergency** room visit as soon as reasonably possible.

Emergency services include reasonable accommodations for repair of **Durable Medical Equipment** if repairs are medically necessary.

Urgent Care

If you experience an **Illness** or **Injury** that is not an **Emergency** but cannot safely wait to be treated until you can see your regular **Primary Care Provider**, you may choose to seek **Urgent Care** instead. You should seek care at an **In-Network Urgent Care** whenever possible. If you are not able to go to an **In-Network Urgent Care** because you are outside of your **Health Plan's Service Area**, you should visit the nearest, appropriate facility unless you are able to travel back to your **Health Plan's Service Area**.

If you must go to an **Out-of-Network Urgent Care**, you should notify your **Health Plan** by the next business day or as soon as otherwise possible and tell your **Health Plan** where you received care. This will help ensure your claims are paid. You will be held harmless for any charges unless you agree in writing to accept financial responsibility for specific treatments or services prior to receiving those services. Your **Health Plan** will work with **Out-of-Network Urgent Care Providers** to settle claims and manage or reduce costs. Any follow-up care you need must be received from an **In-Network Provider** unless **Prior Authorized** by your **Health Plan**. See Section 4. B. 3. Follow-Up to an Out-of-Network Emergency Room or Urgent Care Visit for more information.

Extraction and Replacement of Teeth Due to Injury

Total extraction and/or total replacement (limited to bridge, denture or implant) of **Natural Teeth** by an **In-Network Provider** is covered when these services are needed because of an **Injury**. Crowns or caps for

broken teeth instead of extraction and replacement may be considered if **Prior Authorized** by the **Health Plan** before the service is performed.

Your policy covers one retainer or mouth guard when medically necessary as part of prep work provided prior to covered tooth repair. **Injuries** caused by chewing or biting are not considered to be accidental for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

Gender Confirmation Treatments

Based on a permanent injunction issued on October 11, 2018 and the summary judgment decision issued on September 18, 2018 by the federal district court for the Western District of Wisconsin, all procedures, services, and supplies related to surgery and sex hormones associated with gender confirmation should be reviewed by the **Health Plan** for medical necessity. See Section 4. D. Medical Necessity for more information on this determination.

Genetic Testing/Genetic Counseling

Genetic testing and genetic counseling will only be covered when necessary to diagnose and treat an **Illness**. Testing for informational purposes that cannot reasonably lead to a course of treatment will not be covered.

Home Care Benefits

Home Care Benefits may be covered when medically necessary with a plan of care in place. An **In-Network Provider** must establish the plan of care, approve it in writing, and review it at least every two months unless the **Provider** determines that less frequent reviews are sufficient.

You are eligible for a maximum 50 visits per calendar year. 50 additional visits per calendar year may be available when **Prior Authorized** by the **Health Plan**.

Home Care Benefits means one or more of the following:

- Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
- 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.
- Physical, occupational and speech therapy. These apply to the therapy maximum described in your **Schedule of Benefits.**
- **Medical Supplies**, drugs and medicines prescribed by an **In-Network Provider** and lab services by or for a **Hospital**. These are covered to the same extent as if you were **Confined** in a **Hospital**.
- Nutritional counseling provided or supervised by a registered dietician.

This policy also covers the assessment of the need for a home care plan and its development. A registered nurse, physician extender or medical social worker must do this. An attending physician must ask for or approve this service.

Home Care Benefits will not be covered unless the attending physician certifies that:

- **Hospital Confinement** or **Confinement** in a **Skilled Nursing Facility** would be needed if home care were not provided.
- The patient's **Immediate Family**, or others living with the patient, cannot provide the needed care and treatment without undue hardship.
- A state licensed or **Medicare**-certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

If you are under **Hospital Confinement** when home care is requested, the home care plan must be approved at its start by the **Provider** who was the primary **Provider** of care during your **Hospital Confinement**.

Each visit by a person providing services under a home care plan, evaluating current needs, or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

Up to 50 additional home care visits per calendar year may be **Prior Authorized** by your **Health Plan** if the visits continue to be medically necessary and are not otherwise excluded.

Hospice Care

Hospice Care, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. **Hospice Care** is covered if your **Primary Care Provider** certifies that your life expectancy is 6 months or less and the care is palliative in nature. **Hospice Care** must be authorized by your **Health Plan**. **Hospice Care** includes, but is not limited to, **Medical Supplies** and services, counseling, bereavement counseling for one year after the patient's death, **Durable Medical Equipment** rental, home visits, and **Emergency** transportation. Coverage may be continued beyond a 6-month period if authorized by the **Health Plan**.

Your policy covers **Advance Care Planning** after you receive a terminal diagnosis, regardless of life expectancy. **Advance Care Planning** can include developing healthcare directives, living wills, health care proxies, and health care power of attorney.

Your policy also covers a one-time, in-home palliative care consultation after a terminal diagnosis, regardless of life expectancy.

Hospice Care is available to you when you are **Confined**. **Inpatient Charges** are payable for up to a total lifetime maximum of thirty (30) calendar 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 **Home Care Benefits**, benefits payable under this subsection shall not reduce any benefits payable under the Home Care subsection.

Hospice Care must be provided through a licensed **Hospice Care Provider** approved by the **Health Plan**.

Hospital Services & Inpatient Confinements

Hospital services must be received at an **In-Network Hospital**. In the case of non-**Emergency** care, your **Health Plan** reserves the right to determine in a reasonable manner the **Provider** to be used. In cases of **Emergency** or **Urgent Care** services, **In-Network Providers** and **Hospitals** must be used whenever possible and reasonable (See Emergency and Urgent Care sections above). However, your **Health Plan** must hold you harmless from any effort by third parties to collect from the amount above the **Usual and Customary Charges** for services.

Hospital swing bed **Confinement** is considered the same as **Confinement** in a **Skilled Nursing Facility**.

Services necessary for your admission to a **Hospital**, as well as diagnosis and treatment are covered when they are provided by an **In-Network Provider**. When you are in a health care facility, you agree to conform to the rules and regulations of that institution. Your **Health Plan** may require that your **Hospital** services be **Prior Authorized.**

When you are **Confined** as an **Inpatient** in a **Hospital**, this policy covers a semi-private room, ward or intensive care unit and medically necessary miscellaneous associated **Hospital** expenses, including prescription drugs administered during the **Confinement**. A private room is payable only if medically necessary, as determined by the **Health Plan**.

If you are transferred or discharged to another facility for continued treatment of the same or a related condition, it is considered one **Confinement** for the purposes of determining coverage. Your **Health Plan** will administer claims and medical management services if you transfer between facilities.

Charges for **Hospital** or other institutional **Confinements** are incurred on the date of admission. The benefit levels that apply on the **Hospital** admission date apply to the **Charges** for the covered expenses incurred for the entire **Confinement**, regardless of changes in benefit levels that might occur during the **Confinement**.

If you change **Health Plans** while you are **Confined** as an **Inpatient**, your prior **Health Plan** and new **Health Plan** will work together to transition your care and coverage to the new **Health Plan**. Your **Health Plans** will also work to transfer you to an **In-Network** facility if appropriate. If transfer to an **In-Network** facility is not appropriate, your coverage at the current facility will continue under your prior **Health Plan**.

Except in cases where your coverage ends because you have voluntarily canceled your policy or you have not paid your **Premiums,** your **Benefits** will continue if you are **Confined** as an **Inpatient** until your attending physician determines that **Confinement** is no longer medically necessary, your maximum benefit is reached, the end of twelve (12) months after the date of termination, or the **Confinement** ceases, whichever occurs first.

Kidney Disease Treatment

Inpatient and **Outpatient** kidney disease treatment is covered. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (additional information in Transplants below), donor-related services, and related physician **Charges**.

Treatments for end stage renal disease are also covered by your policy. If you are eligible for **Medicare** due to permanent kidney failure or end-stage renal disease, your **Health Plan** can help you enroll in **Medicare** to help reduce your costs. See Section 3. D. End Stage Renal Disease & Medicare Enrollment to learn more about how this may impact your **Premium** costs.

Mastectomy & Breast Reconstruction (Women's Health and Cancer Act of 1998)

Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies associated with breast cancer treatment includes:

- Reconstruction of the breast on which a mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses (see Durable Medical Equipment) and physical complications of all stages of mastectomy, including lymphedemas,
- Breast implants.

Mental Health & Substance Use Disorder Services

Following the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, services to diagnose and treat mental health and substance use disorder are covered by the **GHIP**. Coverage includes:

- Outpatient Services, meaning non-residential services provided by **In-Network Providers**, as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and MHPAEA. This benefit also includes services for a full-time student attending school in Wisconsin but out of the **Service Area,** as required by Wis. Stat. § 609.655.
- Transitional Services, meaning services provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA.
- Inpatient Services, provided by an **In-Network Provider** as described in **Schedule of Benefits** and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA. This includes court-ordered services as required by Wis. Stat. § 609.65, and these services are covered if performed by an **Out-of-Network Provider** if provided as required by an **Emergency** detention or on an **Emergency** basis. The **Provider** must notify the **Health Plan** within 72 hours after the initial provision of service.
- Detoxification Services
- Methadone Treatment

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be covered under the Uniform Pharmacy Benefit, subject to the benefits provided under the Uniform Pharmacy Benefit Certificate of Coverage.

Nutritional Counseling

Nutritional Counseling is covered when provided by a participating registered dietician or an **In-Network Provider**. This includes Nutritional Counseling specific to preparation for a covered Bariatric Surgery, as **Prior Authorized** by the **Health Plan**.

This counseling consists of the following services:

- Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.
- Re-assessment and intervention (individual and group).
- Diabetes outpatient self-management training services (individual and group sessions).
- Dietitian visit.

Coverage limitations apply; see Section 5. Exclusions & Limitations below for detail.

Oral Surgery & Other Dental Services

Oral Surgery is covered in limited situations by your **GHIP** policy. You should contact your **Health Plan** prior to any oral surgery to determine if the service will be covered and if **Prior Authorization** by the **Health Plan** is required.

When performed by **In-Network Providers**, approved surgical procedures are as follows:

- Surgical removal of impacted teeth and surgical or non-surgical removal of third molars.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
- Frenotomy (Incision of the membrane connecting tongue to floor of mouth).
- Surgical procedures required to correct accidental **Injuries** to the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Apicoectomy (Excision of apex of tooth root).
- Excision of exostoses of the jaws and hard palate.
- Intraoral and extraoral incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.
- Reduction of dislocations of, and excision of, the temporomandibular joints.
- 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.
- Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under this policy) and associated osseous (removal of bony tissue) surgery.
- Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
- Retrograde fillings when medically necessary following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

Coverage under this policy will also include **Hospital** or **ASC Charges** and related anesthetics for dental care if services are provided to a **Participant** who is under 5 years of age, has a medical condition that requires hospitalization or general anesthesia for dental care, or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

Physical, Speech and Occupational Therapy

Habilitation or **Rehabilitation** services and treatment that result from an **Illness** or **Injury** will be covered if provided by an **In-Network Provider**. **Providers** must be registered and must not live in your home or be a family member.

Up to 50 visits per **Participant** for all therapies combined are covered per calendar year. Your **Health Plan** may review utilization and clinical information during the initial 50 visits to verify medical necessity (See Section 4. E. Disease Management, Prior Authorizations, & Utilization Review for additional information). Additional visits may be available when **Prior Authorized** by your **Health Plan**, up to a maximum of 50 additional visits per therapy, per **Participant,** per calendar year.

These therapies benefits are only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

Prescription Drugs and Other Benefits Administered by the PBM

Your coverage for most medications under the **GHIP** is provided by a **Pharmacy Benefit Manager (PBM).** You must obtain pharmacy benefits at a **PBM Participating Pharmacy**, except when not reasonably possible because of **Emergency** or **Urgent Care**. For full detail on services covered by the **PBM**, please see the Uniform Pharmacy Benefits Certificate of Coverage.

Preventive Care & Immunizations

The **GHIP** covers all preventive care services that have received an A or B grade by the United States Preventive Services Task Force (USPSTF) without cost sharing to you as required by the Patient Protection and Affordable Care Act (ACA), regardless of the **Benefit Plan** in which you are enrolled. Check with your **Provider** and your **Health Plan** to verify which services are recommended for you and your family.

Preventive services include routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

Preventive care also includes well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

Primary Care

You are required to select a **Primary Care Provider (PCP)** or **Primary Care Clinic (PCC)** when you enroll in the **GHIP** and when you change **Health Plans**. You must select your **PCP** or **PCC** from your **Health Plan's** list of **In-Network Providers**. Your **PCP** may be a physician, physician assistant, nurse practitioner or other **Provider** if that **Provider** is managing your primary care services. Primary care includes ongoing responsibility for preventive health care, treatment of **Illness** and **Injuries**, and the coordination of access

to needed specialty **Providers** or other services. Your **PCP** or **PCC** shall either furnish or arrange for most of your health care needs, including well check-ups, office visits, **Referrals**, outpatient surgeries, hospitalizations, and health-related services.

Your **Health Plan** is required by **ETF** to ensure you have an assigned, **In-Network PCP** or **PCC** at all times. If you do not choose a **PCP** or **PCC**, or your **PCP** or **PCC** is no longer available, your **Health Plan** will assign a **PCP** or **PCC**, notify you in writing, and provide instructions for changing the assigned **PCP** or **PCC** if you are not satisfied with their selection.

If you select a **PCP** or **PCC** that is **Out-of-Network**, your **Health Plan** will contact you within five (5) business days and will assist you in selecting an **In-Network PCP** or **PCC**.

Radiation Therapy and Chemotherapy

These services are covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an **In-Network Provider**.

Reproductive Services and Contraceptives

The services included in this section do not require a **Referral** to an **In-Network Provider** who specializes in obstetrics and gynecology; however, your **Health Plan** may require that you obtain **Prior Authorization** for some services or they may not be covered.

Maternity Services

Maternity Services for prenatal and postnatal care are covered, including services such as normal deliveries, ectopic pregnancies, cesarean sections, abortions allowable under Wis. Stats. §40.03(6)(m), and miscarriages. Maternity benefits are also available for a **Dependent** child who is covered under this program as a **Participant**. However, this does not extend coverage to the newborn if the **Dependent** child is age 18 or older at the time of the birth.

In accordance with the federal Newborns' and Mother' Health Protection Act, an inpatient stay for a birth will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is medically necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician and in consultation with the mother.

If you are in your second or third trimester of pregnancy when your **Provider** ends participation in your **Health Plan's Service Area**, you will continue to have access to that **Provider** until completion of postpartum care for you and your baby. **Prior Authorization** is not required for the delivery, but the **Health Plan** may request notification of the inpatient stay prior to the delivery or shortly thereafter.

Contraceptive Services

Elective sterilization is covered by this policy, as are contraceptive methods as required by Wis. Stat. § 632.895 (17), including, but not limited to:

i) Oral contraceptives, or cost-effective **Formulary** equivalents as determined by the **PBM**, and diaphragms, as described under the prescription drug benefit in the Uniform Pharmacy Benefit.
ii) IUDs and diaphragms, as described under the Durable Medical Equipment section of this document.
iii) Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

Second Opinions/Consults

In advance of a surgery or following a diagnosis, you may wish to seek a second opinion before proceeding with treatment. A second opinion is covered from an **In-Network Provider** or another **Provider** when **Prior Authorized** by the **Health Plan**.

Skilled Nursing Facilities

Confinement in a licensed **Skilled Nursing Facility** is covered as long as you are admitted within twenty four (24) hours of discharge from a **Hospital** for continued treatment of the same condition. Only **Skilled Care** is covered; **Custodial Care** is excluded.

Benefits include prescription drugs administered during the **Confinement**. **Confinement** in a swing bed in a **Hospital** is considered the same as a **Skilled Nursing Facility Confinement**. A maximum of one hundred twenty (120) calendar days per **Benefit Period** is covered for **Skilled Care**.

Speech & Hearing Screening Exams

Speech and hearing screening examinations are limited to the routine screening tests performed by an **In-Network Provider** for the purpose of determining the need for correction.

Smoking Cessation

Coverage includes pharmacy products that require a written prescription and are described under the prescription drug benefits in Uniform Pharmacy Benefits. Coverage also includes one (1) office visit for counseling and to obtain a prescription, and four telephonic counseling sessions per calendar year. Additional counseling and/or extension of pharmacological products require **Prior Authorization** by the **Health Plan**.

Surgical Services

Surgical procedures, wherever performed, are covered when needed to care for an **Illness** or **Injury**. Coverage includes **Preoperative** and **Postoperative Care** and needed services of surgical assistants or consultants.

Prior Authorization is required for **Referrals** to orthopedists and neurosurgeons for surgeries related to back pain for any **Participant** who has not completed an optimal regimen of conservative care for low back pain. **Prior Authorization** is not required for a **Participant** who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty **Referral**. This limitation does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

Participants seeking surgical treatment of low back pain must participate in a credible **Shared Decision-Making** program provided by the **Health Plan** or its contracted **Providers** consistent with the **Prior Authorization** requirement. This requirement does not apply to **Participants** enrolled in the **Medicare Advantage Benefit Plan**.

Telemedicine & Remote Care

Your **GHIP** coverage includes coverage for services provided remotely. Such services must provide at minimum consultation services that assist you in determining whether additional treatment for a condition should be sought. Such consultation services that result in a **Referral** to a different site of care rather than definitive treatment must be provided at no cost to you. Services that have definitive diagnoses and/or treatment may result in a cost. See your **Schedule of Benefits** for details.

The below **Telemedicine** and remote care service types are covered when provided by an **In-Network Provider** and results in no reduction in quality, safety, or effectiveness. **Health Plans** may create a review process to ensure that services provided by any of these methodologies meet quality, safety, and effectiveness standards.

Evisits

E-Visits are covered by your plan. An **E-Visit** must be initiated by the **Participant** seeking services, not the **Provider**, in order to be covered. **E-Visits** are covered when the same service would be covered if provide in person when performed by:

- A doctor
- A nurse practitioner
- A physician assistant
- Licensed clinical social workers
- Clinical psychologists or psychiatrists
- Physical therapists
- Occupational therapists
- Speech language pathologists

Because **E-Visits** can be completed via messaging services, they may happen over several hours or even days.

Remote Patient Monitoring

Remote Patient Monitoring is covered by your plan under certain circumstances. The remote monitoring device that is used for services must be a home-use medical device as defined by the Food and Drug Administration (FDA), and must be provided as a part of the monitoring services, not billed separately. Devices are provided as a lease to you, and cannot be lease-to-own, purchased to own, or already owned by you. **Remote Patient Monitoring** is intended for long term conditions for which regular measurements need to be taken and must take place for a minimum of 16 days for the service to be covered; monitoring for shorter time periods will not be covered. Devices must be **Prior Authorized** by your **Health Plan** in order to be covered.

Telehealth

Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care **Provider** who is located elsewhere using

interactive two-way, real-time audio and video technology. **Telehealth** can be provided in your home, as well as at a health care facility.

Telehealth will be covered by your **Health Plan** if those services are delivered:

- Outside of your physical presence (e.g., remotely),
- When both audio and video elements are present, and
- When there is no reduction in the quality, safety, or effectiveness of the service.

If you and your **Provider** determine that you cannot successfully complete a **Telehealth** visit with full audio and video, you may opt to change to a **Telephone Visit**.

Any service that is currently covered by your **Benefit Plan** and that can be administered remotely with no reduction in quality, safety, or effectiveness is covered when provided via **Telehealth**.

Telephone Visits

Telephone Visits will be covered if your **Provider** can successfully provide the service without a reduction in quality, safety, or effectiveness. **ETF** encourages **Participants** and **Providers** to determine the best technology solutions to fit their care needs. **Health Plans** may create review processes and criteria to ensure that services provided by audio only meet quality, safety, and effectiveness standards.

Virtual Check-Ins

Virtual Check-ins will be covered on their own as long as they are not related to a medical visit within the past seven (7) days, and as long as they do not lead to a medical visit within the next twenty-four (24) hours or the next available appointment.

Temporomandibular Disorders

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and **Prior Authorized** and medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

- A **Congenital**, developmental or acquired deformity, disease or **Injury** caused the condition.
- 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.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the **Durable Medical Equipment Coinsurance** as outlined in your **Schedule of Benefits**. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

Transplants

Transplants and related services are covered when ordered by a physician. All transplants except corneal transplants require **Prior Authorization**. The medical necessity and appropriateness of a transplant will be determined by medical professionals reviewing each case on behalf of the **Health Plan**.

Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ procurement costs include organ transplantation, compatibility testing, hospitalization, and surgery (when a live donor is involved).

Donor expenses are covered only when the recipient of the transplant is a **Participant** in the **GHIP** and when such charges are included as part of the **Participant's** (as the transplant recipient) bill.

Transplants must be performed at a facility designated by the **Health Plan**.

Travel-Related Preventive Care

Medically necessary travel-related preventive treatment is covered by your **GHIP** policy. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever, and Hepatitis A vaccinations are covered if determined to be medically appropriate by your **Health Plan**. Coverage does not apply to travel required for work. (See Section 5. Exclusions below).

Vision Services

Coverage is limited to one routine eye exam per **Participant** per calendar year. Non-routine eye exams are covered as medically necessary, as determined by your **Health Plan**. Contact lens fittings are not part of the routine exam and are not covered.

Vision screenings for **Participants** age 5 and younger are considered preventive and are not subject to **Deductible** or office visit **Copayments**.

Vision screenings for **Participants** age 6 and older are not considered preventive and are subject to **Deductible** and specialty **Provider** office visit **Copayment** as applicable.

Two visits for orthoptic eye training are covered per lifetime per **Participant;** the first session for training, the second for follow-up. All additional visits are excluded.

5. Exclusions & Limitations

The following is a list of services, treatments, equipment or supplies that are excluded, meaning no benefits are payable under the **GHIP**, or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by your **Health Plan** and the **PBM**. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy benefit administered by the **PBM**. Some of the services listed exclusions may be medically necessary, but still are not covered under this program. Others may be examples of services which are not medically necessary or not medical in nature, as determined by your **Health Plan** and/or **PBM**. As discussed in Section 4. D. Medical Necessity above, the determination of medical necessity is ultimately reached by your **Health Plan.**

A. Excluded Services

The services described in this section are specifically not covered by the **GHIP**.

Administrative & Clerical Charges

1. Charges for any missed appointment.
2. Expenses for medical reports, including preparation and presentation.

Care Needed for Employment

3. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, Smallpox vaccinations, etc.).
4. Vocational rehabilitation including work hardening programs.
5. Physical exams for employment.

Cosmetic Treatments & Services

6. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to **Congenital** bodily disorders or conditions or when associated with covered reconstructive surgery due to an **Illness** or accidental **Injury** (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
7. Removal of skin tags.

Durable Medical Equipment, Durable Diabetic Equipment, and Medical Supplies

8. **Durable Medical Equipment, Durable Diabetic Equipment,** or **Medical Supplies** that are not **Prior Authorized** by your **Health Plan.**
9. **Durable Medical Equipment** and **Medical Supplies** that are provided solely for comfort, personal hygiene and convenience items. Examples of these items include, but are not limited to:
    a) wigs,
    b) hair prostheses,
    c) air conditioners,
    d) air cleaners,
    e) humidifiers,
    f) physical fitness equipment,

g) physician's equipment,
h) disposable supplies,
i) alternative communication devices (for example, electronic keyboard for a hearing impairment),
j) 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.
k) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts.
l) Customization of buildings for accommodation (for example, wheelchair ramps).
m) Replacement or repair of **Durable Medical Equipment** or **Medical Supplies** damaged or destroyed by the **Participant** or lost or stolen.
n) Cold therapy and continuous passive motion devices.
o) Home testing and monitoring supplies unless **Prior Authorized** by your **Health Plan**.
p) Equipment required for **Telehealth** visits.

Experimental & Investigational Treatments

10. **Experimental** services, treatments, procedures, equipment, drugs, devices or supplies, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).
11. 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-insured plans.
12. Coma stimulation programs.

Holistic/Homeopathic Treatments

13. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
14. Hypnotherapy.

Hospital Inpatient Services

15. Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.
16. **Hospital** stays which are extended for reasons other than medical necessity.
17. 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**.

Included or Bundled Services

18. Treatment, services and supplies for which the **Participant** has no obligation to pay or which would be furnished to a **Participant** without charge. These include services or supplies that are typically billed as a part of another service when the service cannot be provided without using the supply or service (e.g., gauze used during surgeries, remote monitoring appliance, etc.). These are sometimes referred to as "bundled services."

Informational Medical Exams and Testing

19. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in Section 4. F. Covered Services.
20. Genetic testing and/or genetic counseling services not medically necessary to diagnose and treat and **Illness**.

Injuries Resulting from Military Action

21. **Injury** or **Illness** caused by an atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
22. 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.

Non-Medically Necessary Residential & Personal Care Services

23. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the **GHIP**.
24. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
25. Residential care except residential care and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.
26. Private Duty Nursing/Personal Care.
27. Services provided by members of the **Subscriber's Immediate Family** or any person residing with the **Subscriber**.

Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

28. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in Section 4. F. Covered Services, Oral Surgery & Other Dental Services above, or which would be covered if it was performed by a physician and is within the scope of the dentist's license.
29. All dental, periodontal, endodontic, or oral surgical procedures not specifically listed in Section 4. F. Covered Services above.

Other Non-Covered Services

30. Services provided by **Out-of-Network Providers**, unless you are enrolled in the **Access Plan**, or another **Preferred Provider Organization (PPO)** plan. This includes non-physician services provided by an **Out-of-Network Provider**, unless you have received **Prior Authorization** from your **Health Plan**, the service is an **Emergency** or **Urgent Care** service outside of the **Service Area**, or an **Emergency** in the **Service Area** when your **Primary Care Provider** cannot be reached. See Section 4. B. Exceptions to In-Network Care Requirement for more information.
31. Services of a specialist without an **In-Network Provider's** written **Referral**, except in an **Emergency** or by written **Prior Authorization** of the **Health Plan.**
32. Any **Hospital** or medical care or service not provided for in this document unless authorized by the **Health Plan**.
33. Charges directly related to a non-covered service except when a complication results from the non-covered service that could not be reasonably expected, and the complication requires medically necessary treatment that is performed by an **In-Network Provider** or **Prior Authorized** by the **Health Plan**. The treatment of the complication must be a covered benefit of the **Health Plan** and **PBM**.
34. Any smoking cessation program, treatment, or supply that is not specifically covered in Section 4. F. Covered Services, Smoking Cessation.
35. Marriage/couples/family counseling.

Reproductive Services

36. 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**.
37. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
38. Services for storage or processing of sperm; donor sperm.
39. Harvesting of eggs and their cryopreservation.
40. 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.
41. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
42. Services of home delivery for childbirth.
43. Sexual counseling services related to infertility.
44. Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

Routine Foot Care

45. The examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet.
46. Cutting, trimming or other nonoperative partial removal of toenails. *Note:* This exclusion does not apply when services are intended to treat a metabolic or peripheral disease or a skin or tissue infection.
47. Treatment of flexible flat feet.

Services Covered by Other Payors

48. 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 and does not enroll in **Medicare Part B** when it is first available as the primary payor, or who subsequently cancels **Medicare** coverage, or is not enrolled in a **Medicare Part D Plan**. See Section 2. F. Medicare Enrollment.
49. Treatment, services, and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services, and supplies for which the **GHIP** is the primary payor, and the VA is the secondary payor under applicable federal law. **Benefits** are not coordinated with the VA unless specific federal law requires such coordination.
50. Treatment, services, and supplies to which the **Participant** would be entitled to have furnished or paid for, fully or partially, under any law, regulation, or agency of any government.
51. Treatment, services, and supplies to which the **Participant** would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government if this contract was not in effect.
52. Services that a child's school is legally obligated to provide, whether the school actually provides the services and whether the **Participant** chooses to use those services.
53. Services to the extent a **Participant** receives or is entitled to receive, any **Benefits**, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means the **Participant** is actually insured under Worker's Compensation.

Services Not Medically Necessary

54. Any service, treatment, procedure, equipment, drug, device, or supply which is not reasonably and medically necessary or is not required in accordance with accepted standards of medical, surgical or psychiatric practice.
55. 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.
56. **Maintenance Care**. The determination of what constitutes "**Maintenance Care**" is made by the **Health Plan** after reviewing an individual's case history or treatment plan submitted by a **Provider**.

Services Outside of Enrollment

57. Expenses incurred prior to the **Effective Date** of coverage by the **Health Plan** and/or **PBM**, or services received after the **Health Plan** and/or **PBM** coverage or eligibility terminates

Services Related to the Commission of a Crime

58. Treatment or service in connection with any **Illness** or **Injury** caused by a **Participant** either engaging in an illegal occupation or the commission of, or attempt to commit, a felony.
59. Services related to an **Injury** that was self-inflicted for the purpose of receiving **Health Plan** and/or **PBM Benefits**.

Therapies Not Covered

60. Treatment, services, or supplies used in educational or vocational training.
61. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).
62. Except for services covered under the **Habilitation Services** therapy **Benefit**, and mandated **Benefits** for autism spectrum disorders under Wis. Stat. § 632.895 (12m) therapies.
63. Physical fitness or exercise programs.
64. Biofeedback, except that provided by a physical therapist for treatment of headaches, spastic torticollis, and urinary incontinence.
65. Massage therapy.

Transplants & Donor-Related Services

66. Services in connection with covered transplants not **Prior Authorized** by the **Health Plan**.
67. Costs related to a failed transplant that is otherwise covered under the global fee.
68. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
69. All separately billed donor-related services, except for kidney transplants.
70. Non-human organ transplants or artificial organs.
71. Transplants not performed at a facility designated by the **Health Plan**.
72. Services of a blood donor. Medically necessary autologous blood donations are not considered to be services of a blood donor.

Travel & Transportation

73. Charges for, or in connection with, travel, except for ambulance transportation as outlined in Section 4. F. Covered Services. This includes but is not limited to meals, lodging and transportation.

Weight Loss, Diet Programs, & Food or Supplements

74. Weight loss programs including dietary and nutritional treatment in connection with obesity unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan**. This does not include **Nutritional Counseling** as provided in Section 4. F. Covered Services, Nutritional Counseling.
75. Any diet control program, treatment, or supply for weight reduction unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the **Health Plan.**
76. Food or food supplements except when provided during a covered outpatient or inpatient **Confinement**.

Vision Correction

77. Eyeglasses or corrective contact lenses.
78. Fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery or keratoconus.
79. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens.
80. Keratoefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.

B. Coverage Limitations

Major Disaster, Epidemic, or Pandemic

If a major disaster, epidemic, or pandemic occurs, **In-Network Providers** and **Hospitals** must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the **PBM** and its **Participating Pharmacies**.

During a major disaster, epidemic, or pandemic, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** if services are unavailable from **In-Network Providers** and/or **Participating Pharmacies**. Any novel services developed that receive emergency authorization or other short-term clearance from applicable federal agencies for use to address the disaster, epidemic, or pandemic, may be covered by the **Health Plan**, subject to instruction by **ETF**.

Circumstances Beyond the Health Plan's Control

If, due to circumstances not reasonably within the control of the **Health Plan**, such as a complete or partial insurrection, labor disputes not within the control of the **Health Plan**, disability of a significant part of **Hospital** or medical group personnel, or similar causes, the provision of services and other **Benefits** covered hereunder is delayed or rendered impractical, the **Health Plan**, **In-Network Providers** and/or the **PBM** will use their best efforts to provide services and other **Benefits** covered hereunder. In this case, **Participants** may receive covered services from **Out-of-Network Providers** and/or **Non-Participating Pharmacies** so long as services remain disrupted.

6. Coordination of Benefits

A. Applicability

This Coordination of Benefits (COB) provision applies to the **GHIP** when a **Participant** has health care coverage under more than one **Plan** at the same time.

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

a) Shall not be reduced when, under the order of benefit determination rules, the **GHIP** determines its benefits before another **Plan**, but
b) May be reduced when, under the order of benefit determination rules, another **Plan** determines its benefits first. This reduction is described in Section C. Effect on the Benefits of The GHIP.

B. Order of Benefit Determination Rules

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

a) The other **Plan** has rules coordinating its benefits with those of the **GHIP**, and
b) Both those rules and the **GHIP's** rules described in the Rules subsection below require that the **GHIP's** benefits be determined before those of the other **Plan**.

Rules

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

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 paragraph c) below, when the **GHIP** and another **Plan** cover the same child as a **Dependent** of different persons, called "parents":
   i) The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year are determined before those of the **Plan** of the parent whose birthday falls later in that calendar year, but
   ii) If both parents have the same birthday, the benefits of the **Plan** which covered the parent longer are determined before those of the **Plan** which covered the other parent for a shorter period of time.

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

c) **Dependent** Child/Separated or Divorced Parents
If two or more **Plans** cover a person as a **Dependent** child of divorced or separated parents, benefits for the child are determined in this order:
   i) First, the **Plan** of the parent with custody of the child,

ii) Then, the **Plan** of the spouse of the parent with the custody of the child, and
iii) Finally, the **Plan** of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' **Plans** have actual knowledge of those terms, benefits for the **Dependent** child shall be determined according to paragraph b) above.

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

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 paragraph d) is ignored.

e) Continuation Coverage
If a person has continuation coverage under federal or state law and is also covered under another **Plan**, the following shall determine the order of benefits:
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.

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

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.

C. Effect on the Benefits of the GHIP

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

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

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

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

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

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

a) The persons it has paid or for whom it has paid,
b) Insurance companies, or
c) Other organizations.

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

G. Subrogation

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

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

b) The **Participant's** own uninsured motorist insurance coverage.
c) Under-insured motorist insurance coverage.
d) Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

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

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

7. Member Rights & Responsibilities

Your **Health Plan** shall comply with and abide by the Patient's Rights and Responsibilities as provided in **ETF's** annual **Open Enrollment** materials. **Health Plans** that have their own Patient's Rights and Responsibilities may use them unless there is a conflict with the **ETF's** materials. In this case, the Patient's Rights and Responsibilities which are more favorable to the **Participant** will apply.

A. New Rights to Benefits Transparency (Rules Pending)

In 2021, the U.S. Congress passed the No Surprises Act. This Act adds new rights to benefits coverage transparency, such as **Advanced Explanations of Benefits (A-EOBs),** searchable **Provider** directory requirements, and access to price comparison tools through your **Health Plan**. While the law states that these rights are effective January 1, 2022, the federal government is still writing the rules that your **Health Plan** must follow to comply with the new requirements. Your **Health Plan** will notify you when each of these new services or features become available. In the meantime, you can check out https://etf.wi.gov/no-surprises-act to find more information on the provisions of the law and any updates on when changes will be implemented.

B. Disenrollment Due to Fraud

No person other than a **Participant** is eligible for health **Benefits** under this policy. The **Subscriber's** rights to group health **Benefits** coverage is forfeited if a **Participant** assigns or transfers such rights or aids any other person in obtaining **Benefits** to which they are not entitled, or otherwise fraudulently attempts to obtain **Benefits**. Coverage terminates the beginning of the month following action of the **Board**. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual **Open Enrollment** period. Re-enrollment options may be limited under the **Board's** authority.

The **Board** may forfeit a **Subscriber's** rights to the health **Benefit** program if a **Participant** fraudulently or inappropriately assigns or transfers rights to an ineligible individual, aids any other person in obtaining **Benefits** to which they are not entitled, or otherwise fraudulently attempts to obtain **Benefits**.
ETF may at any time request such documentation as it deems necessary to substantiate **Subscriber** or **Dependent** eligibility. Failure to provide such documentation upon request may result in the suspension of benefits.

The **Health Plan** shall report to **ETF** any suspected or identified **Participant** fraud. The **Health Plan** must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the **ETF**. Fraud may result in the reprocessing of claims and recovery of overpayments.

C. Enrollment Change Due to Member Behavior

In situations where a **Participant** has committed acts of physical or verbal abuse or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate **Primary Care Provider**, disenrollment efforts may be initiated by the **Health Plan** or the **Board**. The **Subscriber's**

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

D. Right to Obtain and Provide Information

Each **Participant** agrees that the **Health Plan** and/or **PBM** may obtain from the **Participant's** health care **Providers** the information (including medical records) that is reasonably necessary, relevant and appropriate for the **Health Plan** and/or **PBM** to evaluate in connection with its treatment, payment, or health care operations. Each person claiming **Benefits** must, upon request by the **Health Plan**, provide any relevant and reasonably available information which the **Health Plan** believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each **Participant** agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the **Health Plan** and/or **PBM** but also disclosures to:

1) Health care **Providers** as necessary and appropriate for treatment,
2) Appropriate **ETF** employees as part of conducting quality assessment and improvement activities, or reviewing the **Health Plan's** or **PBM's** claims determinations for compliance with contract requirements, or other necessary health care operations,
3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

E. Physical Examination

The **Health Plan**, at its own expense, shall have the right and opportunity to examine the person of any **Participant** when and so often as may be reasonably necessary to determine their eligibility for claimed services or benefits under the **GHIP** (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the **Health Plan**, each **Participant** shall be deemed to have waived any legal rights they may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

F. Proof of Claim

It is the **Participant's** responsibility to notify their **Providers** of participation in the **Health Plan** and **PBM**.

The **Participant's** failure to notify an **In-Network Provider** of membership in the **GHIP** may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If a **Participant** received allowable covered services (in most cases only emergencies or urgent care) from an **Out-of-Network Provider** outside the **Service Area**, the **Participant** must obtain and submit an itemized bill and submit to the **Health Plan** clearly indicating the **Provider's** name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of the claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the **Health Plan** and/or **PBM** does not receive the claim within twelve (12) months, or if later, as soon as reasonably possible, after the date the service was received, the **Health Plan** and/or **PBM** may deny coverage of the claim.

8. Grievances & Appeals

A. Grievance Process

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

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

However, the **Participant** may not appeal to **ETF** issues which do not arise under the terms and conditions of this **Certificate of Coverage**, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, **Experimental** treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. The **Participant** may request an external review. In this event, the **Participant** must notify the **Health Plan** and/or **PBM** of their request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. The **Participant** has no further right to administrative review once the external review decision is rendered.

B. Appeals to the Group Insurance Board

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